

# DISCUSSING ANOREXIA

A conversation analytical study on treatment discussions  
between anorexic patients and professionals

Hanna Falk

*Academic dissertation*

*To be presented, with the permission of the Faculty of Social Sciences of the  
University of Helsinki, for public examination in Auditorium XIV, University Main  
Building, on 30<sup>th</sup> August 2013, at 12am.*

Publications of the Department of Social Research 2013:11  
Sociology

© Hanna Falk

Cover: Jere Kasanen  
Photo: XXXXX XXXX

Distribution and Sales:  
Unigrafia Bookstore  
<http://kirjakauppa.unigrafia.fi/>  
[books@unigrafia.fi](mailto:books@unigrafia.fi)  
PL 4 (Vuorikatu 3 A) 00014 Helsingin yliopisto

ISSN-L 1798-9140  
ISSN 1798-9132 (Online)  
ISSN 1798-9140 (Print)  
ISBN 978-952-10-9064-6 (Print)  
ISBN 978-952-10-9065-3 (Online)

Unigrafia, Helsinki 2013

# Contents

## Contents

### Abstract

### Acknowledgements

### Transcription symbols

<b>Introduction</b> .....	1
<b>1. Eating disorders and their treatment</b> .....	4
1.1. Eating disorders .....	4
1.2. Anorexia Nervosa .....	4
1.2.1. Evaluation .....	6
1.3. Treatment .....	7
1.3.1. Central ideas of hospital treatment .....	8
1.3.2. Structure of hospital treatment .....	9
1.3.3. Psychiatric treatment and psycho education .....	10
1.4. Challenges .....	12
1.5. Hospital environment, eating disorders and social sciences.....	13
1.6. Summary .....	15
<b>2. Method</b> .....	16
2.1. Conversation analysis .....	16
2.1.1. Units of analysis .....	17
2.2. Study of institutional interaction .....	19
2.2.1. Study of institutional interaction in medical care and psychotherapy .....	21
2.3. Data analysis and the research project .....	24
2.4. Summary .....	26
<b>3. Suggesting a problem with thoughts and desires</b> .....	27
3.1. Introduction .....	27
3.2. Pursuing problematic issues in health care .....	27

3.3. Suggesting a problem with thoughts and desires .....	29
3.3.1. Introducing the suggestion .....	30
3.3.2. Continuing the suggestion .....	39
3.3.3. Re-suggesting the problem .....	52
3.4. Summary .....	60
<b>4. Delivering psycho educative turns .....</b>	<b>63</b>
4.1. Conveying a professional view .....	64
4.2. Psycho education in an understanding and supportive context .....	66
4.3. Stepwise move to the educative turn .....	67
4.4. The educative turn.....	77
4.5. Summary .....	100
<b>5. Between professional theory and patient individuality .....</b>	<b>102</b>
5.1. Data .....	104
5.1.1. The Kiddie – Sads – present and lifetime diagnostic interview .....	104
5.2. Half-structured interview as a focus of research .....	105
5.2.1. CA and the institutional interaction in interview situations.....	106
5.2.2. Between professional theory and patient individuality .....	107
5.3. Balancing between professional theory and patient individuality .....	109
5.3.1. Explicating the questionnaire .....	109
5.3.2. Establishing a mutual understanding of the theme .....	122
5.3.3. Follow-up turns related ranking of answer options .....	130
5.3.4. Referring to the questionnaire .....	136
5.4. Summary .....	142
<b>6. Patients’ resisting turns: The turn initial “I don’t know” (emmä tiää) .....</b>	<b>145</b>
6.1. Prior research .....	146
6.2. “I don’t know” in the data .....	147
6.2.1. Turn-initial “I don’t know” as part of a resisting turn .....	148
6.3. Function of the turn-initial “I don’t know” in a resisting turn .....	152

6.3.1. Evasive .....	152
6.3.2. Transforming the frame of the conversation .....	159
6.4. Taking a distance from the professional's agenda .....	164
6.4.1. Talking about the illness .....	165
6.5. Summary .....	171
<b>7. Discussion</b> .....	<b>173</b>
7.1. Summary of the results .....	174
7.2. Study of institutional interaction and treatment of anorexic patients .....	176
7.3. Use of the results and possible topics for further research .....	177
<b>References</b> .....	<b>179</b>



## **Abstract**

This dissertation examines the institutional interaction in the treatment of anorexic patients. The research describes how challenges of the treatment of adolescent eating disordered patients described in the literature and standard care guidelines are visible in the interaction of the treatment discussions between the professionals and the patients. This study shows how these different challenges and central concepts are visible in the interaction, how they are manifested by interactional choices and how the challenges are thus reproduced in the interaction.

The four empirical chapters look at the professionals' interactional ways of pursuing the patient's recognition of illness, confronting her by suggesting a problem in the treatment and producing psycho educative turns using a supportive, understanding approach . One chapter focuses on the psychiatrist's ways of creating a co-operational, shared situation in a half-structured diagnostic interview. The last empirical chapter examines the notion of resistance from the patient's perspective: the patient's ways of producing resisting turns using the turn-initial "I don't know."

The data consists of one-on-one discussions between the patients and professionals involved in the treatment. All the patients in this data suffer from anorexia nervosa and are 13-17-year-old girls in the fairly early stages of this treatment program. The analysis is conducted using conversation analysis as method.

The main result is that the central challenges considered by the professionals involved in the treatment can be clearly pinpointed in the interaction. The treatment situation The analysis of this study shows that professionals use specific interactional ways to work with the different challenges and to implement an approach.

One central finding of this study is that professionals use the patients' own words to carry out their interactional projects, be it suggesting a problem in the patient's thoughts and desires or producing psycho educative turns. The study shows on the level of immediate interaction how professionals direct the discussion towards showing patients their relation to the illness, its symptoms, and the actions they take due to the illness.

The study also shows how patients carry out the resistance mentioned in the text-books. On the level of immediate interaction, resistance is not by any means limited to a clear denial of the illness or un-co-operative behavior.

The results relate strongly to results found in conversation analytical studies on psychotherapeutic interaction and interaction concerning the treatment of addictions.



## Acknowledgements

First of all, I want to thank the patients and the medical professionals who participated in this research and allowed me to film their private discussions. I also thank the Helsinki University Hospital for Children and Adolescents, especially Dr. Veli-Matti Tainio for his help and cooperation.

The thesis has been funded by the Gyllenberg foundation and Emil Aaltonen foundation. Emil Aaltonen foundation granted me a three year scholarship for young researchers. I'm thankful for that.

A big thank you to my supervisor Anssi Peräkylä, whose idea this whole thesis was in the first place. He has introduced me to the research of institutional interaction and provided the best possible supervision. He has also supported me with the different choices I have made during these years regarding this process.

This dissertation is part of the research project "*Emotion, interaction and institutions*". I want to thank Anssi P. and Johanna Ruusuvuori for their many, many valuable comments, encouragement and guidance. I'm also deeply grateful to Liisa Voutilainen, Taru Ijäs-Kallio and Mikko Kahri for all their valuable comments, discussions, peer support and the fun, relaxed atmosphere.

I wish to thank the pre-examiners of this thesis, Sanna Vehviläinen and Tim Rapley for their many essential comments. I also thank Esa Lehtinen for agreeing to be my opponent.

I thank Charles Antaki, who also has read and commented my dissertation. I also thank all the different participants in the data sessions during these years for their comments and discussion: Mika Simonen, Nataliya Kondratyuk, Melisa Stevanovic, Timo Kaukoma, Maari Kivioja, Elina Weiste as well as Liisa, Taru and Mikko.

I thank the participants and teachers of the "Thursday seminar" of the discipline of Sociology for their comments. I also want to mention my fellow sociologists from the year 1998, especially my dear friend Maria Leinvuo!

I thank my childhood friends Milla, Lotta and Telle for their friendship and important encouragement! Especially Telle, who is a survivor of a similar project has been able to speak from experience and give me hope.

Thank you Liisa Voutilainen for becoming my good friend and all our talks and your peer support. I really hope we can be colleagues in the future!

I thank my father in law Olli, my mother in law Eija and Pekka. Special thanks to Eija-Mamma and Pekka for their numerous childcare sessions. I also thank my dear in law family Annina, Markus, Vilppu and Helmi for being an important part of my life, for all our summers at Mustikkaranta with many more to come.

I thank my dearest brother Anssi and his family, Henna and Ebba. Thank you Anssi for your cooperation in our creative projects in our childhood, it has created a basis for my current creative work. Thank you Henna and Anssi for all our talks and relaxed times, past and future.

I want to thank my grandparents, although they have passed away many years ago. I especially want to remember my grandmother, Mummi, who was a part of my daily life since I was a baby until I was 14 years old.

I'm deeply grateful for my parents, Liisa and Pasi for their love, support and encouragement. Thank you for providing me with a feeling of being important, loved, competent and able to carry out this kind of a project. You have also provided me with an appreciation of academic education. Thank you mother for your love, support, humor and great help! In this context I especially have to mention my father, because he is the reason I have come to study sociology in the first place. Thank you for giving me the opportunity to find the researcher in me. Thank you also for being Alvar's dear Mummi and Pappa and for taking care of him.

Finally, I thank my spouse Auri. Thank you for your love, life, laughter, support and all the emotions and interaction! We have been together for 14 years and I wouldn't want to spend my life anywhere else. Two years ago our lives changed when our son Alvar was born. I'm so thankful for him and to him for the unimaginable amount of love he has brought to my life. Thank you Alvar for your funny and witty comments! I'm so happy to see you are an observant boy with a kind and empathetic personality.

This autumn our lives will change again as there will be four of us. I dedicate this book to my family.

I end these acknowledgements citing the words of Alvar, who at the moment expresses his gratitude towards everybody and everything:

“Thank you car, thank you lake, thank you waters.”

Thank you life!

Mustikkaranta, Somero, July 2013

Hanna Falk

## Transcription symbols

P:	Speaker identification
[ ]	Brackets: onset and offset of overlapping talk
=	Equals sign: no gap between two utterances
(0.0)	Timed pause: silence measured in seconds and tenths of second
(.)	A pause less than 0.2 second
.	Period: falling or terminal intonation
,	Comma: level intonation
?	Question mark: rising intonation
↑	Rise in pitch
↓	Fall in pitch
-	A dash at the end of a word: an abrupt cutoff
<	The talk immediately following is “jump started”, it begins with a rush
><	Faster-paced talk than the surrounding talk
<>	Slower-paced talk than the surrounding talk
___	Underlining: some form of stress, audible in pitch or amplitude
:	Colon(s): prolongation of the immediately preceding sound
◦ ◦	Degree sign surrounding a passage of talk: talk at a lower volume than the surrounding talk
.hh	A row of hs preceded by a dot: an inbreath
hh	A row of hs without a dot: an outbreath
##	Number signs surrounding a passage of talk: spoken in a “creaky” voice (vocal fry)
£	Smiley voice
@	Animated voice

## Introduction

Food, obesity, dieting and the right kind of nutrition are a focus of attention and discussion in Western society today. One phenomenon related to this topic is eating disorders, which are syndromes related to abnormal eating behavior and lead to the disruption of an individual's mental, physical or social performance. Over the past few decades, young women have become especially vulnerable for such disorders, the most common of which are starvation disorder (*anorexia nervosa*) and binge eating disorder (*bulimia nervosa*) (Suokas & Rissanen 2007, 355).

Within the medical field eating disorders are considered as difficult and complex illnesses, and their treatment is a challenge for professionals as well as patients. Eating disorders are both mental and somatic illnesses and thus especially serious and difficult. Due to the psychiatric aspect of the illness, denial and resistance to treatment is common. On the other hand, the physical aspect, i.e. the lack of nutrition, causes severe somatic symptoms and at its worst is fatal (Suokas & Rissanen 2007, 356).

In anorexia, attempts at normalizing eating behavior are experienced as uncomfortable. For many patients, the denial of illness and avoidance of treatment are among the main obstacles to therapeutic engagement. Clinicians are often placed in a position of constantly attempting to persuade reluctant patients to change their behavior (Guarda & Coughlin 2009, 171-172). It is crucial for the motivation of the patient and the ultimate success of the treatment that the relationship between the professional and the patient be based on trust and understanding. It is also important for professionals to be supportive and firm and to assume a guiding role (Suokas & Rissanen 2007, 362). The professional's role in psycho-education is often similar to that of a trainer's, constantly encouraging the practice of healthy behaviors (Guarda & Coughlin 2009, 173). Eating disordered patients often have a need to please, and avoid expressing their own views directly. This is a challenge, as they can express acceptance and alignment towards the treatment but still continue their hazardous behavior (Kuusinen 2001, 218).

The serious illness, which is deadly at its worst and a treatment process with patients inclined to resist treatment, make up a complex combination of aims and challenges for professionals. As mentioned above, the right kind of interactional approach is significant during the treatment process and crucial to its success. In other words,

professionals must educate patients about their illness, its symptoms and how it creates skewed perceptions of eating and body image. This must also be done in an understanding, supportive and firm way. It must be very challenging when the other participant has a complex and/or reluctant approach to the subject at hand, the treatment and the recovery process. Most of the challenges usually arise because the patient does not consider herself ill, and resists treatment, the central aim of which is to get the patient to acknowledge her/his illness. Thus interaction and its special features play a crucial role in the recovery process and should thus be studied more closely.

This study responds to this need by focusing on the treatment of patients with anorexia, and the interaction between professionals and patients in a setting providing such treatment. The methodological and theoretical tools of this research derive from conversation analysis, especially the conversation analytical study of institutional interaction. The aim of this research is to describe how the challenges involved in the treatment of adolescent eating disordered patients are visible in the interaction during treatment discussions between the professionals and the patients.

The study has been carried out in collaboration with doctor Veli-Matti Tainio, head of the centralized services of HUS (the Hospital District of Helsinki and Uusimaa) child and adolescent psychiatric clinics. The study is part of the Academy of Finland project “Emotion, Institutions, Interaction”, led by Professor Anssi Peräkylä with Dr. Johanna Ruusuvaori as a senior researcher. Other studies in this project deal with emotion in cognitive therapy (Liisa Voutilainen), interaction between doctors and patients with respiratory conditions in primary healthcare (Taru Ijäs-Kallio) and mother-infant interaction (Mikko Kahri). In addition to this doctoral thesis, the data has been used in two separate master’s theses, one by Elina Weiste and the other by Suna Pyykkö.

The video recorded data of this study come from the day treatment unit for eating disordered adolescent patients of The Helsinki University Hospital for Children and Adolescents. The data consist of dyadic discussions between patients and professionals involved in the treatment. All the patients in this data suffer from anorexia nervosa and are 13-17-year-old girls in fairly early stages of this treatment program. The patients spend the days at the unit, nights and weekends at home. The treatment is full time, so the patients do not attend regular school classes. They are treated by a multi-

professional team with psychiatric nurses, a pediatrician, a psychiatrist, a dietician, a physiotherapist and a social worker. The nurses have the closest contact with the patients, spending the most time with them during the days. All patients have their own nurse and they have weekly one-to-one discussions. The patients meet regularly with the other members of the team. At the unit the patients have a daily timetable with regular meal times and weightings. Each patient has a meal plan that is planned with the dietician and updated regularly. They also have group discussions.

Of the seven chapters in this study four are empirical. The first chapter will introduce the reader to the medical professionals' perceptions of eating disorders, especially anorexia nervosa, and their treatment. The second chapter introduces the reader to conversation analysis, the study of institutional interaction and especially that of medical care and psychotherapy. The third chapter focuses on the notion of resistance and lack of recognition of illness. It considers the professionals' interactional ways of pursuing the patient's recognition of illness, confronting her by suggesting a problem in the patient's treatment. In the fourth chapter I focus on psycho education and a supporting, understanding approach to the patient. The fifth chapter deals with the psychiatrist's ways of creating a co-operational, shared situation in a half-structured diagnostic interview. The sixth chapter focuses on the notion of resistance from the patient's viewpoint, and looks at patients' misaligning turns by using the turn-initial "I don't know" as a window for the analysis.

The seventh and last chapter is a summary of the results of this study and a discussion.

# **1. Eating disorders and their treatment**

In this chapter I will introduce the reader to eating disorders and their treatment. There is a great deal of literature on eating disorders written for different audiences: the patients (Van Der Ster 2005, Crisp et al. 1996), their parents (Charpantier et al. 2010) and by professionals for professionals (Lönqvist et al. 2007). I will mainly focus on the official texts of Finnish psychiatry textbooks and standard care-guidelines concerning the treatment of eating disordered patients. By doing this I want to present to the reader the professional norms, knowledge and resources framing the interaction. At the end of the chapter I will take a brief look at the social scientific research on eating disorders.

## **1.1. Eating disorders**

Within the medical field eating disorders are considered as syndromes related to abnormal eating behavior, which lead to severe disruption in mental, physical and social functions. In the ICD-10 disease classification, eating disorders are divided into anorexia nervosa (starvation), bulimia nervosa (pathological binge eating), their less common variations, and other eating disorders (Suokas & Rissanen 2007, 355). Eating disorders are most common among young girls. Still, the number of boys affected is increasing and nearly every tenth person suffering from an eating disorder is male. The lifetime prevalence of any eating disorder has been reported as 17.9% among women and 6.5% among men (Pompili et al. 2006, 9). The incidence of eating disorders has clearly increased during the past decades (Suokas & Rissanen 2007, 355).

As the main diagnosis of the patients in the data of this study is anorexia nervosa, I will focus on this disorder more specifically, leaving the other eating disorders aside.

## **1.2. Anorexia Nervosa**

According to the official Finnish standard care guidelines, as well as psychiatry textbooks, anorexia nervosa is an intentionally inflicted and maintained state of starva-

tion. It usually begins at the age of 12-18 from an attempt to lose weight, which then leads to an uncontrolled cycle of starvation. A typical anorexia patient is a 14 to 16-year-old girl (Suokas & Rissanen 2007, 355-356; <http://www.kaypahoito.fi/web/kh/suositukset/naytaartikkeli/.../hoi33030>).

The central feature of this disorder is the fear of being fat and a skewed body image. Individuals suffering from this illness aim for a very low target weight, which then tends to shift downwards as the dieting progresses. They adopt very limited eating habits and exercise compulsively. In a prolonged disorder medical consequences are common and usually very severe. Girls begin to lack normal menstruation (*amenorrhea*), and patients suffer from the depletion of bone structure (*osteopenia*) as well as other symptoms caused by starvation and possible vomiting or use of laxatives. Also, binge eating, vomiting and the use of laxatives or diuretics occasionally occur in about half of the cases. In appearance patients can be very thin with bluish limbs, dry skin and lanugo hair. Their heart rate and metabolism slow down, and they have low blood pressure as their body tries to maintain the most important vital signs. During their lifetime anorexia patients suffer more than average from severe depression and anxiety disorder. Three out of four school-aged patients with eating disorders suffer from another psychiatric disorder. The traits of an obsessive-compulsive personality disorder and demanding personality are related to anorexia. These traits tend to stay with the patient even after they recover from anorexia (Suokas & Rissanen 2007, 356-357).

As the starvation of the patient progresses, the denial of the symptoms usually increases. An anorexic patient usually covers her thinness with clothes and rationalizes her behavior by describing it as healthy dieting. Noticing the weight loss usually raises a strong emotional reaction in the patient's family, but the patients themselves are not usually worried about their state (Suokas & Rissanen, 2007, 355-356).

About half of anorexia patients recover completely, 30% continue to have symptoms and 10%-20% become chronic anorexics. Later on, patients have been shown to suffer from depression, personality disorders and compulsive-obsessive disorder. The gravity of the disease, a low BMI and a long period of illness before getting treatment are



factors that worsen the prognosis. Intensive treatment can improve this: intensive psychotherapeutic and somatic treatment has been found to reduce early mortality related to eating disorders. Diverse somatic and psychotherapeutic treatment also reduces later mortality

(<http://www.kaypahoito.fi/web/kh/suositukset/naytaartikkeli/.../hoi33030>).

There is no particular factor underlying anorexia nervosa. Factors involved in developing anorexia are psychological, biological, genetic as well as socio-cultural (Federici & Kaplan 2009, 1-11).

### **1.2.1. Evaluation**

According to Finnish standard care guidelines the basic medical evaluation of eating disordered patients is done in primary medical care. School health care is in a very important position in terms of the initial observation of possible eating disorders. Less serious disorders can be corrected with a few intensive supportive visits to the doctor. If the problem is not corrected quickly, the patient should be directed to a medical unit specialized in psychiatric and somatic assessment of eating disorders. More extensive examinations, especially of anorexic patients, should be implemented by specialized professionals. The aim of a child and adolescent psychiatric evaluation is to determine whether the patient is suffering from an eating disorder and whether any other simultaneous psychiatric symptoms or illnesses exist, paying special attention to possible self-destructivity. The patient's psychological development, performance and the effect of the disorder on the patient's childhood and adolescent development are also evaluated

(<http://www.kaypahoito.fi/web/kh/suositukset/naytaartikkeli/.../hoi33030>).

The child and adolescent psychiatric evaluation usually consists of the initial interview with the patient, individual examinations and meetings with the parents. The symptoms and illness are evaluated through getting to know both the patient's and the family's history. The patient's situation is examined from different perspectives while at the same time supporting the family. Based on the examinations

a treatment plan and agreement is made together with the patient and her family. (<http://www.kaypahoito.fi/web/kh/suosituksset/naytaartikkeli/.../hoi33030>).

The patient should already be motivated to undergo treatment during the evaluation process. Creating a relationship of trust is important, as many patients are reluctant to reciprocate and reveal their symptoms and habits. The support of the patient's friends and family is a significant factor in the success of the treatment. People close to the patient should display their concern even if the patient denies her symptoms. This still might help the patient to recognize the eating disorder (Suokas & Rissanen 2007, 361).

### **1.3. Treatment**

According to the Finnish standard care guidelines as well as textbooks, the choice of an anorexia patient's place of treatment is influenced by the patient's weight, somatic state and motivation for treatment. Outpatient treatment is usually the primary choice. The aim of the treatment is to correct undernourishment, normalize the patient's eating behavior and achieve a psychosocial recovery. That is possible if the patient's BMI is over 13 or the relative weight is over 70% of the average weight in relation to height. It requires that the patient be sufficiently motivated for treatment, and the situation must be improving quickly. Other requirements are that no other medical abnormalities exist, the patient is supported by her family and social network and she has not been previously hospitalized with anorexia. In situations where the patient resists the idea of hospital treatment despite her life threatening mental or somatic state, the treatment must be started in any case (<http://www.kaypahoito.fi/web/kh/suosituksset/naytaartikkeli/.../hoi33030>).

It is said that the beginning the treatment of an anorexic patient is often demanding because of the patient's ambivalence: he patients usually want to get better but resist the idea of weight gain and normal eating (Kuusinen 2001, 218). A trusting relationship between the patient and professional is very important. It is also essential for the professional to display understanding towards the patient. On the other hand, the professional should also display sufficient firmness and guidance for the patient to

be able to give up the destructive behavior. In the beginning of the treatment it is especially important to inspire and support the patient's personal motivation. An individually planned, punctual, firm and consistent treatment program is crucial. It is also important for the patient to be an active participant when planning the program (Suokas & Rissanen 2007, 362). Seriously ill anorexic patients are usually in need of hospital treatment at least in the early stages of their treatment.

Day treatment at the hospital is also possible for patients who are not in acute need of inpatient care but whose condition is debilitating to their everyday lives (Suokas & Rissanen 2007, 362). One clinical advantage of day treatment for some patients is that they are not removed from their usual environment during nights and weekends. For these individuals dependence on the inpatient unit may be avoided as they must self-regulate and self-monitor themselves whenever they are not in the day program. This may help them to be more independent as well as apply the learned skills and strategies from the treatment setting to real life. At the same time the patient is supported by hospital treatment and the treatment program (Dancyger, Fornari & Katz 2009, 108).

### **1.3.1. Central ideas of hospital treatment**

According to the standard care guidelines, studies show good results of early intensive treatment of adolescent anorexic patients. In the hospital the patients can be treated at the day ward so that they can spend the nights and weekends at home, but otherwise they concentrate solely on the hospital treatment and do not attend regular school classes. The patients in the data of this study are from a day treatment unit.

These patients are in the early stages of their treatment at the unit. Their treatment history, however, is longer, meaning that they have been treated elsewhere as outpatients and/or have been hospitalized for some periods of time in other hospitals before entering the Helsinki University Hospital and this particular unit. According to the Finnish standard care guidelines there is no research on the optimal length of hospital treatment. A healthy goal weight and a timeline to achieve this are set at the beginning of the hospital period. It is known that the risk of relapse is smaller the closer the patient is to the goal weight on discharge. Still, the length of the hospital period is based on

the need of treatment, and reaching the goal weight should not be the only criteria when defining this

(<http://www.kaypahoito.fi/web/kh/suositukset/naytaartikkeli/.../hoi33030>).

The patient's situation is evaluated taking into account possible other underlying mental disorders. Hospital treatment as well as further treatment after discharge are planned individually. It is also important to inform both the patient and her family about eating disorders. Their motivation is crucial for the success of the treatment. Supporting the patient's family is very important throughout the treatment (Suokas & Rissanen 2007, 360-361).

The hospital treatment of anorexic patients requires close cooperation and a clear division of responsibility in the multi-professional team in charge of diagnosis and treatment. The professionals responsible for the treatment should have sufficient knowledge of the bio-psycho-social physiopathology of eating disorders. They should also have enough understanding and experience of the possible emotions and emotional reactions that patients with eating disorders can arouse in the professionals involved in their treatment. The milieu of the treatment should be safe and offer patients clear boundaries as well as support and understanding. Today it is recommended to combine different methods and individual planning of the treatment. A more flexible, individually planned treatment program is known to be as effective as a strict and controlling one. It also helps to develop the young patient's ability to care of her better (<http://www.kaypahoito.fi/web/kh/suositukset/naytaartikkeli/.../hoi33030>).

### **1.3.2. Structure of hospital treatment**

According to the Standard Care Guidelines the treatment should focus on both somatic and mental problems. At first the priorities are normalizing the patient's nutritional state, eating habits and behavior. The patient's current consumption of food and the need of energy are assessed and the nutritional treatment is planned individually in cooperation between the patient, her family, the doctor and the dietician. A goal weight must be set for the patient. It must be set at a minimum to the weight at which the patient's menstruation is normalized (on average 90% of the average weight in relation to height), preferably a couple of kilograms over that. Intermediate targets are

important. They should be realistic and defined together with the patient (<http://www.kaypahoito.fi/web/kh/suosituksset/naytaartikkeli/.../hoi33030>). Monitoring the patient's behavior and weight gain is especially important at this point as the patients might have a tendency to hide food, vomit or try to fake weight gain by drinking water or hiding heavy objects in their clothes before weighing. It is still important that the professionals avoid an accusatory attitude towards the patient even if it is necessary to monitor the patient's behavior (Suokas & Rissanen 2007, 363).

The aim is for the patient to accept the idea of a normal weight, adopt a balanced, healthy diet and be able to eat in various social situations. The dietician plans the diet together with the patient. Although the dietician is in charge of planning the meals and guiding the patient in the process, the patient's opinions are also taken into consideration to a reasonable extent as this increases the patient's feeling of self-control and helps her to accept the weight gain. In the hospital the patients are expected to adjust to the hospital's meal times and they eat normal hospital food, an example of a nutritious meal. A weighing every three days is sufficient. If the patient is in critical condition and has to gain weight more quickly, exercise may be prohibited. All things related to the meal plan are discussed and decided between the multi-professional team in charge of the treatment, and everyone involved in the treatment is informed. The goal weight is gradually increased to match the average weight in relation to height. As the patient's overall situation improves, it is important to acknowledge her mental as well as social well being (<http://www.kaypahoito.fi/web/kh/suosituksset/naytaartikkeli/.../hoi33030>).

### **1.3.3. Psychiatric treatment and psycho education**

According to the textbooks and standard care guidelines psycho education plays an important role in the treatment process. Psycho education is an educative method of work used especially in the treatment of serious mental illnesses. Education is based on the existence of a serious illness and the realities related to it. The aim of psycho-education is to inform the patient about the disorder and the mechanism of the symptoms and their persistence. The education should touch upon issues such as normal weight, normal eating, symptoms of anorexia and their consequences, and teach the patient a normal way to eat. It is also important to educate the patient about the recov-

ery process, self-control, alternative behavioral patterns, problem solving skills and the skewed thoughts concerning weight and body figure. The professionals act as experts, conveying the correct information to the patient and in this way reassuring the patient in the recovery process (Suokas & Rissanen 2007, 364).

The psychosocial interventions aim to help the patient's psycho-pathology and her symptoms. This means helping the patient understand the importance of her nutritional and physical rehabilitation, recognize her feelings, understand and change harmful behavior and skewed perceptions about the eating disorder, and improve performance. In the acute state of the disorder in which correcting the nutritional state is the priority, full psychotherapy is not topical. On the other hand, patients often need psychotherapeutic work to be able to accept weight gain (<http://www.kaypahoito.fi/web/kh/suositukset/naytaartikkeli/.../hoi33030>).

By giving patients information and guidance about the illness professionals can help them perceive their illness and the skewed beliefs and false facts underlying the disordered eating behavior. Psycho education aims to emphasize one's own choices and decisions, an orientation especially important in the treatment of anorexic patients. They must feel that what is considered to be for their benefit is based on their assessment and no one else's (Kuusinen 2001, 219). Treatment is based on co-operation: the medical staff acts as experts who provide the patient with support, correct information on the illness and tools for recovery. The decision to get better and the work towards recovery are the patient's responsibility (Suokas & Rissanen 2007, 364).

Gaining the patient's trust takes time and effort, and successful treatment is possible only if the professional is supportive and empathetic. Recovering from severe anorexia requires new ways of thinking and acting. Psychotherapy is also a method of treatment after the acute phase of the illness, but there is no evidence, however, of any individual form of psychotherapy being clearly better than others, at least with adult anorexics (<http://www.kaypahoito.fi/web/kh/suositukset/naytaartikkeli/.../hoi33030>). Possible forms of therapy include cognitive-behavioral therapy (Pike & Yamanano 2009, 187-203), inter-personal psychotherapy (Murphy & al. 2009, 257-274), dialectical behavioral therapy (Wisniewski et. al 2009, 275-290), and later on in the process,

individual psychodynamic therapy (Suokas & Rissanen 2007, 365). Different methods can be used in treating child and adolescent anorexia as well (Suokas & Rissanen 2007, 364).

#### **1.4. Challenges**

As mentioned earlier, anorexia nervosa is a condition characterized by the denial of illness, ambivalence towards treatment and treatment resistance. Since dieting is strongly ego-syntonic in anorexia, attempts at normalizing eating behavior are experienced as uncomfortable. The denial of illness and avoidance of treatment are some of the main obstacles to therapeutic engagement for many patients. Clinicians are often placed in a position of constantly attempting to persuade reluctant patients to change their behavior (Guarda & Coughlin 2009, 171-172).

As most challenges usually arise from the resistance and lack of identifying the illness, the most demanding goal of the treatment is to get patients to recognize their own illness. It is crucial for the success of the treatment that the relationship between the professional and patient be based on trust and understanding in order for it to work and motivate the patient. It is also important for the professionals to be supportive and firm (Suokas & Rissanen 2007, 362). Psycho-education is also very important and the professional's role is often like a trainer's, constantly encouraging the practice of healthy behaviors (Guarda & Coughlin 2009, 173). The aim of this research is to describe how these central challenges of treating adolescent eating disordered patients are visible in the interaction during treatment discussions between professionals and patients. These challenges and the concepts related to them – resistance towards treatment, lack of recognition of illness, support and understanding, as well as co-operation and motivation – are widely referred to in the textbooks and guidelines. For example, resistance and fear of recovery are concepts not only used in the textbooks and guidelines aimed at professionals. Self help books aimed at both individuals suffering from this illness and their parents (Van Der Ster 2005, Crisp et al 1996, Charpentier 2010) deal with these issues as well, as they are concepts generally related to the illness and central to the discussion of the treatment in the textbooks. Nevertheless, these concepts and related challenges are rarely explicated and

problematized thoroughly but rather taken as givens. In this study my aim is to display how these concepts of resistance, co-operation, firmness, support and understanding as well as the challenges of treating a resisting, ambivalent patient are produced in the interaction. How is the idea of lack of recognition of the illness and the aim to pursue it manifested in the interaction? How is resistance visible in the patients' interaction and how do they display misalignment? How do the professionals deliver psycho educative turns that are not confrontational but instead supportive and understanding? How does the psychiatrist work to create a co-operational situation in a half-structured diagnostic interview, when a central challenge is to avoid the patient's feeling of being overruled and treated merely as a medical case?

In this study I focus on the notion of resistance and lack of recognition of the illness from the angle of both the professionals' and the patient's interaction. I also look at the challenge of creating a co-operational situation in the treatment process with patients who are considered to be reluctant towards treatment.

## **1.5. Hospital environment, eating disorders and social sciences**

The hospital environment has been the focus of several ethnographic studies. These studies have focused on children's experiences as patients and the nursing of young patients (Livesley & Long 2013), nursing rituals in acute adult care (Wolf 1986), newly qualified nurses taking on the nursing role in a hospital setting (Bjerknes & Bjork 2012) as well as interaction in a Japanese mental hospital (Nomura 1987) and how culture is related to an emergency physician's habitus (Hightower 2010). Institutional ethnography focuses on the social organization of health knowledge from the standpoint of those involved in and subordinated to its managerial uses (Rankin & Campbell 2009).

In the field of social sciences eating disorders have been studied as a phenomenon, which on the one hand has its roots in the different eras of history and their values (see Hepworth 1999, Brumberg 2000) and on the other hand is a socio-cultural illness typical of today's society (Gordon 1990). Hepworth (1999, 3) has examined the ways in which different forms of knowledge have emerged during specific historical periods in western societies to construct anorexia nervosa as an object of medical



science. She challenges the dominant notion of anorexia as a psychopathology. Rather, she sees the dominant psychiatric definition of anorexia nervosa as socially constructed through discourse.

In many studies eating disorders are seen as a reflection of contemporary society's values and particularly its demands towards women. It has been suggested that eating disorders are a reaction welling from society's fears of the power of women. Eating disorders would thus be a fight for autonomy and physical privacy. (see Bordo 1993, Orbach 1986). MacSween sees anorexia as an attempt at the level of the individual body to deal with the irreconcilability of individuality and femininity in a bourgeois patriarchal culture. Women's bodies are constructed through culture and the anorexic struggle has social resonances in the cultural control of feminine desire with issues concerning power, desire and self-discipline (MacSween 199, 100, 252).

Anorexia has been seen to be closely related to society's values stressing coping, individuality and performance accountability (e.g. Puuronen 2004). Puuronen argues that it is constructed in relation to the cultural requirements of being an "ideal citizen" and the contemporary social world. Anorexia and obesity are both part of the same health-discourse. Anorexia relates to a continuum of "healthy eating" and acts as the subject's mode of life management in modern day Finland (Puuronen 2004, 11).

Previous sociological studies have considered eating disorders and their background in the context of broader cultural phenomena. Although interaction, conversation and medical treatment are naturally cultural and societal phenomena, this study does not focus on the nature of eating disorders or anorexia nervosa in relation to a societal context or the illness as cultural phenomena. Conversation is an institution in itself as it is strongly regulated by norms such as taking turns to speak, making corrections and so on. The speaking subjects orient to these norms – either by following or breaking them – and by taking different, changing roles such as speakers and listeners or as producers of different actions; as presenters of accusations or claims, for example (Peräkylä 1995, 179). By focusing on the interaction itself, the study is mainly oriented to the micro level of the practice of treating eating disorders and how anorexia and its treatment are reproduced in the interaction. On a broader level it also looks at the medical institution.

## **1.6. Summary**

In this chapter I have described both the illness and the institution that constitute the focus of this study of institutional interaction. I have introduced the reader to anorexia nervosa, its treatment and the challenges related to treating this particular illness. The aim of this study is to describe the interactional ways used by the medical staff in relation to the protocol of the treatment and the challenges it involves. Unlike most sociological studies, this study does not focus on the nature of eating disorders themselves or the illness as cultural phenomena. The context of this research is the study of institutional interaction and the focus is on the interactional repertoire used by professionals in an institution treating the illness. This is studied by using conversation analysis. In the next chapter I will introduce the reader to the context of this study, the conversation analytical study of institutional interaction.

## **2. Method**

In this chapter I will introduce the reader to the methodology of this study, conversation analysis and more specifically, the conversation analytical study of institutional interaction. The chapter will end with an examination of the data analysis and the research project.

### **2.1. Conversation analysis**

The theory and methodology of this research come from the field of interaction research, conversation analysis (CA). Conversation analysis considers talk as an essential vehicle for social interaction (Drew & Heritage 1992, 16-17). The central idea of conversation analysis is that both informal everyday interaction as well as institutional interaction involve certain structures and regularities within which the interaction is produced. These basic normative structures are ‘tools’ which the participants of the interactional situation use in establishing an intersubjective connection – in simple terms: a mutual understanding. Central structures include turn taking, sequential structure and repair (Ruusuvuori et al. 2001, 15).

The methodology of CA is based on ethno methodology. Ethno methodology’s research interest is the study of the everyday methods people use for the production of social order (Garfinkel 2002). Ethnomethodology’s goal is to document the methods and practices through which society’s members make sense of their world. According to this research tradition social order is produced through social actions such as speech, corporality or textuality. In line with this perception the focus of conversation analysis is on the ways people use to construct a mutual understanding or a mutual perception of the situation they are sharing. On a closer level this means the ways the participants of the situation, the speakers, produce their own actions and interpret the actions of others (Heritage [1984] 1996).

Harvey Sacks and his colleagues at the University of California developed the CA method during the 1960s (Sacks 1992, Sacks, Schegloff & Jefferson, 1974). The idea

was to study the organization of social action in a data driven way using naturally occurring data that is, naturally occurring conversations.

The central idea developed by Sacks is that a conversation is not chaotic, nor is the mutual understanding reached by the discussion participants a mere coincidence. On the contrary, interaction is, in every detail, an organized activity (Hakulinen 1998, 13). Conversation analytical research first focused mainly on informal everyday conversations that subsequently gave (an) impetus to the idea that talk in interaction is organized in a highly subtle way (Lerner 2004).

Conversation analysis thus aims to find out what the function of different turns of speech is and what kind of actions they enable. Basic actions include asking, greeting and requesting something. Interest is oriented towards the various ways the participants of the discussion seek understanding from one another or how different features related to the topic (the topic is something new or already known, it is delicate or difficult) are displayed to others. All in all, conversation analysis tries to explicate ways of interaction with which people reach *intersubjectivity*, the state where they are able to understand each other and the situation they are sharing (Hakulinen 1998, 15).

To this date, in CA the specific research questions are not determined in advance although previous research and CA concepts are used as resources in the research process. Nevertheless, the naturally occurring data, audio and video tapes, are first transcribed. After this an exploration of the data is begun in an unmotivated way, resulting in defining the interactional phenomena to be examined.

### **2.1.1. Units of analysis**

As mentioned, the early CA studies showed that interaction is in fact finely organized. They have specified interactional practices such as turn taking (Sacks, Schegloff, Jefferson 1974), repair (Schegloff, Jefferson & Sacks 1977), openings (Schegloff 1979) and closings (Schegloff & Sacks 1973). Likewise, the concepts of adjacency pair and preference are central to conversation analytical theory.

Turn taking is a central form of social organization. Taking turns to speak one at a time in a conversation is presupposed and normative. The turns of talk form *adjacent pairs*. In its basic, unexpanded form an adjacency pair is characterized by certain features. It is composed of two turns by different speakers. These turns are adjacently placed, one after another. They are relatively ordered, which means that they are differentiated into “first pair parts” and “second pair parts”. First pair parts are utterance types such as question, request, offer, invitation or announcement. Second pair parts are responsive utterance types such as answer, grant, reject, accept, decline or agree/disagree (Schegloff 2007, 13). Adjacency pairs are also pair-type related, meaning that not every second pair part can properly follow any first pair part (Schegloff 2007, 13). A certain type of first pair part calls for a certain type of second pair part. For example a question calls for an answer, an invitation for acceptance or rejection (Sacks 1992, Goodwin & Heritage 1990, 288). Adjacency pairs compose pair types and these types are exchanges such as greeting-greeting or question-answer. The relationship of adjacency or “nextness” between turns is central to the ways in which talk-in-interaction is organized and understood. Next turns are understood by co-participants to display their speaker’s understanding of the just-prior turn and to embody an action responsive to the just prior turn so understood (Schegloff 2007, 13-15).

Many sequences also involve expansions of this basic unit described above. Such expansions involve additional participation by the parties through additional turns, over and above the two, which compose the minimal version of the sequence. These expansions occur in the three possible places that a two-turn unit permits. They can occur before the first pair part as pre-expansions, between the first and the projected second pair parts as insert expansions or after the second pair part as post-expansions. Various forms of expansions can occur in each of these positions (Schegloff 2007, 26).

Some sequence types have one central type of second pair part. In greetings, for example, there really is only one type of second pair part, the return greeting. These sequence types are the exception because the vast majority of sequence types have alternative types of responses, which a first pair part makes relevant. For example, an invitation can be accepted or declined. Alternative types of second pair parts, which a

first pair part makes relevant, are still not equally valued. Sequences are the vehicle for accomplishing an activity, and that response to the first pair part which embodies or favors furthering the accomplishment of the activity is the favored, or in CA terms, the “preferred” second pair part (Schegloff 2007, 58-59).

For example, a preferred response to an invitation is usually an acceptance. Preferred and dispreferred responses are systematically designed differently (Pomerantz 1984, 64): preferred straightforwardly, dispreferred with delays and justifications. *Preference* is a structural phenomenon; the different designs of the second pair parts represent an organized way of speech.

Adjacency pairs have an essential part in the progression of interaction. Broader action sequences, sequences, which consist of adjacent pair parts are the interest in CA research, especially in the study of institutional interaction (Peräkylä 1998).

## **2.2. Study of institutional interaction**

In addition to everyday conversation, CA is also used at present to study institutional interaction and institutional discussions. The term “institution” is traditionally used in both sociological and lay language for certain official instances of the society such as the justice system, medical care or the media (Peräkylä 1998, 178). These institutions are based on legislation and their operations are restricted by formal rules of conduct. On the other hand, also the more informal organizations of our common life world such as the family, a meal (ritual), religion or even friendship are commonly called “institutions”.

These institutions might have their official, formal side, but in addition, they have many unofficial and informal manifestations. In CA the term “institutional interaction” primarily refers to the study of official institutions (Peräkylä 1998, 178-179).

Some features are particular for institutional interaction and distinguish it from “ordinary conversation” (Drew & Heritage 1992, 21). For one, institutional interaction involves at least one participant’s orientation to some core goal or task conventionally associated with the institution. This means that institutional interaction

is usually informed by goal orientations of a relatively constricted conventional form. It may also often involve special and particular constraints on what one or both of the participants will treat as allowable contributions to the business at hand. Institutional interaction may also be associated with inferential frameworks and procedures that are particular to specific institutional contexts. For example, an encounter between a doctor and a patient has a certain framework and consists of certain procedures that are related to the institutional context and not the particular individual participants involved in the interaction (Drew & Heritage 1992, 22).

In contrast to everyday conversation, in institutional interaction the participants have specific institutional roles such as the role of a doctor, a patient or a participant in a business meeting (Peräkylä 1998, 177). A conversation analytical study of institutional interaction aims to find out how such roles are maintained in interaction and how the participants' actions create, uphold and shape that institution and the tasks it implements.

The primary focus lies on the interactional process. CA is interested in the actions of all the participants in an institutional conversation because they all have an active influence on the course of the conversation. In this way institutionality is a phenomenon, which is not only molded but also upheld in interaction (Ruusuvuori et al. 2001, 14-24). A researcher studying the interaction in a certain institution needs sufficient knowledge of that institution (Arminen 2005, 31). The study of institutional interaction poses specific challenges for conversation analysis, because the analysis of institutional interaction differs from the analysis of interaction itself. To illuminate the institution's role in and for interaction in a given setting, the analyst needs to show the points related to the institution and the ways they are visible in the interaction (Arminen 2005, 31).

By describing the interactional process of a certain institution, CA may show what actions take place in the interaction, how the conversation proceeds, and the possible problematic features of the interaction. By looking at the interactional process it is also possible to specify, supplement and correct supposed, possibly stereotypical perceptions regarding the institution (Raevaara et al. 2001, Peräkylä & Vehviläinen 2003).

In many institutions there is a perception of “good interaction”, a theory of the right kind of interaction for the institutional work, i.e. a stock of interactional knowledge (Peräkylä & Vehviläinen, 1999, 2003). Stocks of interactional knowledge contain a description of the “right” interaction in that institutional setting. For example, in this research the challenges mentioned also contain a description of the kind of interaction the professionals should aim for in order to overcome these challenges. Therefore, the stocks of interactional knowledge conceptualize and organize the interactional situations of the institution (Peräkylä et al. 2005).

The institutions studied by conversation analysts have included counseling (Vehviläinen 2001), AA meetings (Arminen 1998, 2001), court room events (Atkinson 1992, Drew 1992), meetings (Koskinen 2001), homeopathic consultations (Lindfors 2000), pharmacy counseling (Pilnick 1997) as well as TV interviews (Berg 2001, Clayman 1992, Greatbatch 1992).

### **2.2.1. Study of institutional interaction in medical care and psychotherapy**

The closest models for this research are naturally those studies of institutional interaction that focus on medical care (e.g. Sorjonen 2001, Heritage & Sefi 1992, Peräkylä 2001, Maynard & Frankel 2006, Heath 1992, Ruusuvuori 2001 & 2003, West 2006, Maynard 1992, Raevaara 2001, Bergman 1992, Heritage & Maynard 2006, Ijäs-Kallio 2011) and psychotherapy ( see Antaki, Barnes & Leudar 2005, Peräkylä 2004, Vehviläinen 2003, Forrester & Reason 2006, Peräkylä, Antaki, Vehviläinen & Leudar 2008, Ehrling 2006, Voutilainen 2010).

The studies of interaction in medical care vary from communicating and responding to diagnosis (Peräkylä 2001), diagnostic rationality (Maynard 2003, Maynard & Frankel 2006), and negotiations about treatment decisions between doctors and patients (Stivers 2006) to collaborative work on the clinical object (Heath 2006) and questioning during comprehensive history taking (Boyd & Heritage 2006).

On the interaction in psychotherapy the focus point has been on pursuit of a therapeutic agenda in solution-oriented therapy (Gale 1991), agency, accountability and responsibility in therapy talk (Kurri 2005), formulations (proposing a version of



what the patient has said directly after he has said it and adding a transformation to the version) in psychotherapy (Antaki 2008), and clients' responses to therapists' reinterpretations (Bercelli, Rossano & Viaro 2008) as well as AIDS counselling (Peräkylä 1995) and lexical substitutions as a therapeutic resource (Rae 2008).

Antaki has looked at the ways in which producing formulations work as a way of maintaining the respective and attentive culture of psychotherapy. When producing formulations the therapist summarizes the client's own words or draws out a seemingly natural implication from them, while editing them in a tendentious way. Unlike other interactional actions related to, for example, psychotherapy, reinterpretative statements or corrections, formulations promote the sense that one has listened to the other speaker and has extracted something that they themselves might have said. They also serve the therapist's interests in many ways, shaping symptoms for example (Antaki 2008, 26-42).

Regarding interaction in psychotherapy, Bercelli, Rossano and Viaro have focused on clients' responses to therapists' reinterpretations. By reinterpretations they mean therapists' turns in which they propose their own version of the clients' events and experiences. The therapist's version is grounded in another version previously provided by the client. According to Bercelli et al., in addition to just accepting the therapist's reinterpretations, clients can do much more. They can display their understanding of and agreement with the therapist's reinterpretations, and provide the therapist with possibly unknown evidence to support and further develop, enrich and modify the re-interpretations. Therapists welcome and also pursue such extended responses (Bercelli, Rossano & Viaro 2008, 43-61).

There is little prior CA research on the treatment of eating disordered patients. The closest study of interaction with eating disordered patients is by Beach (1996), whose case study focuses on the interaction between an eating disordered patient and her family. Interaction in psychiatric settings has been studied by, among others, Bergmann (1992).

On the other hand, many studies prior to this have focused on the interaction concerning a group of patients suffering from the same illness. One central study on the interaction of one particular group of patients is the conversation analytical study

of the interaction between dieticians and diabetic patients (Pyörälä 2006). Another study focusing on a particular group of patients is Taru Ijäs-Kallio's study on the interaction between doctors and respiratory infection patients in primary health care (Ijäs-Kallio 2011). Beach and Anderson have focused on interaction concerning cancer patients (Beach & Anderson 2003).

This study also focuses on one patient group suffering from the same illness. The data can be used to look at the interactional ways and situations particular to the treatment of these patients. On the other hand, as there is more than one occupational group represented in the data, it is also possible to focus on the ways that are particular to different professionals involved in the treatment of anorexic patients.

As mentioned, there is very little prior research on the interaction in this particular area of medical treatment. However, from the point of view of the central interactional concepts/challenges of this study - resistance, alignment and misalignment, psycho education/advice giving or confronting the patient - many studies on institutional interaction in different fields touch upon the same concepts. For example, resistance is a central concept in psychoanalysis, and in CA it has been studied by Vehviläinen and Peräkylä (Vehviläinen 2008 120-138, Peräkylä 2004). Resistance towards the therapist's optimistic questions in narrative and solution-focused therapies has also been studied by MacMartin (2008, 80-99), and students' resistance towards counselors' advice by Vehviläinen (2001, 205-214).

When studying emotional experience in psychotherapeutic interaction, Voutilainen has looked at misalignment as a therapeutic resource (Voutilainen 2010). Misalignment is also the focus of a study of "after hours" calls to a British GP's practice (Drew 2006, 416-444). Advice giving practices have been studied in different instances including general practitioners' appointments (Peräkylä et al 2001, 161-182), discussions between community health nurses and first-time mothers (Heritage & Sefi 2001, 359-417), student counseling (Vehviläinen 2001, 155-228), meetings between dieticians and diabetic patients (Pyörälä 2006), and discussions in child protective services (Juhila 2000, 105-130).

The professionals' ways of pursuing agendas related to the institutional setting have been studied by Gale (1991) in the form of interaction in solution-focused therapy.

Halonen has looked at professionals' ways of pursuing problematic issues in the study of alcoholic patients' "Myllyhoito" (a Finnish version of the Minnesota treatment) PKKG sessions, in which the therapist points out examples of the problematic use of alcohol in the life story told by the patient (Halonen 2001, 62-81). In AIDS counseling, therapists use different interactional ways of pursuing talk of dreaded, difficult issues (Peräkylä 1995, 232-286).

I will look at many of these studies more closely in the upcoming empirical chapters, but first I will go through the data analysis of this study and the research project in general.

### **2.3. Data analysis and the research project**

The data consists of 13 tapes of videotaped dyadic discussions between the patients and the professionals. All in all there are seven patients and four professionals. The professionals who took part in this research are a psychiatrist, a pediatrician and two nurses. The discussions last approximately 35 minutes per tape totaling about 7.5 hrs of data. Eight of the tapes are of unstructured discussions between two patients and four professionals. Five of the tapes are of half-structured diagnostic interviews between the psychiatrist and four patients. This book has three chapters based on the unstructured discussions and one chapter on the diagnostic interviews.

The data of this study comes from the day treatment unit for eating disordered adolescent patients at The Helsinki University Hospital for Children and Adolescents. All the patients in this data suffer from anorexia nervosa and are 13-17-year-old girls in fairly early stages of treatment in the unit. The study has been approved by the ethical board of the Helsinki University Hospital. All the patients have given their approval for taping and using them as data in this study. All names details which could give away the identity of the patients have been changed in the transcriptions.

The data was gathered with the help of Dr. Veli-Matti Tainio, the head of the centralized services of the HUS child and adolescent psychiatric clinics. He chose the patients for the data and negotiated the permission for filming with the patients and their parents. The camera was in the room during filming of the data but the discussions

took place without the researcher present. The professional was in charge of beginning the filming and turning the camera off at the end.

As the method of conversation analysis is data driven, I began my study with an unmotivated viewing of the data. The research process was also my introduction to CA as I was not familiar with the method. This made the beginning of my study and the exploration of the data a learning process. The first observation that guided me towards a more motivated data viewing was the turn-initial “I don’t know,” which seemed to be a frequently used term in the patients’ speech. This also directed my interest towards the ambivalence of the turns as well as the simultaneous existence of resistance and co-operation in the discussions. After the first research topic, the turn-initial “I don’t know” and the ambivalence and misalignment in the patients’ talk, the other topics arose more easily from the data. The overall interest after the second topic, pursuing the recognition of illness, came to be the central challenges of the treatment of anorexic patients as they are presented in the textbooks and guidelines and how these are manifested in the interaction. This was the result of the topics – ambivalence, misalignment, resistance, co-operation and the lack of recognition of illness – all common characteristics of anorexia and its treatment. As the discussions were “professional driven” the topics of three chapters focused on the actions of the professionals.

The videotapes were transcribed using the detailed notation developed by Gail Jefferson (Sacks, Schegloff & Jefferson 1974). In addition to words, the focus was also on breaks, overlaps and prosody as well as the non- verbal expressions in the talk. In my analysis I have focused on verbal interaction leaving nonverbal communication aside. This is because the verbal interaction offered a very rich data and in my opinion the research was more coherent and clear when the analysis focused on that.

Eight of the tapes were transcribed completely and five partly. From the five partly transcribed tapes I have chosen the parts relevant to the chapters of this study.

## **2.4. Summary**

In this chapter I have introduced the method of this study as well as the field it relates to, the study of institutional interaction. I have also gone through the data, the analysis and the research project regarding my study and the following empirical chapters. The next chapter focuses on the professionals' ways of pursuing the recognition of illness.

### **3. Suggesting a problem with thoughts and desires:**

Professionals' ways of pursuing recognition of illness in discussions with eating disordered patients

#### **3.1. Introduction**

This chapter deals with question – answer sequences in which the professionals ask patients about problems related to their illness and its symptoms. The focus of this chapter is on the actions the professional takes to stay on the topic despite the patient's misaligning turn. This is important because the situation is extremely problematic for the professionals because they must try to maintain a cooperative atmosphere and at the same time confront patients about their illness. This is also a challenge in the context of treating eating disorders, because the patients usually lack the recognition of their illness and are anxious to hold on to it. I will show how the professionals work with this challenge by first asking a question containing presuppositions, accounts and claims. After the patient's ambivalent response they stay on the topic with a follow-up question using the ambivalence in the patient's turn and reinforcing their agenda. I call this action "suggesting a problem" and its broader agenda "pursuing the recognition of illness." On the level of interactional work the focus of analysis is on the design of questions and follow-up turns and the actions they contain: claims, accounts and questions. The interest is also on how the professionals link their turns and stay on the topic.

#### **3.2. Pursuing problematic issues in health care**

There are many institutional contexts where the topic is delicate or problematic in one way or another. Be it because of the patient's denial of her problems or a lack of the sense of illness or issues difficult to confront, professionals have different ways to pursue problematic issues. What these ways have in common is that they are usually not straightforward.

As in eating disorders, the denial of the illness is a central feature in alcoholism. The counselors in "myllyhoito", a treatment program for alcoholics based on the AA-

ideology, pick up on the elements in the patient's talk that indicate alcoholism and by doing this, use the patient's talk as proof of the alcohol addiction (Halonen 2001). In myllyhoito, patients' life stories related to alcohol consumption form a graphic diagram of the development of their alcohol use. The counselor listens and interrupts the patient's story with a question when there is something in the patient's turn that the myllyhoito ideology considers an indication of alcoholism. The counselor does not actively seek these indications but picks up on them as they appear in the patient's talk. The counselor's questions are thus related to the patient's prior turn, and the follow-up questions are based on the patient's own words. While the counselors' follow-up questions bring to the patients' attention things that indicate alcoholism in their story, such as the amounts consumed or the frequency of drinking, the questions are also designed to emphasize the patients as active individuals in the story. The patients' prior turn, on the other hand, has been designed in the zero people, as events just happening to them.

The aim of this is to seek proof of alcoholism in the patient's own words. Although patients already have a diagnosis when they come to treatment many alcoholics do not feel they are sick. Many do not really believe that alcoholism is their problem. In this way the context is similar to the data of this study because denial and resistance are also central in eating disorders and their treatment. Patients lack the sense of being ill, and this is challenging for the treatment. In this data the professionals also use the patient's talk, usually the prior turn as a basis for their turns, in which they suggest the problems. The professionals pursue the recognition of illness by following up the suggestions from the patients' turns. They orient the discussion to the patient's illness and anorexic mind by suggesting problems that presuppose the presence and uncontrollability of the patient's anorexic desires.

In AIDS counseling (Peräkylä 1995) the aim of the counseling is to prepare the client to live with the disease and to go through, for example, difficult feelings and fears related to the illness and the future. As these themes can be very hard for the clients to think and talk about in AIDS counseling, the counselor does not ask about these issues straightforwardly but addresses them more delicately. The counselor can, for example, topicalize worry-related themes that were brought up in the client's prior turn. With a follow-up question the counselor brings the dreaded issue a little closer in

the discussion by using the worry already mentioned in the client's own talk. Some of the follow-up questions can be more neutral, and stay on the topic brought up by the client. Another way for the counselor to address these issues is to retrieve themes that were mentioned or absent in the client's earlier talk. In this case the action of addressing this dreaded issue is not related to and followed up on the patient's previous turn; it is based on something he or she has mentioned earlier in the discussion. Still, the counselor's turn is in some way related to the client's talk.

In this data the patients' turns are very ambivalent. The patients agree with the theoretical possibilities that they may have anorexic thoughts and the illness itself. The professionals pick up on the "admitting" side of the patients' turns and suggest the problem explicitly, enforcing the problematic side mentioned and admitted to in the patient's ambivalent turn. In these professionals' turns the illness is suggested as being actual and the reason behind the problems in the recovery, by this meaning the patient's weight loss or lack of progress. At this point the patients usually withdraw from the frame offered by the professional.

In myllyhoito the counselor's questions are meant to confront the patients about alcoholism, while in AIDS counseling they are confronted with the facts that make the illness so serious and frightful. The problems suggested have to do with the "core issue", which is that the patients are in that situation to begin with. In this data the professionals confront their patients about the same thing: the eating disorder and its connection to the problems in the recovery. Rather than taking up these issues straightforwardly, by producing an assessment about the patient's situation, the professionals do this by asking questions that suggest problems related to the patient's eating habits. The questions contain presuppositions, claims and accounts related to the uncontrollability and presence of the patient's anorexic thoughts and desires.

### **3.3. Suggesting a problem with thoughts and desires - pursuing recognition of illness**

I will now describe the features of the trajectory of "suggesting a problem" using data extracts.



### 3.3.1. Introducing the suggestion

The professionals usually introduce their suggestion in a question, which is related to the topic of the discussion prior to the suggestion. The question is designed to present the problem as an option among others rather than a fact. Thus the problem being suggested in the introductory turn can be heard as “lighter” because the problematic issue is not as strongly offered in the turn.

In the next extract of a session between a nurse and a patient it is mutually known and brought up in the beginning of the session that the patient’s weight has gone down. The nurse and the patient are going through the patient’s situation and her current feelings. The topic prior to the suggestion has been on the patient’s friends and her hobby, basketball.

#### Extract 1.

1 N: nii just et et sä niihin koripalloystäviinska- pidä sen enempää,

*yes right so so you don't keep in touch with your basketball friends that much,*

2 P: no e:n hirveesti [°oo pitäny et,°

*well I haven't kept that much like,*

3 N: [yhteyttä.

*[in touch.*

4 N: .hhjoo.

*.hhyes.*

5 P: muutenkaan paitsi mitä nyt harkoissa sillon näkee [°muuten mut,°

*anyway except when you happen to see them in pra[°ctice anyway but,*

6 N: [mm-hh.

- 7 (0.7)
- 8 P: °en nyt (0.2) vapaa-ajal oikeestaa° (0.5) kyl mejän koulus on aika moni sii-  
 °not in (0.2) my free time really° (0.5) there are quite many in our school from  
 t-
- 9 mejän jengistä mut neki on vaan semmosii et (1.2) et sillee tuntee mut (.)↓ei  
 nyt  
 our team but there also just those that (1.2)that like know me but (.)↓I
- 10 oo (0.2) °kauheesti niiden kaa°,  
 don't (0.2) °spend much time with them°,
- 11 N: joo.  
 yes.
- 12 (0.5)
- 13 N: **miltä tota noin ni(.) onks tullu nyt semmosia (0.2) semmosta oloa et pitäis**  
 how have you like (.) have you now gotten those (0.2) the feeling that you
- 14 **päästä (0.2) liikkumaan tai,**  
 have to(0.2) exercise or,
- 15 P: ei↓ oikeestaan nyt hirveesti ollu mitään et (0.2)[>mitä se oli<,  
 not↓really now I haven't had that much of anything so (0.2) [>what was it<,
- 16 N: [°mm-hh.°
- 17 P: nyt täl viikol olik se maanantai vai tiistaina (0.2) ni sit mä halusin lähtee  
 viel  
 now this week was it Monday or Tuesday (0.2) so then I still wanted to go
- 18 kävelee sillo illalla ku ei niinku oikeen pystyny olee siin sisällä mut,  
 for a walk in the evening when I like couldn't really stay inside but,

19 N: joo.

*yes.*

20 P: ei niinku ei oikeestaan se on ollu ainut kerta nytte (0.2) nytte (0.5) nytte (.)

*not like not really it was the only time now (0.2) now (0.5) now (.)*

21 °kolmeen viikkoonki et°,

*°in three weeks so°,*

22 N: mm-h (0.2) lähiks sä sitte?

*mm-h (0.2) did you go then?*

The nurse introduces the subject in question in lines 13-14, suggesting a problem or rather asking about its existence. The problem in question is the patient's possible need to exercise. (Note: the patients are not allowed to exercise so the will/need to do so is problematic.) The question is related to the prior topic, as basketball has been central in the patient's life and playing basketball is exercise. The word "now" in the nurse's question also relates the suggestion to the topic as it is presupposing that the patient has had the need or will to exercise before and is now enquiring if the need is current. The question is formulated so that it underlines the uncontrollable part of the desire: have you gotten the feeling that you have to exercise? She could have asked, for example: have you felt like exercising?

The patient answers in the negative in lines 15, 17-18 and 20-21. She formulates the answer so that the general answer is "no", but states that there has been only one time in a long period that she has wanted to go for a walk. This example can be heard as meant to enforce the statement that she does not have any desire to exercise: there is just this one time she has felt the need to go for a walk. By giving such an example the patient does not turn down the nurse's suggestion completely, but displays recognition that this need exists, is part of the illness, although in her current situation the need is not relevant. She also displays reflection on her own situation and by doing so assures the nurse of the honesty of her evaluation. After the patient has ori-

ented the discussion away from the orientation to her illness the nurse follows up with a question on the same topic in line 22. In the question the nurse does not suggest a problem but continues to pursue the orientation to the patient's anorexic mind by asking the patient if she acted out the desire she mentioned. The patient offers the one-time wish as an example of how weak her anorexic desires are. The nurse does not end the topic with the patient's response, which oriented the discussion to her recovery, but continues to pursue the orientation to the illness with the follow-up question.

In the next extract the problem is also introduced in a question that is even more immediately related to the topic being discussed. This extract is from a meeting with a patient and the pediatrician (the nurse is also present). The topic of the discussion is very problem-oriented in itself: the patient's weight has gone down and the pediatrician is telling the patient how serious her current situation is.

### **Extract 2.**

1 D: <siis> ku me puhutaan näist prosenteista ni tämmöses niinku miinus

*<so> when we speak of these percentages so like around this*

2 kahdenkymmenen tie<sup>o</sup>noillah<sup>o</sup>,

*minus tw<sup>o</sup>entyh<sup>o</sup>,*

3 (0.2)

4 D: ni se on aika vähän,

*so that is quite little,*

5 (0.7)

6 D: eiks tottah.

*don't you think.*

7 D: sun ikäselle ja sun kokoselle <sup>o</sup>tytölle<sup>o</sup>.

*for a girl your age and °size°.*

8 (0.4)

7 P: °mm m[m°],

8 D: [*<se>*] on aika pieni pai°no° .hhh **onks sul ollu ihan semmonen et°tä°  
sä**

*[<it] is quite a low weig°ht° .hhh have you had a feeling like you  
rea°lly°*

9 **haluat** (.) **laihtua laihtua laihtua vai onks se vaan ollu niin et sul ei oo**  
*want to* (.) *lose lose lose weight or has it just been that you don't have*

10 **ruoka°halua°.**

*an app°etite°.*

11 (0.4)

12 P: °no° (0.5) emmä siis nyt (.) halunnu et toi paino laskee,

*°well°(0.5) I didn't want* (.) *the weight to go down,*

13 (.)

14 D: nii.

*yes.*

15 (0.2)

16 P: mut (.) emmä sit kans niinku halunnu syödä °e°t sillai (.) enemmän ku siin  
(0.2)

*but* (.) *then I also didn't like want to eat °s°o like* (.) *more than what there is*  
(0.2)

17 ruoka- eiku siin ateriasuunnitel[mas on],

*in the food- I mean the m[eal plan],*

18 D: [niin joo] joo .hhh,

*[ok yes] yes .hhh,*

19 P: et sit se vaan niinku (0.2) °sit se kuitenkin (0.2) laski sit°,

*so then it just like (0.2)°then it went down (0.2) anyway°,*

In lines 1-7 the pediatrician firmly orients the discussion to the patient's illness by telling and showing the patient how serious her condition is. In line 8 the pediatrician states that the patient's weight is quite low and continues now with a suggestion, a question in which she suggests reasons for this weight loss. The suggestion is immediately related to the topic of the discussion just prior to the suggestion. She gives two suggestions of which the first is related to anorexic thoughts, the desire to lose weight in lines 8-9: "have you been like you really wanted to lose lose lose weight?" The other suggestion is more physical and "involuntary" in lines 9-10: the patient has not had an appetite. In her ambivalent answer in lines 12, 16-17 and 19 the patient first says that she did not want her weight to go down, denying the suggestion that she just wanted to lose weight. After this the patient expands her turn by telling that she also did not want to eat more than what was agreed in the meal plan, now displaying slight acceptance of the idea that she might have a problematic relationship with food.

In the next extract the psychiatrist also introduces a suggestion in a question right at the beginning of a session. The psychiatrist has started the discussion by asking the patient how she is doing.

### **Extract 3.**

1 Pa: no (.) kyl mä oon sillai henkisesti menee paremmin,

*well (.) I am like mentally I'm better,*

2 Ps: =mm.

3 (0.8)

4 Pa: mut (1.0) paino on (0.2) > taas laskussa.<

*but (1.0) my weight is (0.2) >going down again.<*

5 Ps: =mm.

6 (2.0)

7 Ps: mut miltäs sust tuntuu (0.2) mikäs sitä ↑selittää.

*but what do you feel (0.2) what is the ↑explanation.*

8 Pa: no (0.4) en mä tiiä (0.6) mä oon ainaki (0.2) syönnny enemmänki (0.2) ku mitä

*well (0.4) I don't know (0.6) at least I have (0.2) eaten more (0.2) than what*

9 toss mun ateriasuunnitelmassaki [on] ja (.) °en mä tiiä. °

*there is in my meal pl[an] and (.) °I don't know.°*

10 Ps: [mm]

11 (2.0)

12 Pa: enkä mä mi- ni ku (0.4) ku mä lähden täältä (.) lenkeille [että] mitään et (1.2)

*and when I- like when (0.4) when I leave here I don't (.) [jog] or anything so (1.2)*

13 Ps: [mm]

14 Pa: °en mä tiiä. °

*°I don't know.°*

15 (4.5)

**16 Ps: no minkälainen (0.8) ajatus sul itsellä on että ku ollaan puhuttu paljon siitä**

*well what do you (0.8) think about it when that we have talked a lot*

17 että (2.8) et toisaalta sinullaki on (.) halu siihen et täält- pääsisit tästä

*about (2.8) that on one hand you too have (.) a desire to- to get out of this*

18 tilanteesta eroon (0.4)ja toisaalta (0.2) on sit sellasii haluja (0.2) et haluis

*situation (0.4) and on the other (0.2) you have those desires (0.2) that you still*

19 vielä vaan laihduuttaa ja (0.2)eikä tee mieli syä- syödä (0.4)ni minkäläinen

*just want to lose weight and (0.2) and don't feel like ea- eating (0.4) so wh-*

20 tällanen henkien taisto sussa on menossa tällä hetkellä.

*what kind of a battle of spirits do you have going on right now.*

21 (2.2)

22 Pa: no (0.8) kyl >en mä tiä mä oon nyt< aina ku tekee mieli jotain ni kyl mä sit niin

*well (0.8) yes >I don't know now always<when I want to have something I like*

23 ku syön sitä [ku] mä aattelen et kerranki ku on alipainonen [ni ]sit vois syödä,

*eat it when I[ think] that for once when I'm underweight so [I co]uld eat,*

24 Ps: [ni ]

[nii ]

[ye-]

[yes,]

25 Ps: .hh joo.

*.hh yes.*

26 (2.0)



27 Pa: et (.) mut et kyl se (0.3) siis (0.4) kyl se (.) anorektikko osa (0.2) ottaa kyl  
joskus

*so(.)but it does (0.3) I mean (0.4) the (.) anorexic part (0.2) does sometimes*

28 sillai (0.2) vallan.

*like (0.2) take over.*

29 Ps: mm.

30 (4.0)

31 Pa: mut ° siit ei pääse pois ° (0.2) niinku (0.2) helposti.

*but °one can't get away from it° (0.2) like (0.2) easily.*

32 Ps: mmm.

In lines 1 and 4 the patient says that mentally she is feeling better, but her weight has gone down. The psychiatrist receives this in line 5. There is a pause in line 6, and the patient does not expand her turn. In line 7 the psychiatrist takes the turn and asks a question which calls for the patient's account for the weight loss.

The patient begins her turn in line 8 with a "well," a pause and an "I don't know" preliminary to the next thing (Weatherall 2010). After a pause she states in lines 8 and 9 that she has eaten even more than she is supposed to and has not been exercising. These are the two things that one is to do while in treatment. She ends her turn with a tagged "I don't know" (Potter 1996) in line 9.

In his turn in lines 15-19 the psychiatrist picks up on the contradiction brought up in the patient's turn and describes the patient's ambivalence towards the treatment: she wants to get out of this situation but at the same time she also has the desire to lose weight. In the question the psychiatrist combines these two sides as a battle of spirits in the patient's mind at the moment. The question presupposes and implies that the patient is also currently ambivalent towards the treatment and that her mind is still not well. Yet, the question is open, asking for the patient's own assessment of her current

ambivalence. The psychiatrist's follow-up question refers to both their past discussions and the patient's prior turn. He begins his turn in lines 16 and 17 by referring to their past discussions with "we have talked a lot about." In lines 17 – 19 he describes the patient's ambivalence as something that she has had before and in lines 19-20 calls for the patient's assessment of the situation right now.

The patient gives a two-part answer in which she both brings up her improvement and admits to some part of the eating disorder still being current. In the first part in lines 21-22 she tells that nowadays if she feels like eating, she eats. Then in lines 26-27 and 30 she states that on the other hand "the anorectic part" takes over sometimes; it's not easy to get rid of.

In these extracts the professionals introduce the suggestion in a turn that is related to the topic of the discussion prior to the suggestion. The questions include the orientation to the patient's illness but they are designed so the problematic issue being suggested is more of an option than a fact – implying that the presupposition of the problem's 'realness' is not particularly strong. After the professionals have introduced the suggestion they usually continue the suggestions. They do this either in the following turn or after some more neutral questions.

### **3.3.2. Continuing the suggestion**

When the professionals continue the suggestion after introducing it they do it in follow-up turns which are related to and followed up on the patient's previous turn.

The next extract is the discussion of Extract 1 continued. The nurse and the patient have been talking about the patient's friends and basketball. After the nurse has introduced the problem the patient has declined the suggestion and oriented the discussion to a more normal frame by expanding her turn with a description and an example of how little she actually exercises or feels the need to do so nowadays. After the patient has done this, the nurse has stayed on the same topic, asking the patient follow-up questions that call for the patient to elaborate on the issues she brings up in her responses. First in line 1 the nurse continues to pursue the topic by asking the patient if she acted on her desire to go for a walk.

**Extract 4.**

1 N: mm-h (0.2) lähiks sä sitte?

*mm-h (0.2) so did you go then?*

2 P: no sit me lähettii (0.2) sillee >äitin kaa< vaan semmoselle iltakävelyllle

*well we went (0.2) like >mother and me< only for a little evening*

3 °vähä et°,

*°walk so°,*

4 N: joo (0.5) onks se nii et te käytte nyt sit aina (0.2) et jos jos sä lähet ni sä  
lähet

*yes (0.5) is it so that now you always go (0.2) if you go you go with*

5 sit äidin tai,

*with mother or,*

6 P: = joo no en mä oo yksin [ollu oikeestaa (1.0) kertaakaa.

*= yes well I haven't gone [alone at all (1.0) really.*

7 N: [°joo°.

*[°yes°.*

8 (1.5)

9 P: ja ei tuu mitään et >pitäis oikeestaa< mennä yksin ja ei oikeestaan oo  
sellast

*and I don't feel like > I'd have to< go alone really and there really isn't a  
time*

10 aikaakaan millo vois mennäkää yksin et,

*I would be able to go alone so,*

11 N: joo.

*yes.*

12 (1.0)

13 N: **jännittäiskö se yksin (.) lähteminen että,**

***would going alone (.) make you nervous,***

14 P: no (0.5) <emmä nyt tiiä> (0.2) e:i: oikeestaa.

*well (0.5) <I don't know really> (0.2) n:ot really.*

15 N: **voisko siinä tapahtua nii että lähtiski juoksemaan tai,**

***would it be possible that you would start running or,***

16 P: =no en mä nyt ainakaan juoksemaan lähtis mut <sitte> (0.5) jos on semmonen

*=well I wouldn't run for sure but <then> (0.5) if you have this feeling*

17 olo niin sit voi↑ lähtee kävelee niinku tosi pitkään?

*you might ↑go for a really long walk?*

18 N: joo.

*yes.*

19 P: mut,

*but,*

20 N: **menee sit se ajan,**

***you lose track,***

21 P: nii.

*yes.*

22 N: °ajan taju jotenki et jatkaa ja jatkaa että°,

*°track of time somehow that you go on and on so°,*

23 P: mut [en mä nyt,

*but [I wouldn't,*

24 N: **[ei malta lopettaa.**

*[you don't want to stop.*

25 (1.5)

26 P: no: ↓jos mä ↑nyt lähtisin kävelee ni en mä nyt usko et mä kävelisin  
pidempään ku

*well ↓if I ↑did go for a walk now I really don't think I would take a longer  
walk*

27 mitä me ollaan äidin ka- kävelty et,

*than we have taken wi- mother so,*

28 N: joo °hjoo°.

*yes °hyes°.*

29 P: paitsi >et ei sitä< ois niin kiva kävellä yksin jos on (.) joku [joka °tulee  
mukaan°?

*and >it wouldn't< be as nice to go for a walk by myself if there is (.)*

*[somebody who °comes with me°?*

30 N: [mm.

After the patient has answered the question and said that she has only gone for a short evening walk with her mother, the nurse continues to pursue the topic and picks up on the patient's turn, posing still a more neutral follow-up question in lines 4-5 and asking again for specification: Does the patient always go with her mother when she goes for a walk The patient agrees instantly in line 7 and after a pause expands her

turn with an elaboration in lines 6 and 9 and 10 in which she reinforces that she has not even had the desire to go alone and she has not been for a walk by herself at all. Even though this unwillingness to go for a walk by her was not explicated in the nurses turn, the patient offers this on her own initiative. After the nurse has received this answer in line 11 she continues to pursue the topic. In line 13 the nurse ignores the orientation to the patient's normality, which was implicitly offered in the patient's turn, and picks up on what the patient has stated about the lack of desire to exercise alone. She asks a follow-up question in which she suggests a problematic reason for this: it makes the patient nervous. The patient declines with a hint of hesitation in line 14.

The nurse continues to orient the discussion to the patient's problem in line 15 by asking another follow-up question related to the patient's turn in which she mentioned the lack of need to go for a walk alone. The nurse offers a candidate understanding for this lack of need to go for a walk alone. It is positioned as a possibility that is forecast as expanding as she designs the turn: "Would it be possible that you would start running or..." (Which she is not allowed doing). In this candidate understanding the nurse suggests another problematic reason that now brings up again the uncontrollability of desires and their possible existence. The patient turns this suggestion down in lines 16-17 but shows a slight acceptance by telling that she could possibly take a really long walk. In lines 20, 22 and 24 the nurse continues from this with a formulation in which she suggests a problematic description of the situation the patient is talking about: she would lose track of time and would not want to stop. The use of the word "somehow" in line 22 softens the nurse's formulation by describing the possible situation, as something the patient would not do as a planned, willful decision. The patient does not pick up on this formulation but withdraws and returns the conversation from the nurse's problematic formulation to a more normal frame in lines 26-27. She turns down the formulation by stating that if she went for a walk alone she probably would not walk any longer than she would with her mother. In line 29 she continues by giving a reason for not wanting to go alone: it's not as nice as in company.

In the following extract the psychiatrist also continues to suggest the problem by following up on the patient's turns. The psychiatrist and the patient have been discussing the patient's weight loss. This has been the topic throughout this session: the

psychiatrist has oriented the discussion to the patient's problem a few times before. Before this extract the psychiatrist has asked the patient if her desire to lose weight is as strong as it was at the beginning of the treatment. The patient has answered immediately in the negative, telling the psychiatrist that she does not have the desire to lose weight anymore.

### Extract 5.

1 Pa: °nii ja sit (1.8) ja sit° (1.0) kyl se (.)ehk halu laihtuu (0.2) kyl se ehk vähä  
*°eyes and then (1.8) and then° (1.0) the (.) maybe the desire to lose weight (0.2)*  
*it*

2 (0.2)

3 Pa: vieläki siinä (.) ehk (1.0) <kymmenen prosenttii> jäljellä tai -jotain (0.6)  
*maybe is still there (.) maybe (1.0) <ten percent> of it or ↑something (0.6)*

4 et (0.2) kyl se aina välillä ku ei nää oikee itteen[sä ]°sillai (0.4) oikeen e,t°  
*so (0.2) it is there once in a while when I can't really °see myse[lf] (0.4) like correctly so,°*

5 Ps: [mm]

6 Ps: mmm.

7 (4.0)

8 Ps: millasena sä näät itses. hh (1.8) tänään. hhh  
*how do you see yourself .hh (1.8) today. hhh*

9 Pa: iha ihan semmosena normaalipainosena [ihmisenä].  
*just like a normal weight [person.*

10 Ps: [mm]

11 Ps: **onks sul sellasii hetkiä ku sä näät itses lihavana.**

*do you have moments when you see yourself as fat.*

12 (1.2)

13 Ps: no joo.

*well yes.*

14 Ps: **mm (1.0) et nää nii ku nää (0.6) nää ase- nää ajatus (.)kuviot on vielä**

*mm (1.0)so these like these (0.6) these pat- these ways of thinking are still*

15 **aika vahvoina,**

*quite strong,*

16 Pa: joo.

*yes.*

17 Ps: °joo ° (0.8) mut -sitte se vaikee asia onki mistä (.) mistä tota mitä ei (.)

*°yes° (0.8) but ↑then the hard thing is what (.) what umm what (.)*

18 mitä (.) mitä **mikä tota mikä niinku (0.2) saa (1.2) sut (0.8) pitämään**

*what (.) what **what umm what like (0.2) makes (1.2) you (0.8) consider***

19 **itsees lihavana mikä saa sua (0.4) haluamaan sitä laihtumista,**

***yourself as fat what makes you (0.4) want to lose weight,***

20 mehän ollaan (0.2) lähestytty sitä niin et me ollaan tutkittu sun

*we have (0.2) looked at it from the point of view of your*

21 elämänhistoriaa hhh (0.3)°mut° (.) jos sä nyt mietit (0.2) mietit sitä että

*life history hhh (0.3)°but° (.) if you now think (0.2) think about what*



- 22 (0.6) ihan just niin ku sä tällä hetkellä a- a- haluat vastata että et mistä se  
*(0.6) just like you want to answer a-a- at this moment that why is it*
- 23 johtuu että se (0.4) sulla tänään (0.2) että sä hal- et edelleen sul on sitä  
*that you still (0.4) today (0.2) that you wa- that you still have the*
- 24 laihtumisen halua et mitä minkälaista (0.6) mielipidettä sul on tähän  
*desire to lose weight so what kind of an (0.6) opinion do you have*
- 25 asiaan.  
*on this matter.*
- 26 (8.0)
- 27 Pa: no ei ku £ mul ei oo sitä haluu laihtua [mut]£,  
*well no because £ I don't have the desire to lose weight [but]£,*
- 28 Ps: [nii,]  
*[yes,]*
- 29 (1.0)
- 30 Ps: paitsi pikkuse,  
*except a little,*
- 31 Pa: joo.  
*yes.*

After this the patient extends her turn in lines 1 and 3-4 by admitting that possibly ten percent of the desire to lose weight is still there. After having got an answer to his question the psychiatrist does not leave the topic but continues it in line 8 by asking the patient how she sees herself today. In line 9 the patient answers that she sees her-

self as a person of normal weight. Again, the topic could be closed with the “outcome” that the patient recognizes that she has been ill but is quite ok nowadays. Instead, the psychiatrist pursues the orientation to anorexic thoughts and follows up on the patient’s response with a question in line 11: does the patient at any time see herself as being fat. In the question he suggests a problem and does this despite the patient’s “normal” answer.

In line 13 the patient admits to this without any elaboration and with slight hesitation. Again, the patient’s turn can be heard as closing but from the patient’s accepting turn the psychiatrist continues the suggestions in lines 14-15 with a follow-up turn and suggests the problem now in a strong formulation of the patient’s acceptance: The ways of thinking are still quite strong. The patient has stated earlier that sometimes her anorexic part takes over. In the beginning of this extract the patient stated that perhaps a 10% share of her mind still has anorexic thoughts. In his turn the psychiatrist formulates the patient’s slight acceptance to a stronger level. This is possible because of the patient’s own words brought up earlier. The patient accepts this formulation with one word in line 16.

From the patient’s acceptance the psychiatrist continues with a follow-up question in which he suggests the problem again. He begins this question in line 17 by stating that this is difficult, and in lines 18-19 for the first time asks the question in which he suggests that the patient wants to lose weight and wonders what might be the reasons she still feels fat. The will to lose weight is very strongly presupposed in the question; it is brought up as a fact: what makes you still want to lose weight? In lines 21-22 he orients the discussion away from looking at the past with “we have looked at it from the point of view of your life history but if you now think...” In lines 22-24 he asks the question more clearly, calling for the patient’s opinion on this. He orients the discussion explicitly to the patient’s present feelings, as he did in line 8, by asking about “this moment” and “today” in lines 23 – 24. This time the psychiatrist asks straightforwardly “why is it that you still have the will to lose weight?” disregarding any ambivalence that might have been in the patient’s prior answers. Again the psychiatrist suggests the will to lose weight and he suggests it as a fact. After a long pause the patient now withdraws from the line of (slight) acceptance of the psychiatrist’s suggestions by stating that she does not have the will to lose weight as the

psychiatrist suggested. The psychiatrist receives this, overlapping the patient in line 28 with a “yes” prosodically forecasting an expansion. This expansion emerges after a pause in line 30. The expansion confronts the patient’s previous turn (in which she denied the psychiatrist’s problematic suggestions) by adding “except a little.” The psychiatrist orients the discussion back to the problematic suggestion.

Again, in the next extract the professional pursues the orientation to the patient’s ill thoughts and desires by continuing to suggest the problem despite the patient’s closing and normalizing turns.

### **Extract 6.**

1 Ps: **onks sul ollu tässä tota,**

*have you felt,*

2 (1.8) ((psykiatri kirjoittaa vihkoon))

*(( the psychiatrist is writing))*

3 Ps: **missää vaiheessa sellast tunnetta et sä oot liian lihava.**

*at any point that you are too fat.*

4 Pa: no (0.5) ehkä silloi josku viidennel luokalla.

*well (0.5) maybe sometime in the fifth grade.*

5 (1.0) ((psykiatri kirjoittaa vihkoon))

*((psychiatrist writing))*

6 Pa: mut (0.6) ei sillee (.) et mä oisin (0.2) ajatellu sillon.

*but (0.6) not like (.)I would have (0.2) thought that then.*

7 (2.2) ((psykiatri kirjoittaa vihkoon))

((psychiatrist writing))

8 Ps: entäs NYT.

*what about NOW.*

9 Pa: no sitte kyl viime keväänä mä ajattelin et (.) kuudennen (.) syksyl et vähä mä olin

*well then last spring I was thinking that (.)in the fall (.) of sixth grade that I was*

10 niinku siin kumminki jotenki (1.2) emmä nyt tiiä lihava mut (0.2) pyäree tai

*a little like somehow (1.2) I don't know fat but (0.2) round or*

11 semmone mut se nyt (.) oli kumminki se kehitysvaihe taas et oli [sem]<sup>o</sup>mone. <sup>o</sup>

*like that but that was (.) really a phase of development again that [ther]e <sup>o</sup>was. <sup>o</sup>*

12 Ps:

[mm]

13 Pa: nyt mä niinku tajuun sen et (.) <sup>o</sup>se oli se vaihe vaa et,<sup>o</sup>

*now I like realize that (.) <sup>o</sup>it was only a phase so. <sup>o</sup>*

14 Ps: mm hh (0.4) nok onks sulla niinku (0.6) vaikee <tota> (1.0) -se (0.8) et sä

*mm hh (0.4) well is it hard for you (0.6) like <um> (1.0)↑that (0.8) you*

15 haluisitki olla laiha (0.2) ja tän hoidon tavoiteha on yrittää antaa sulle lisää

*would like to be thin (0.2) and the goal of this treatment is to try to give you*

16 **RUOK(h)AA. hhh**

**more F(h)OOD .hhh**

17 Pa: no [emmä nyt ] haluu olla enää,

*well [I don't] really want to be anymore,*

18 Ps: [yk(h)s ta(h)vote,]

*[o(h)ne g(h)oad,]*

19 Ps: et sä et haluu.

*so you don't want to.*

20 Pa: en haluu olla tosiaankaan enää näin °laiha,°

*I really don't want to be this °thin° anymore,*

21 Ps: mm.

The psychiatrist and the patient are discussing the patient's illness and its history. The psychiatrist asks a question in lines 1 and 3 in which he introduces the orientation: he asks the patient if she has felt fat at any time in recent years. The patient admits that she has in line 4 but continues in line 6 by stating that it was not anything she thought about then. In line 8 the psychiatrist orients the discussion to the present by asking "what about now." In lines 9-10 the patient admits again that she felt a little fat or round the previous spring and in lines 11 and 13 continues by stating that she understands it was part of her physical development. By emphasizing her understanding of her appearance in reality, the patient sets an unproblematic tone for her answer. This can also be heard as closing the topic because the patient is telling: this is not problematic, I already understand it now myself.

The psychiatrist picks up on that part of the patient's response which admitted the recent feeling of being fat and asks a follow-up question in which he orients the past tense offered in the patient's turn and offers the feeling of being fat as a current state: the treatment is difficult for the patient because she wants to be thin and the aim of the treatment is to feed her. He does not take into account that part of the patient's answer in which she emphasized her healthy understanding of her body image. Instead, the psychiatrist enforces the part which admitted to the feeling of fatness and strongly presupposes that the patient still has an anorexic mind set. The patient declines in line 17, stating that she does not want to be thin anymore and enforces this statement in line 20. She brings the discussion away from the problematic frame and orients it to her improvement.

When the professionals continue to pursue the orientation to the patient's anorexic mind, they do it by follow-up turns that are related to the responses. The patient's responses to the professional's turns of introducing questions, as well as the continuing follow-up questions and formulations, are quite ambivalent. On the one hand the patients display acceptance of the suggestions but in the same turn also take a distance from the suggestion, usually by orienting the discussion to their "normality" or recovery. The patients do admit to anorexic thoughts and desires being once relevant and current but they decline the suggestion that they are also current at the moment and the reason behind the lack of progress in the recovery. The patients' turns also could

be heard as turns ending the topic. The “pursuing” of the orientation to the patient’s mind not being well yet becomes clear in these continuing sequences as the professionals stay on the topic and produce follow-up turns despite this.

### 3.3.3. Re-suggesting the problem

In one discussion of the data the professional returns to the same suggestion throughout the discussion after the discussion has moved on to new topics . When the professional re-suggests the problem after introducing it earlier in the discussion, his utterances are designed to presuppose rather strongly that there is a problem in the patient’s thoughts and desires. Still, he “makes way” for the suggestion with a prior turn(s), which initiates the topic related to the suggestion.

In the next extract the psychiatrist re-suggests the problem after the discussion has moved on to a different topic. The topic concerning the patient’s loss of weight has come up right at the beginning of the discussion. The patient has mentioned this herself. The patient has also said that mentally she is feeling better. The psychiatrist has introduced the orientation to the patient’s anorexic mind right after this and continued it with two more turns. When the patient has oriented the discussion away from the suggestion they have moved on to a different topic. Before the next extract the psychiatrist has asked the patient how she feels about the fact that the pediatrician (Liisa) has told the patient she might have to move to an inpatient unit in the hospital due to her recent weight loss. Now the psychiatrist initiates the topic and follows up with the re-suggestion.

#### Extract 7.

1 Ps: ni et (1.0) ei- (0.8) suomalaiset sanoo sillä tavalla >mä en tiiä käytetäänko

*so(1.0) no- (0.8) finns have a saying >I don’t know if it used in your*

2 teijän perheessä sellasta sanontaa ku että< (0.4) kiristys uhkailu ja lahjonta

*family this saying that< (0.4) blackmail threats and bribery*

- 3 (0.2) lasten kasvatukses (0.4) eli (0.2) e- onks tää tuttu sulle tää ilmasu.  
*(0.2) when raising children (0.4) so (0.2) s- are you familiar with this saying.*
- 4 Pa: ei .  
*no.*
- 5 Ps: se tarkoittaa että la- vanhemmat helposti <kiristää> et £saa sitäh hh jos et tee tätä£  
*it means that ch- parents easily use <blackmail> you £won't get it hh if you don't do this£*
- 6 tai uhkaa @ jos jos et syö niin sitten mä@ e- £teen  
*or threaten @ if if you don't eat then I will@ d-£do*
- 7 jot(h)ain.£  
*something£.*
- 8 Pa: °joo,°  
*°yes°,*
- 9 Ps: tai lahjonta (.) @sy:ö nyt nii saat@  
*or bribery (.) @ea:t now and you'll get@*
- 10 onks nää käytössä teil (0.3) kotona (.) sun mielestä,  
*do they use these (0.3) at home (.) in your opinion,*
- 11 (2.0)
- 12 Pa: °no ei° (0.2) kyl se aika paljon siin alus oli,  
*°well no° (0.2)it was used quite a lot in the beginning,*
- 13 Ps:jo:o.  
*ye:s.*



14 (3.0)

15 Ps: toimiiks ne (.) siis mä ajattelin et sen takii et (.) ku ilmeisesti se hh nelonenki se

*do they work (.)I mean I'm thinking because (.) apparently the hh four it's*

16 >on vähä nii ku< kiristystä ei se nyt ei [ei en] tarkoit et Liisa sanois sillä taval

*>it's a little like< blackmail it's not really [no I]don't mean that Liisa would say*

17 Pa: [joo, ]

[yes,]

18 Ps: (.) mut et et se on niin ku uhka (.) eks nii et hän tuo sulle niin ku uhan

*that (.) but that it's like a threat (.)isn't it like she gives you a threat*

19 [sem]mosen (0.2)

*[a so]rt of (0.2)*

20 Pa: [°joo°,]

[°yes°,]

21 Ps: .hh sellaset se- (.) eihän hän sillä tavalla (.) sano että et hän tekee sen vaan et

*.hh those ki- (.) she doesn't say it like that (.) that she will do it but rather*

22 sit tavalla jos et sä pysty syömään ni se (.) on se luo- kulku miten asiat sit

*in a way that if you're not able to eat so that (.) that is the way how things*

23 menee .hh mut se mut se ei ilmeisesti ei kuitenkaan riitä pysäyttää (0.4) onkse

*go then .hh but it but it apparently is not enough to stop (0.4) is it*

24 näin et s et se tehoo hetken mut sit se se ei kauaa tehoo.

*so that i- that it works for a moment but then it it doesn't work for long.*

25 (2.0)

26 Pa: no joo (0.4)mut (0.2) >se ei oo sitä et mä en pysty syömään mut mä

*well yes (0.4) but (0.2) >it's not that I'm not able to eat but I*

27 syön<,

*eat,<,*

28 Ps: =mm

29 (2.0)

30 Pa: ja sit mä oon koko ajan ↑laskennu sitä niin et paino ois ↑noussu,

*and then I have ↑counted the whole time so the weight woul ↑rise,*

31 Ps: mm,

32 Pa: mut sei ↓ookaa.

*but it ↓hasn't.*

33 Ps: mistähän se voi johtuu.

*why is that do you think.*

34 Pa: °en mä tiiä° ,

*°I don't know°,*

In lines 1-3, 5-7 and 9-10 the psychiatrist introduces the subject by describing a Finnish saying about the ways parents use to bring up a child: the three central ways are blackmail, threats and bribery. First in line 3 the psychiatrist asks if the patient is familiar with this saying, and when the patient declines he elaborates on its meaning in lines 5-7 and 9. In line 10 he asks if these methods are used in the patient's home.

The patient answers in line 12 that they are not, but in the beginning they were used quite a lot. The patient's turn is designed to indicate that everything is all right now.

The psychiatrist, however, does not leave the topic after the response from the patient but re-suggests the orientation to the patient's anorexic mind by asking a question which ends up as a turn strongly presupposing that the patient is still not in control of the eating disorder. The psychiatrist's question "do they work?" orients the talk from the past tense offered in the patient's turn to the present. He does not wait for an answer but continues his turn by elaborating on why he is asking this in lines 15-16 and 18-19. The elaboration is now related to the subject they were discussing prior to this sequence: the threat of having to move to the inpatient unit. The psychiatrist states that the pediatrician has, if not actually threatened the patient, made it clear what the consequences of her weight loss would be. In lines 21-22 the psychiatrist continues the elaboration, suggesting a possibility that the patient has a problem with eating: "if you're not able to eat." He then continues to describe how these threats just work temporarily, orienting the patient to recognize that she is not really better yet; she still has the anorexic mindset.

The psychiatrist ends the turn by asking for the patient's confirmation on this, summarizing that "they (the threats) work for a moment but not longer." In the beginning of the session the psychiatrist has first introduced the orientation to the patient's anorexic mind by asking what kind of a battle of spirits she might have in her mind at the moment, including in the question both the patient's "healthy" side that wants to recover and her anorectic side which wants to keep losing weight. In this re-suggestion there are no "options"; only the anorectic side is offered in the question.

The patient replies in lines 26-27, 30 and 32 that it is not about her not being able to eat. She does eat and she has counted calories so her weight should have gone up, but it hasn't. The patient does not buy into the psychiatrist's suggestion of the problem. She rejects the explanation suggesting that the problem is in her mind and actually directs the problem to the connection between the meal plan and weight gain: she has eaten and counted calories (followed the plan), but it has not worked like it should have.

The next extract is from the same session later in the discussion. When the professional has introduced the suggestion in the beginning of the discussion, he has asked the patient about these two sides the patient tells about: the physical side, which is worse and the mental side that is better. He has formulated it as a “battle of spirits”: one part of the patient wants to get out of this situation but the other part wants to keep losing weight. After introducing the suggestion the psychiatrist has confronted the patient about the weight loss by suggesting a problem in the prior extract. When the patient has withdrawn from the orientation to her problem, the discussion has moved away from that orientation to other topics.

### Extract 8.

1 Ps: mä ajattelin et ku me alotettiin nää haastattelut sit me puhuttiin

*I was thinking that when we began these interviews we talked*

2 syyllisyydestä paljo= muistatko?

*a lot about guilt=do you remember?*

3 Pa: joo.

*yes.*

4 Ps: ni niin tota (0.4) mietin et miten tällanen n- niin ku (1.0) <eilinen riita> ni

*so so umm (0.4) I'm thinking how this kind of a l- like the (1.0) quarrel  
yesterday*

5 (0.2) mites minkälaisia semmosia jälki (0.2) vaikutuksia ku sit sen vähän sen

*(0.2) how what sort of after (0.2) effects a little after the quarrel so*

6 riidan jälkeen ni mitä sä mahdat a- tuntee ja ajatella sitte (0.2) näit-

*what are you t- feeling and thinking then (0.2) thes-*

7 <tällasten riitojen jälkeen.>

< *after these kinds of quarrels.* >

8 (2.4)

9 Ps: osittain sitä on jo tossa sun kuvauksessa mut jos sä °mietit sitä et ° (.)

*it is partly already in that description you gave but if you °think about°*

10 minkälaisiin tunnelmiin sä jätit.

*(.) what kinds of feelings it left you with.*

11 (4.0)

12 Pa: no (10.0) kyl mä eile aika hyvin sillai suhtauduin (.) siihen.

*well (10.0) yesterday I did take it like (.) quite well.*

13 Ps: mm.

14 (4.0)

15 Pa: et ( 4.0) ei se nyt eilen (0.2) kauheesti (1.0) mitenkään (0.6) vaikuttanu (0.6)

*so (4.0) yesterday it didn't (0.2) have an effect (1.0) on me (0.6) really (0.6)*

16 jotenki (1.0) mut kyl s- ne yleensä ne riidat vaikuttaa °silai ° (0.6) aika paljon et (.)

*somehow (1.0) but it i- usually the quarrels have °like° quite (0.6) a big effect so*

17 >joskus on semmosta et jos on ollu< riita (.) ni sit (0.4) on koko päivän sillai (1.0)

*(.) >sometimes it's like if there has been < a quarrel (.) so then (0.4) I'm like*

18 tosi surullinen [tai] vihanen tai (0.2) ahdistunut.

*(1.0) really sad [or] angry or (0.2) anxious the whole day.*

19 Ps: [mm]

20 Ps: mmm.

21 (7.0)

22 Ps: ja mä=miten tähän sopii se sitte että (1.2) et ku mä ajattelin et k sä sanoit  
et

*and I =how does it then fit into this that (1.2)I'm thinking that you said that*

23 sä oot (0.2) et (.) mielialat on kuitenkin paremmat ja (0.2) voiks olla myöski  
*you are (0.2) that (.) you're in better spirits and (0.2) could it also be*

24 että (.) et niin£ <kierosti> jollai lailla£ (.)et sä jotenki myös tunnet  
mielihyvää

*that (.)so £<deviously> in some way£ (.) that you also feel pleasure when*

25 ku <se paino on laskenu.>

*the < weight has gone down.>*

26 Pa: e.i.

*n:o.*

27 Ps: sitä sun mielestä ei oo nyt.

*you don't think that's the case now.*

28 Pa: ei (.) tällä kertaa ( ) (0.3) en oo ollu yhtää,

*not (.)this time ( ) (0.3) I haven't been at all,*

29 (0.6) mä oisin >halunnu et se nousee.<

*(0.6) I would have >wanted it to rise.<*

The topic before this extract has been the patient's situation at home and her relationship with her parents. The patient has said that they just had a big quarrel at home. In lines 1-2, 4-7 and 9-10 the psychiatrist asks a question in which he calls for the patient's assessment about her feelings after a fight she has just had at home with her parents. In her response in lines 12 and 15-18 she tells that this latest fight did not

have such a negative effect on her but that usually after these situations she feels very sad, angry and anxious.

After the patient has given an answer to and stated that she did not feel so bad after the quarrel the psychiatrist does not leave the subject but follows up on the patient's response with a question, which he relates to the patient's words. He begins by asking "and how does it then fit into this that...", "this" probably meaning the lack of a negative effect of this last fight on the patient. He then retrieves what the patient said about her good spirits at the beginning of the session, and combines the mental and physical sides that the patient mentioned earlier. He suggests a problem that is related to the weight loss: the patient is in good spirits because she has lost weight, making the patient again accountable for the suggested problem. The patient turns this down straightforwardly in line 26, and after the psychiatrist's interpretation/formulation of this "no" in line 27 the patient continues with an elaboration on how she is not happy about the weight loss and is surprised that the weight has gone down.

When re-suggesting the problem already pursued earlier in the discussion the professional first initiates a topic that is not directly related to the patient's problematic ways of thinking and desiring. After this topic has been stabilized in the discussion the professional can then, in his further question, bring in the patient's problematic ways of thinking and desiring as a topic which is linked to the first topic. The first topic, in other words, serves as a springboard for the suggestion of the problem. In the same way as with the turns that continued the suggestions, this suggestion also strongly presupposes that the patient still has anorexic thoughts and desires.

### **3.4. Summary**

As mentioned at the beginning of this chapter, when it comes to eating disorders and their treatment, the lack of a sense of being ill presents the biggest challenge for the treatment as it results in strong resistance (Suokas & Rissanen). In this chapter I have shown the professionals' ways of working with this central challenge. By suggesting problems related to the patient's anorexic thoughts and desires the professionals orient the patient to seeing that her mind is not well. The issue is problematic. On the one hand the professionals have to maintain the co-operational situation and on the other

hand they must confront the patient about issues that raise resistance and even anger. The professionals deal with this difficulty by addressing the issue gradually: the problem is initially introduced in a less confrontative turn and pursued by continuing the suggestion in turns that are more straightforward. When continuing the suggestions the professionals also use the patients' own words as a basis for their suggestion. These are the turns in which the pursuit for the recognition of illness is visible in the interaction. These are also the turns after which the patients withdraw from the orientation to their ill mind.

When addressing problematic issues the professionals working in the context of illness do not usually initiate and pursue the subject straightforwardly. As in the context of alcoholism (Halonen 2001), an illness in which the lack of a sense of illness is also central, the counselor in myllyhoito does not address the issue directly when confronting the client with his addiction to alcohol. Instead, when the client is telling his life story related to his drinking history the counselor interrupts the story and asks a follow-up question in which she refers to the client's own words in his description of his drinking. The question is designed to demonstrate to the client (and others present) that the client has indeed himself revealed that he is addicted to alcohol. As mentioned in our data, the patient's own words are also used as a basis for the turns in which the professionals show the patient that her mind is not well. Their role is nevertheless far more active in the situation. The discussion in itself is led by the professionals: they produce the questions while the patient is in the role of the responder. When pursuing recognition of illness the professionals produce different kinds of turns, initiating the topic and introducing the suggestion and then continuing with follow-up turns. This makes the project of *pursuing* quite clear.

In AIDS counseling sessions (Peräkylä 1995) the issue being pursued is frightening, but the situation is different because patients know they are sick. Still, the issue is also difficult to confront as the topic(s) are dreadful and patients may be in denial of the reality of the illness or otherwise may want to avoid talking about it. As in this data, AIDS counselors do not address the dreaded issues straightforwardly but use different interactional means to bring them into the conversation. After introducing the topic earlier in the discussion the counselors often pursue it by relating it to the "worry issue" in the patient's turn. In this data the professionals use similar means as they



introduce the suggestion in a less confrontative turn, and after this move on to suggestions which they relate to the patients' own turns.

In contrast to the context of AIDS counseling, in these discussions the object of pursuit is the patients' sense of being ill and the connection between their ill mind and the deterioration of their physical condition. Even though the key point also here is to make patients confront the reality of their illness, the biggest challenge is to get patients to see that they are ill, so recovery can begin.

In the next chapter I will look at professionals' non-confrontative turns in the context of psycho education.

## **4. Delivering psycho educative turns**

Psycho-education plays a very important role in the treatment process of anorexic patients. Psycho education is an educative method of work used especially in the treatment of serious mental illnesses. The basis of education is the existence of a serious illness and the realities that are related to it. The aim of psycho education is to inform the patient about the disorder and the mechanism of the symptoms and their persistence. The education should touch upon issues such as normal weight, normal eating, symptoms of anorexia and their consequences, and teach the patient a normal way to eat. It is also important to educate the patient about the recovery process, self-control, alternative behavioral patterns, problem solving skills and skewed thoughts concerning weight and body figure. The professionals act as experts, conveying the correct information to patients and in this way reassuring them in the recovery process (Suokas & Rissanen 2007, 364). According to the textbooks, the professional's supportive and understanding approach is very important for creating a trusting relationship with a patient who is reluctant towards treatment, as well as for helping to motivate the patient. The professionals must also act as firm guides if they are to succeed in helping patients give up their destructive behavior (Suokas & Rissanen 2007, 362).

This chapter continues the theme that concerns the different interactional ways the professionals use to work with these central challenges of treating eating disordered patients. In the previous chapter I looked at the interactional ways the professionals use to confront a patient about her symptoms and pursue the recognition of illness. The turns used to do this were confrontative and questioning and suggested a problem in the patient's behavior. From the patient's ambivalent turn the professionals picked up on the ambivalence and pursued the suggestion of a problem.

This chapter focuses on psycho education and the professionals' ways of delivering these educative turns in an understanding and supportive context. As opposed to the prior chapter's suggestion of a problem, the patient's will to recover is not questioned in the turn design of the cases in this chapter. In psycho educative turns the professionals bring up their views concerning the patient's situation. The turn can consist of direct advice, evaluation of the patient's current situation or the treatment process in general, or giving information about the illness, the patient's current situa-

tion or the treatment and recovery process. All in all the turns convey the professionals' view to the patient.

Professionals deliver the psycho educative turns in an interactional context that emphasizes the supportive and understanding nature of the professional – patient relationship. They acknowledge the patient as a person wanting to and being able to recover. They do this by taking a stepwise move into the educative turn. They produce prior turns, which both create a context for the topic and display alignment with the patient. The actual educative turns are also designed to display alignment, support and understanding. In the previous chapter I showed that when a problem is suggested is implied that the patient's mind is still not well and she is resisting treatment. Thus, the resisting side of the patient is addressed and presupposed. Here the co-operating, aiming-to-recover side of the patient is emphasized in the turns. The turns display professional opinion, but use different ways keep it in the context of the patient wanting and being able to recover.

In this chapter I will first focus on CA studies focusing on advice giving practice. Then I will demonstrate the stepwise move as well as the psycho educative turns with extracts. For both of these segments I will also demonstrate how the stepwise move into the psycho educative turn and the actual educative turn create a supportive, aligning interactional environment through turn design.

#### **4.1. Conveying professional view**

When giving advice or guiding a patient, healthcare professionals usually do interactional work to deliver the advice in a context in which the relevance of the advice is displayed by connecting it to the patient's turns. The advice is also delivered in a form that displays co-operation towards the patient and underlines the patient's individuality. This is especially done when discussing situations in which the patient's own actions are part of the health problem. Patients' life styles related to their health problems seems to be one of these topics. In these discussions the doctors usually ask patients about their lifestyle right after the problem, i.e. the reason for the visit, has been presented (Peräkylä et al. 2001, 162). When giving advice, the doctors deliver it only in a form, which is in alignment with the patients' descriptions about their lifestyle.

The patients usually describe their lifestyle as unproblematic: not the (partial) cause of their health problem. In this situation the doctors keep asking specifying questions but do not make correcting remarks or give advice. The advice is given usually when the patients themselves have described their lifestyle as problematic and thus offered it as an actor in the health problem. Overall, not questioning or confronting patients about their lifestyle seems to be the doctors' overriding interactional choice (Peräkylä et al. 2001, 181-182).

In dietary counseling of diabetic children and adolescents, negotiation is an action the dieticians use to define problems and find solutions related to patients' eating habits in collaboration with the patients (Pyörälä 2006, 127). When the discussion touches upon delicate issues, usually the patient's excess weight, and dieticians produce guiding turns and suggestions that follow up on the patient's own words step by step so that the solution or change in the patient's eating habits is produced in co-operation with the patient. Guidance is also done in a supportive context, the dietician displaying acknowledgement and approval of the patient's own suggestions. When discussing the weight issue in Finnish primary health care, dieticians stay on a general level if the patient still has not displayed approval of the changes in her diet, an action common when discussing delicate issues. Guidance is thus produced in alignment, not confrontation, with the patient (Pyörälä 2006, 127– 138).

In addition to weight and lifestyle issues, advice giving seems to constitute a major challenge to professionals. In British primary health care, health visitors visiting first-time mothers with newborn babies at home also often take a stepwise shift into actual advice giving (Heritage & Sefi, 377). This is done when the mothers themselves do not initiate advice giving, that is, they do not ask for advice. This is usually the case, and this is when the HVs generally initiate advice giving in the context of routine inquiries into a range of health and baby management issues. Thus the HVs establish the need for advice and its associated problems before the actual advice is given (Heritage & Sefi, 389).

In student counseling, counselors also use a stepwise move when giving advice (Vehviläinen 2001, 179). Advice giving is not considered a central task for student counseling; rather its aim is to help the students find solutions. However, while giving advice counselors progress with question-answer-sequences basing the advice on the

patient's turn (Vehviläinen 2001, 179, 180). In this way the client's view is acknowledged in the interaction, and the professional information is offered on as individual a level as possible and in alignment with the client. This helps the client to receive and accept the advice given and enables the professional to balance between client-centered work and the need to give advice. Asking for the clients' own views also helps them to think about the topic and solution themselves (Vehviläinen, 193). Professionals involved in the treatment of adolescent anorexic patients employ practices rather similar to those mentioned above. They usually take a stepwise move into the psycho educative turn, creating a context for the turn with prior turns that initiate the topic as well as keep the discussion on that topic. The professionals also design both the prior and the educative turns in alignment with the patient so that the patient's own stance is not questioned. The design of preceding turns as well as the educative turn (the focus of this chapter) produce interaction displaying support and understanding.

#### **4.2. Psycho education in an understanding and supportive context**

As mentioned above, psycho education is an educative method of work used especially in the treatment of serious mental illnesses. The basis of education is the existence of a serious illness and the realities related to it. In this chapter, educative turns are those in which professionals express their professional view regarding patients' situation and treatment. The topics of the turns are related to the topics of psycho education: normal weight, normal eating, symptoms of anorexia and their consequences, the recovery process, self control, alternative behavioral patterns, problem solving skills and skewed thoughts concerning weight and body figure. The turn can consist of direct advice, evaluation of the patient's current situation and giving information about the current situation. All in all the turns convey the professionals' view to the patient. As mentioned, the professionals take a stepwise move into the actual educative turn. The overall pattern of moving into the turn is as follows:

1. Initiating the topic in a question
2. Patient's response
3. Follow-up question(s) staying on the topic

#### 4. Patient's response

#### 5. Educative turn

The professionals usually begin the shift to the informative turn by initiating the topic with a question concerning the patient's view or evaluation. After the patient's response the professionals continue the topic with follow-up questions before the actual educative turn. The questions are usually designed to be non-confrontational and keep the topic being discussed in alignment with the patient. All in all the turns display acknowledgement of the patient's stance, of the patient as a co-operative patient. In this way the professionals actually design the context of a co-operative patient by presupposing it in the turn design.

Both the turns before the educative turn as well as the actual turn are constructed as supportive and understanding by acknowledging the patient's position (recovery is difficult), acknowledging what the patient has said about the topic, and acknowledging the patient's progress and will to recover.

In this chapter I focus on the overall pattern of delivering the educative turns by describing both the stepwise move and the design of those turns as well as the actual educative turns. First I will demonstrate the stepwise move with extracts. Then I will move to the extracts and analysis describing the educative turns.

### **4.3. A stepwise move to the educative turn**

As in similar advice giving situations in which the treatment and its current state/possible worries are discussed, the professionals in these extracts often produce the actual psycho educative turn after first initiating the topic, usually with a question. After this they stay on the topic by producing follow-up turns related to it. The turns are designed to be aligned with the patient and contain elements that display understanding, support and acknowledgement of the patient's position. These steps prepare the way for information the professional wants to convey, and contextualize the information delivery to be in alignment with the patient through turn designs that display support and understanding of the patient's position and are not confrontational. Thus a possibly delicate topic regarding the patient's treatment is discussed in

an interactional environment where the professional's and the patient's co-operation is emphasized.

In the following extract the nurse and patient are discussing the patient's currently updated and upgraded meal plan and how the patient has felt about it. The central issue is the constantly increasing amount of food the patient has to consume, the aim being naturally to gain weight. The nurse asks a question to shift the topic from the meal plan to the patient's weight, which is the central issue of the informative turn.

**Extract 1.**

1 N: . **hh (.)tuntuuks vielä et se nyt se neljäkymment tuntuis paljoltah**

*hh (.) does it still feel like the now the forty feels like a lot h*

2 (0.6)

3 N: . hh j[os]-

*hh [if]*

4 P: [ee]i,

*[no]o,*

5 N: mm,

mm,

6 (0.4)

7 P: >mut sit <emmä tiiä(.) sen(0.2) eteen joutuu syömään niin paljon

*>but then< i don't know (.) one has to (0.2) eat so much to*

8 (0.4)

9 N: mm,

10 (0.2)

11 P: et (0.2) sais sen takas siihen

*to (0.2) get it back there*

12 (0.8)

13 N: joo.

yes.

14 (4.2)

15 N: **.hh mut oisko(0.2) sen eteen valmis sit tekemäänki töitä et sit söis nyt**

*.hh but would (0.2) you be ready to work for it that you would eat now*

16 **vähä enempi (0.2) et sais sen painon sinne neljäänkymmeneen**

*a little more (0.2) so you could get the weight up to the forty*

17 **ta<sup>o</sup>kas<sup>o</sup>,**

*aga<sup>o</sup>in<sup>o</sup>,*

18 (2.5)

19 P <sup>o</sup>no<sup>o</sup> (0.4)<sup>o</sup>kai on<sup>o</sup> pakko yrittää lainaki,£

*<sup>o</sup>well<sup>o</sup> (0.4) <sup>o</sup>i guess i have to try £at least£,*

20 (0.3)

21 N: mm,

In line 1 the nurse asks the patient a closed yes/no- question about the patient's next goal, which is 40 kg. He designs the question to ask for the patient's feelings: "does it still feel?" and includes a presupposition in the question: that the patient feels that 40 kg would be a too high a weight goal. There is a "still" in the question which presupposes that there is progress going on and marks the conversation as something that is related to this process: "Does it still feel like..." He also displays acknowledgement



that the patient might still have mixed feelings about the treatment and the recovery process and at the same time initiates a topic on this very subject.

In line 4 the patient declines but after a pause continues her turn in line 7 and 11, taking it back a bit “but then” implying a differing view. She states that she would have to eat so much to achieve this goal, showing a clear contradiction between her feeling about the goal and the ways to get there. She says she wants to recover (wants to gain weight) but then again does not necessarily want to (as getting better means eating more). After a pause in line 12, the nurse acknowledges the patient’s turn in line 13. This is followed by a long pause in line 14. This would be a place for the patient to expand her turn. The patient does not produce a turn and the nurse takes the turn in line 15, posing a follow-up question related to the patient’s turn. With the question he stays on the topic and picks up on the contradiction in the patient’s previous turn. He makes a suggestion that emphasizes the part in the patient’s turn, which implied a will to recover: “but then would you be ready to work for that.” The “but” in the nurse’s turn marks the upcoming turn as an expansion to the patient’s turn. He then continues to elaborate on the work, eating a little more, and ends his turn by explicating the goal, to get her weight to 40 kg. The nurse designs the question to suggest the patient’s possible will to work for the next goal and at the same time describes what has to be done in order for the recovery process to proceed. He also describes this as an easier task than the patient did in her description: in contrast to the patient’s “eat so much” the nurse describes it as “eat a little more.”

After a pause the patient replies quite hesitantly in line 19. She states that she guesses she at least has to try. The nurse follows his educative turn from this turn, taking up on this hesitance in the patient’s turn. This will be shown further in extract four.

In the next extract the nurse also makes a stepwise move to the informative turn, an evaluation of the patient’s current weight. The extract is from the beginning of a weekly meeting between the patient and her nurse. After asking how the patient is doing the nurse initiates a topic concerning the weighing they have had at the ward in the morning.

## Extract 2.

1 N: jäiks sua mietityttämään toi (0.5) aamun (0.5) painonotto,

*has the weighing of this (0.5) morning (0.5) been on your mind,*

2 P: no °hmhh° (0.5) ehkä vähän mut (.) ei nyt (.) kauheesti,

*well °hmhh° (0.5) maybe a little but (.) not that (.) much,*

3 N: mmm.

4 (0.75)

5 N: mikä siinä herätti semmostah,

*what was it that made you think,*

6 P: no siis haluis et se rupeis jo nousemaa=ei nyt aina et se ois aina vaan siin samassa

*well it's because I would like the weight to begin to rise now = that it wouldn't*

*just stay at the same level,*

7 tai laskenu vähän tai,

*or go down a little bit,*

8 N: mm-m,

9 P: et se aina hyppis siin sata grammaa tai kaks sataa grammaa jo°honki suuntaa°.

*that it would not constantly jump between a hundred or two hundred grams up  
°or down°.*

In line 1 she asks the patient if the weighing has been on the patient's mind. The turn is designed to ask for the patient's experience and give her the chance to talk about her thoughts. At the same time it presupposes and suggests that something in the

weigh-in could be troubling the patient, thus displaying empathy and acknowledging the patient's position. The nurse's question is also designed to project a "yes"-interrogative answer, making it more constraining than other types of questions. The question is calling for a type- conforming "yes" response (Raymond 2003). At the same time the nurse initiates the topic of her upcoming educative turn in which she conveys her professional view to the patient.

In line 2 the patient gives an ambivalent answer with signs of hesitation: with a "well" and a pondering "hmmh" she says she has thought about the weigh-in "maybe a little" but not much. After the patient does not continue to elaborate on her turn the nurse follows up with a question in line 5 asking the patient what it was that was troubling her. In her turn the nurse picks up the part from the patient's ambivalent answer that slightly admitted that the weigh-in was on her mind and continues to pursue the topic. She produces a perspective display series-type of question (Maynard 1992, 2003), enhancing the troubling part of the patient's answer. Still, as the troubling part was included in the patient's answer, the nurse's follow-up turn is not misaligned with the patient's turn. By continuing the topic the nurse makes way for her upcoming educative turn, an evaluation of the patient's current weight situation. As in a perspective display series, she co-implicates the recipient's perspective in the presentation of her professional assessment (Maynard 2003, 42).

In lines 6-7 and 9 the patient answers that she would prefer that her weight would begin to rise already and not stay at the same point, go down a bit or change within a 200 gram margin. After this the nurse delivers her educative turn. This will be shown in extract five.

In the next extract the nurse also makes a stepwise move into the informative turn, advice about the patient's current meal plan. The nurse and the patient are going over the patient's current situation. The extract is the previous extract's conversation continued a bit later. The nurse shifts the topic to eating situations at the unit, which is also the subject of her upcoming informative turn.

**Extract 3.**

- 1 N: **.hhonks totanoinni ne ruokailutilanteet täälä osastolla sun mielestä,**  
*.hh do you ummlike think the eating situations here at the unit,*
- 2 (0.7)
- 3 N: **.hh °mm° samantyyppisiä ku kotona semmosia helppoja vai,**  
*.hh °mm° are the same as at home like easy or,*
- 4 (0.5)
- 5 N: **[miten sä vertaisit.**  
*[how would you compare them.*
- 6 P: [joo no siis koton se menee ehkä vielä sillee ettei ajattele yhtää.  
*[yes well at home it's more like you don't think about it at all.*
- 7 N: joo-o.  
*ye-es.*
- 8 P: mut siis (0.2) kyl ne nyt tääl on ihan helppoi kans et °ei [oo mitään  
*but like (0.2) they are also quite easy here as well so t°her[e are no*
- 9 N: [°joo.°  
*[°yes.°*
- 10 P: ongelmi°  
*problems?°*

- 11 N: **tuleeko tota (0.5) tarkkailtua vielä (.) muitten (0.2) °syömisiä tai°,**  
*do you like (0.5) still keep watch (.) of how (0.2) °others eat or°,*
- 12 P: no [ei: ku (0.2) no ei ny oikeestaa et,  
*well[no: 'cause(0.2) well not really so,*
- 13 N: **[°ruokamääriä tai°,**  
*[°the amounts of food or°,*
- 14 N: °hhjoo.°  
*°hhyes°.*
- 15 P: tietää ↑miten niil muillaki on jo ni ei se,  
*you know ↑how the others have it so it's not,*
- 16 N: **niit ei tartte enää sit °katsoa [tai°,**  
*so you don't have to watch them °anymore [or°,*
- 17 P: [no ei.  
*[well no.*
- 18 N: °hhjooh.°  
*°hhyess h°.*
- 19 N: **eikä tunnu vaikeelta itse↑ (0.7) syödä siinä.**  
*and it doesn't feel difficult for you↑ (0.7) to eat there.*
- 20 P: ei: °tunnu yhtää°?  
*not °at all°?*
- 21 N: °hhjoo.°  
*°hhyes°.*

22 N: **harmittaaks sua se että et mä oon (.) niinku mukana siinä (0.2)**  
**mut**

*does it bother you that i am(.) like with you there (0.2) but*

23 **niinku (0.2) ruoan (0.2) ottamisessa ja,**

*like (0.2) when taking (0.2) the food and,*

24 P: no ei [niinku oikeestaa et (0.2) <e:i: °nytte> (0.2) mitenkää°,

*well [not exactly that (0.2) <n:ot: so> °much (0.2) really°,*

The patient has stated that when she is at home she hardly remembers being ill and eating as well as the situations involving eating is easy. In line 1 the nurse asks a question calling for the patient's evaluation of the situations involving eating at the hospital unit. By doing this the nurse initiates the stepwise move to her educative turn, shifting the conversation and the topic towards the topic of her educative turn, which is related to the principles and practices of the eating situations at the unit. She designs it so that it follows up on the patient's previous statement regarding similar situations at home. By asking in lines 1 and 3: "are the situations at the unit similar to what they are at home, easy or..." she displays acknowledgement of the patient's statement about her current attitude towards eating. Thus the nurse stays in line with the patient, including the patient's evaluation as a presupposition in her turn design, as she calls for the patient's evaluation on the same situations at the unit. On the other hand the "or" in line 3 can be heard as forecasting a contrast to this description. The pause in line 4 pursues a response from the patient as she could come in already. She does not and the nurse continues in line 5 with "or how would you compare these?"

The patient begins her answer, overlapping the nurse in line 6. In lines 6, 8 and 10 she compares the situations at home to those at the unit as the nurse requested, stating that at home they are very simple but they are easy and non-problematic at the unit as well. The nurse continues the topic in line 11, partly shifting the trajectory from a focus on generic contrasts between the eating situations at home and in the unit to her specific actions when eating. She asks the patient in lines 11 and 13 if the patient still

monitors the other patients' eating or the amounts of food they eat. By doing this she keeps the discussion on the topic she initiated, which is also the topic of her upcoming educative turn. The question also shifts the topic closer to the specific topic of the educative turn, which is related to the eating situations at the unit. By designing the turn as a question about the patient's evaluation the nurse does not confront or clearly question the patient's non-problematic evaluation. As the patient herself stated that eating at the unit is easy but not as easy as at home, the nurse has a chance to ask about possible problems related to eating and still not misalign with the patient. She also adds "still" in her turn, indicating that this is something that is mutually recognized as a prior problem so they are on the same line when taking this topic up.

The patient begins her answer by overlapping the nurse in line 12, and produces the answer in lines 12 and 15 in which she states that this is not a problem anymore. The "not really" in the turn design still leaves room for a small chance that the problem still exists to some extent. The patient says that because she knows now how the other patients have it she does not have to monitor them. The nurse follows up on this in line 16 with a formulation aligning with the patient's turn: "you don't have to watch them anymore." She is still staying on the topic and her turn also acknowledges the patient's experience in this matter. The patient confirms this in line 17. In lines 18 and 19 the nurse first receives the patient's confirmation and then continues the formulation by stating "and it doesn't feel difficult to eat." With the "and – preface" she displays that this formulation is continuing the same topic. The patient confirms this in line 20.

After keeping the discussion on the topic and receiving the patient's evaluation of the non-problematic eating situations at the unit the nurse asks a question in lines 22-23 which now creates a context for the upcoming educative turn. As they have discussed prior to this turn, the patient considers eating at the unit as non-problematic. The nurse now asks the patient if it bothers her that the nurse is with her when she takes food on her plate. The following educative turn (shown in extract six) contains an explanation for why this is considered necessary. With her previous turns she has initiated the topic (eating at the unit) and created a context for the educative turn by staying on the topic (talking about the nature of the situations).

I have shown how professionals create a context for their psycho educative turns by producing prior turns that initiate the topic and keep the discussion on the topic while directing it closer to the educative turn. In addition to creating a context for the turn, the prior turns are designed to display understanding and alignment with the patient they acknowledge the patient's position and work to create a supportive, co-operational interactional environment in which the patient's co-operational side (which is aiming for recovery) is presupposed and emphasized. These interactional elements are also included in the psycho educative turns. We will now look at them more closely.

#### **4.4. The educative turn**

Professionals produce the psycho educative turn after creating a context for it by producing prior turns related to the topic. The upcoming educative turn is produced as part of a dialog between the patient and the professional as the turn follows up on the prior conversation. By displaying understanding, alignment and presupposing a co-operative patient in the turn design, professionals also create a co-operative, supportive, interactional environment for the educative turn. When delivering educative turns professionals also do interactional work to keep the discussion in an encouraging and supportive context.

In the following extract (extract 1 reproduced and continued) the nurse and the patient are discussing the patient's current situation: her current weight, her next goal weight and her current feelings about these issues.

#### **Extract 4. (Extract 1. continued)**

1 N: . hh (.)tuntuuks vielä et se nyt se neljäkymment tuntuks paljoltah

*hh (.) does it still feel like the now the forty feels like a lot h*



2 (0.6)

3 N: . hh j[os]-

*hh [if]*

4 P: [ee]i,

*[no]o,*

5 N: mm, ((nyökkää))

*mm, ((nods))*

6 (0.4)

7 P: >mut sit <emmä tiiä(.) sen(0.2) eteen joutuu syömään niin paljon

*>but then< i don't know (.) one has to (0.2) eat so much to*

8 (0.4)

9 N: mm,

10 (0.2)

11 P: et (0.2) sais sen takas siihen

*to (0.2) get it back there*

12 (0.8)

13 N: joo.

*yes.*

14 (4.2)

15 N: .hh mut oisko(0.2) sen eteen valmis sit tekemäänki töitä et sit söis nyt

*.hh but would (0.2) you be ready to work for it that you would eat now*

16 vähä enempi (0.2) et sais sen painon sinne neljäänkymmeneen

*a little more (0.2) that you could get the weight up to the forty*

- 17 ta°kas°,  
aga°in°,
- 18 (2.5)
- 19 P °no° (0.4)°kai on° pakko yrittää £ainaki,£  
°well° (0.4) °i guess i have to try £at least£,
- 20 (0.3)
- 21 N: mm,
- 22 (3.2)
- 23 N: **et sehän voi tuntuu nyt vaikeelt ku >se on<(0.2) niin paljon liittyy**  
*it can feel difficult now when >it is< (0.2) so much related*
- 24 **siihe syömiseen tota liikuntaa joutunu vähentää .hh et sit ku sais ne**  
*to eating you have had to cut down on exercise .hh so when those*
- 25 **molemmat tähän mukaan ni se syöminenki varmaan niinku**  
*both would be in this so the eating would probably like*
- 26 **helpottais(.) .hh mut et sais semmosen turvallisen painon nyt**  
*get easier (.) .hh but that (one) could get one's weight to a safe level*
- 27 **sulle ni (0.2) se ois varmaan semmonen ensimmäinen tavoteh,**  
*so (0.2) that would probably be the first goal h,*
- 28 (1.5)
- 29 P: °joo°,  
°yes°,

As shown in ex.1, the nurse has produced turns, which have initiated the topic and created a context for the upcoming educative turn. After the patient's slightly reluctant reply (I guess I at least have to try) to his prior turn, which suggested that the patient would be willing to work for the next goal weight, the nurse continues with the educative turn in lines 23-27. He formulates the patient's previous turn by stating that it can feel difficult, and then continues to elaborate on why this is so: the patient has had to cut down on exercise and eat more. Aligning with the principals of psycho education, the nurse is giving the patient the correct information about her disorder and the kind of difficulties it might inflict upon the patient in this process. In lines 24-27 he continues the turn by elaborating on the professional opinion in the situation. He gives information on the recovery process in lines 24-26, telling the patient how the process will get easier as the difficulties are overcome. He then ends his turn in lines 26-27 by giving his professional view, informing the patient about the next target in the treatment process. The patient receives this with agreement, although with a minimal response.

By beginning the educative turn as a formulation of the patient's prior quite reluctant and ambivalent turn (it can feel difficult), the nurse both displays acknowledgement and understanding of the patient's position and conveys information on her symptoms: this is part of the game. The nurse continues with a candidate understanding of this difficulty in lines 23-24: the patient has had to cut down on exercise and at the same time she has had to eat more. The nurse also designs the turn to display their cooperation in the process: he does not individualize the patient as the sole actor and responsible party in the process but designs the turn in the Finnish zero person, which leaves open the possibility of many actors in the process. In this way the nurse delivers the professional information in a supporting and understanding environment, underlining the co-operative nature of their treatment relationship.

In the following extract the nurse delivers the educative turn after initiating the topic and calling for the patient's evaluation of it. The topic is on weight progress.

**Extract 5. (Extract 2. reproduced and continued)**

- 1 N: jäiks sua mietityttämään toi (0.5) aamun (0.5) painonotto,  
*has the weighing of this (0.5) morning (0.5) been on your mind,*
- 2 P: no °hmhh° (0.5) ehkä vähän mut (.) ei nyt (.) kauheesti,  
*well °hmhh° (0.5) maybe a little but (.) not that (.) much,*
- 3 N: mmm.
- 4 (0.75)
- 5 N: mikä siinä herätti semmostah,  
*what was it that made you think,*
- 6 P: no siis haluis et se rupeis jo nousemaa=ei nyt aina et se ois aina vaan siin samassa  
*well it's because i would like the weight to begin to rise now = that it wouldn't just stay at the same level,*
- 7 tai laskenu vähän tai,  
*or go down a little bit,*
- 8 N: mm-m,
- 9 P: et se aina hyppis siin sata grammaa tai kaks sataa grammaa jo°honki suuntaa°.  
*that it wouldn't constantly jump between a hundred or two hundred grams up °or down°.*
- 10 (1.5)
- 11 N: **.hhh tommonen (.) sadan tai kahen sadan gramman- ni just et katotaan sitte**  
*.hhh that kind of a (.) a hundred or two hundred gram- so we'll just see*
- 12 **pitkällä [niinku]**  
*in the long [like]*

13 P: [niii, ]

[yees, ]

14 N: välillä aina sitä punnitusta [mutta .hhhh ]

*run how the weighing goes [but .hhhh]*

15 P: [niin no ei siin] nii,

*[yes well it's not] that,*

16 N: et sillä tavalla mut nythän se on ihan selkeesti et (.) ollu (.) vähän

*so like that but now it clearly like (.) has (.) been a little*

17 laskusuunnassa ja,

*downwards and,*

18 (0.7)

19 N: ja sit varmaan just herättää (.) ajatuksia se että et (0.7) sitä

*and then it must make you (.) think about the fact (0.7) that*

20 ateriasuunnitelmaa on (0.5) sä oot pystyny sitä (.) nostamaan mut et se  
[ei,]

*the meal plan has been (0.5) you have been able to (.) raise it but that it  
[does not],*

21 P:

[°mmm°]

22 N: nyt kuitenkin vielä näy .hhh vielä näy siinä painossa?

*anyhow show yet .hhh yet in your weight?*

23 P: °mmm°,

24 N: mutta totah,

*but well h,*

25 (1.5)

26 N: sulla on nyt kaheskymmeneskolmas päivä sit se seuraava ni,

*you have that next on the twenty third so,*

27 P: °nii joo°.

*°well yes°.*

As demonstrated in extract 2, the nurse has initiated the topic of her upcoming educative turn (patient's current weight) by asking the patient if the weighing in the morning has left her feeling troubled. After the patient's ambivalent reply (maybe a little but not so much) she picks up on the "yes"-side of the answer and continues on the topic by calling for the patient's elaboration on this.

The patient states in lines 6, 7 and 9 that she would like the weight to start going up instead of going up and down a few hundred grams all the time. After a pause the nurse begins the educative turn in line 11 first by commenting on the end of the patient's turn. She begins the turn by stating that this kind of 200 gram change is something they will look at over a longer period, displaying to the patient that this is something that is not troubling. In lines 16-17 the nurse continues her turn with a "but," implying there is still something else in the patient's turn she will comment on. The nurse now picks up on the part in the patient's turn which mentioned the weight also still going down and produces an expert judgment on the patient's situation: "it (the weight) clearly has been a bit downwards and." After a pause she continues her turn in line 19 with an expert judgment on the patient's situation: the patient has been able to raise her meal plan (eat more) but it does not show in her weight yet. She designs this to emphasize the patient's position: "and then it must make you think" and delivers the judgment in lines 20 and 22 as something she presupposes is on the patient's mind. By doing this she delivers her evaluation on the patient's non-improved situation in an unfrontative way. In line 23 the patient receives this with a quiet "mmm", a quite minimal response.

In this extract the nurse conveyed her own worry and her professional opinion about the patient's situation, the weight going down. She did it in a context in which the patient was presupposed to be a person who wants to recover and is thus worried about the weight not rising as expected, and not happy about it. The nurse also displayed that the patient had done as was expected. With the design of the steps leading to the informative turn, the previous questions, the nurse was able to deliver the informative turn in a context which again underlined the patient's will to recover and the cooperation of the patient and the nurse.

In the next extract the nurse also delivers the educative turn after first creating a context for it as part of a dialog between the patient and herself. The topic is on the unit's eating situations and the principles regarding these as well as the treatment.

**Extract 6. (Extract 3. reproduced and continued)**

1 N: .hnonks totanoinni ne ruokailutilanteet täälä osastolla sun mielestä,

*.hh do you ummlike think the eating situations here at the unit,*

2 (0.7)

3 N: .hh °mm° samantyyppisiä ku kotona semmosia helppoja vai,

*.hh °mm° are the same as at home like easy or,*

4 (0.5)

5 N: [miten sä vertaisit.

*[how would you compare them.*

6 P: [joo no siis koton se menee ehkä vielä sillee ettei ajattele yhtää.

*[yes well at home it's more like you don't think about it at all.*

7 N: joo-o.

*ye-es.*

- 8 P: mut siis (0.2) kyl ne nyt tääl on ihan helppoi kans et °ei [oo mitään  
*but like (0.2) they are also quite easy here as well so t<sup>h</sup>er[e are no*
- 9 N: [°joo.°  
 [°yes.°
- 10 P: ongelmi?°  
*problems?°*
- 11 N: tuleeko tota (0.5) tarkkailtua vielä (.) muitten (0.2) °syömisiä tai°,  
*do you like (0.5) still keep watch (.) on how (0.2) °others eat or°,*
- 12 P: no [ei: ku (0.2) no ei ny oikeestaa et,  
*well[no: 'cause(0.2) well not exactly so,*
- 13 N: [°ruokamääriä tai°,  
 [°the portions of food or°,
- 14 N: °hhjoo.°  
 °hhyes°.
- 15 P: tietää ↑miten niil muillaki on jo ni ei se,  
*you know ↑how the others have it so it's not,*
- 16 N: niit ei tartte enää sit °katsoa [tai°,  
*so you don't have to watch them °anymore [or°,*
- 17 P: [no ei.  
 [well no.
- 18 N: °hhjooh.°  
 °hhyess h°.



- 19 N: eikä tunnu vaikeelta itse↑ (0.7) syödä siinä.  
*and it doesn't feel difficult for you↑ (0.7) to eat there.*
- 20 P: ei: °tunnu yhtää°?  
*not °at all°?*
- 21 N: °hhjoo.°  
*°hhyes°.*
- 22 N: harmittaaks sua se että et mä oon (.) niinku mukana siinä (0.2) mut  
*does it bother you that i am(.) like with you there (0.2) but*
- 23 niinku (0.2) ruoan (0.2) ottamisessa ja,  
*like (0.2) when taking (0.2) the food and,*
- 24 P: no ei [niinku oikeestaa et (0.2) <e:i: °nytte> (0.2) mitenkää°,  
*well [not exactly that (0.2) <n:ot: so> °much (0.2) really°,*
- 25 N: [°ja°,  
*[°and°,*
- 26 N: **et siin välissä kun (.) kun totanoinni (.) sä otit itse ni (0.2) niinku**  
*'cause in between when (.) when like (.) you took it yourself (0.2) so*  
*like*
- 27 **puhuttiinkkin (.) ni (0.2) mä aattelin mun mielest on ehkä parempi**  
*we discussed (.) so (0.2) i thought i think it's maybe better*
- 28 **että mä oon nyt taas (.) siinä mukana ettei [lähde,**  
*that i'm again there now (.) with you so it [doesn't get,*
- 29 P: [nii joo.

*[oh well yes.*

- 30 N: et sillon kun mä en ollu ni tuntu et ne pikkuhiljaa vähän ehkä  
*'cause when i wasn't so it felt like they gradually maybe got*
- 31 pienenee ne (0.2) ne annokset ei ole (.) paljosta kysymys mutta (.)  
*a little smaller the (0.2) the portions it's (.) not a question of much*  
*but (.)*
- 32 mutta tota,  
*but like,*
- 33 P: niin no joo: (.)[ kyl se on ehkä sillee parempi et varsinki jos mä en  
mittaa  
*well yes ok: (.) [it is maybe better so especially if i don't measure*
- 34 N: **[ihan,**  
*[really,*
- 35 P: et siin on sit niinku,  
*it is then like,*
- 36 N: joo.  
*yes.*
- 37 P: et sama [jos ottaa liian vähän.  
*the same [if you take too little.*
- 38 N: **[joku katsomassa.**  
**[somebody watching.**
- 39 P: nii.  
*yes.*

- 40 N: =<sup>o</sup>.hhjoo<sup>o</sup>.  
 =<sup>o</sup>.hhyes<sup>o</sup>.
- 41 N: **et vaikka se ehkä ärsyttäis sillä hetkellä ku [ajattelee et se on nyt  
 siin**  
*'cause though it might be annoying at the moment when [you think that  
 there she is*
- 42 P: [nii.  
 [yes.
- 43 N: **ja .hhja katot ja tarkkailee[mutta tota,  
 and .hh and watching and observing [but like,**
- 44 P: [mm-mh.. ((hymyilee))  
 [mm-mh. ((smiles))
- 45 N: **niinku aikasemminki on käyny et et sitte ku pikkase ottaa  
 vähemmän**  
*like it has happened before that that when you take a little less*
- 46 **ni sit seuraavalla kerralla taas vähän vähemmän [ja,  
 so then the next time you take a little less again [and**
- 47 P: [nii: <sup>o</sup>ei se<sup>o</sup>,  
 [yes: <sup>o</sup>it's not<sup>o</sup>,
- 48 N: **ja tuntuu >et en mä voi ainakaan syödä< enempiä ku eilen ja (.) ja  
 (.)**  
*and it feels >like i can't eat any< more than yesterday and (.) and (.)*
- 49 **sit (.) lähtee semmonen pieni kierre niin yritetään sitä nyt sit pitää**

- then (.)it spins into a little cycle so let's then do try to keep*
- 50 **kiinni että.hh** °et aina laittaa lasit täyteen ja°,  
*to it that .hh °that always fill up the glasses and°,*
- 51 P: mh[h.
- 52 N: [°ja se annos on just just se (.) oikee määrä ja,°  
*[°and the portion is just just the (.) right amount and°,*
- 53 N: et ku se ateriasuunnitelma on kuitenkin vaan se minimi (0.2) että et  
 sen  
*'cause the meal plan is still only the minimum (0.2) that that one*
- 54 **ainaki** pitäis saada että et mielummin sitte vähän °enemmän°. *at least should get that so preferably then a little °more°.*
- 54 P: mm-m.
- 55 N: =kun sen ateriasuunnitelman °verran°↓ (.) mutta tota:,  
*=than the meal plan °portion(?)°↓(.) but well:,*
- 56 (1.5)
- 57 N: et p- et (.) ettei vaan lähde (0.2) sitte pienemmän↓ [°pidetään  
 niistä  
*so l-that (.) it doesn't get (0.2) smaller then so [°let's stick to*
- 58 **kiinni**°. *it°.*

As shown in extract three, the nurse has initiated the topic of her educative turn with a question shifting the topic towards the educative turn. The discussion is on the pa-

tient's evaluation of the eating situations at the unit. She uses follow-up turns to stay on the topic, shifting it towards the educative turn and creating a context for it.

Before the actual educative turn the nurse directs the discussion specifically to the topic of her upcoming turn. When asked, the patient has stated that eating does not feel difficult, nor do those situations at the hospital unit. In lines 22-23 the nurse asks the patient if it irritates her that the nurse is with her when she takes food on her plate. In line 24 the patient answers in the negative although slightly ambivalently: "not exactly...not really". The nurse continues her turn, overlapping the patient in line 25, and in line 26 she moves to the educative turn. She begins it with a pre-sequence in lines 26-28 (Schegloff 2007), making her upcoming turn relevant. She refers to a period when the patient took care of the food rationing her, and in lines 26-27 she adds "like we discussed," displaying that this is something they have thought about together. In line 27 she moves on to explicate her own view of the situation, i.e., why she is now with the patient when the food is rationed. In lines 27-28 she says: "so I thought I think it's maybe better that I'm there again now," displaying that this is her opinion but softening the straightforward professional "order" with "maybe." and in this way marking it more like something the patient can also influence. By doing this the nurse maintains the co-operational, aligning interactional environment. She begins explaining this opinion in line 28 with a more straightforward claim, "so it doesn't get," but repairs, and in lines 30-32 produces a more elaborative explanation instead of a clear presupposition. She says, "Because when I wasn't there it felt like the portions maybe got a little smaller" displaying that this is her own feeling about the situation, not a claim of the patient's intentions. She also adds mitigating features such as "maybe a little smaller," again displaying that she is not claiming that this necessarily happened and thus not confronting or misaligning with the patient. If she had said, for example, "so it doesn't get out of hand" she would have displayed a more one-sided presupposition, excluding the patient in the process. By designing the elaboration in this way the nurse included the patient as an actor in the process as she gave the patient a reason for her presence but designed it as her personal view, which is open to correction. In lines 32-33 she still adds, "It's not a question of much but," mitigating the part which implies that the patient has reduced the portions of food.

The patient produces an aligning response in lines 33, 35, 37, and 39, confirming the nurse's perception of the situation in which the patient has rationed the food herself. She states that especially if she does not weigh the portions they tend to get smaller and having somebody there is better.

After the patient's confirming response the nurse continues her educative turn with an elaboration in line 41. As the patient has now stated that the amounts tend to get smaller if she does not weigh them, and it is better to have someone monitoring her, the nurse can design the elaboration more straightforwardly. In lines 41, 43 and 45-46 she states that even if supervision is annoying, without supervision the portions have gotten smaller and smaller. She says this now without the mitigating features, as a fact the patient is also agreed on. In lines 48 – 50 and 52 – 55 she continues to elaborate on a description of how the situation can worsen if the illness gets the upper hand (?) and then how this must be taken into consideration and prevented. She continues with a statement that the meal plan is only the minimum. As the nurse describes the risk and what must be done to prevent it, she designs the turn "let's then do try to," again marking the patient and herself as co-workers. In lines 57- 58 she ends the turn by stating that "we will stick to the plan".

In this extract the nurse gave the patient information about the meal plan, the patient's current situation in terms of eating, the treatment principles and pitfalls of the illness, as well as what must be done at this point of the treatment in order to tackle the pitfalls. She did it in a context in which the patient is presupposed to be a co-operative, active participant in the treatment. The educative turn was designed to present her professional view and information in alignment with the patient and acknowledging the patient's position.

The next extract is the prior extract continued. After the nurse's educative turn the patient produces an agreeing and aligning elaboration related to the educative turn. The nurse follows up on this with an elaboration of the educative turn.

**Extract 7. (Extract 6. discussion continued)**

- 1 N: et ku se ateriasuunnitelma on kuitenkin vaan se minimi (0.2) että et sen  
2 *'cause the meal plan is still only the minimum (0.2) that that one*  
3 ainaki pitäis saada että et mielummin sitte vähän *°enemmän°*.  
*at least should get that so preferrably then a little °more°.*
- 4 P: mm-m.
- 5 N: =kun sen ateriasuunnitelman *°verran°*↓(.) mutta tota:,  
*= than the meal plan °is°↓(.) but well:,*
- 6 (1.5)
- 7 N: et p- et (.) ettei vaan lähde (0.2) sitte pienenemään↓[ *°pidetään niistä*  
*so l-that (.) it doesn't get (0.2) smaller then so [°let's stick to*  
8 *kiinni°*.  
*it°.*
- 9 P: [nii: °ja (.) nii°.  
[y:es °and (.) yes°]
- 10 N: *°hhjoo.°*  
*°hhyes.°*
- 11 (1.5)
- 12 P: ja kylhän sen (.) kotonaki et pitää olla aikamoinen et  
*and at home (.) it also has to be quite much because*
- 13 (.) viime viikonloppunaki no en mä viimeviikonloppun mut sillee et (.)  
*(.) last weekend or I didn't last weekend but like sometimes (.)*
- 14 joskus huomaa et niinku kaataa johki lasii sillee vähän ni sitte on sillee et  
*you notice that you like pour a little something in a glass and then you're*

- 15 kaadaks mä nyt lisää,  
*like do I pour more,*
- 16 N: mm-[m.
- 17 P: [sit miettii hetken sit kumminki (0.2) kaataa yleensä et,  
*[then you think for a moment and usually you (0.2) pour more so,*
- 18 N: nii.  
*yes.*
- 19 (0.7)
- 20 P: kyl siin niinku pitää kyl niinku sillee miettii et ottaa nyt varmasti sen  
*you really have to think like that you take the right amount for*
- 21 verran?  
*sure?*
- 22 N: **joo (0.2) ja käydä ittensä kanssa vähän sitä.hh (0.2) pohdintaa et vitsi**  
*yes (0.2) and contemplate it a little .hh (0.2) that gee*
- 23 **että et pidäkö mä nyt niinku et kumman mä lähden (.) kumpa**  
*that that do I now like which way do I go (.) which*
- 24 **(0.2)[suuntaan,**  
**(0.2)[direction,**
- 25 P: [niin.  
*[yes.*
- 26 N: **että annanko mä .hh niinku itselleni (0.2) luvan vähä (0.2) vähä tota**  
*that do I like .hh give myself (0.2) permission to (0.2) to umm*
- 27 **(0.2) vähentää vai että et (.) olenko tiukkana jahh (.) et ei et nyt mä kyl**



- (0.2) *cut down a little or that (.) do I stay firm andhh (.) that no now I'm*
- 28 niinku (0.2).hh pidän täst kiinni et taa- tää vie kaikki eteenpäin.  
*like (0.2) staying with this that t- this all takes me forward.*
- 29 P: mm-m.
- 30 N että terve<sup>o</sup>dyttää et<sup>o</sup>,  
*makes me bet<sup>o</sup>ter so<sup>o</sup>,*
- 31 (0.7)
- 32 N: <sup>o</sup>et ku on<sup>o</sup> (0.2) se vaatii vaan semmost lujuutta [iteltä varmasti ettäh,  
<sup>o</sup>so because<sup>o</sup> (0.2) it just demands firmness [ on my part for sure so hh,
- 33 P: [nii.  
 [yes.
- 34 N: ei ihan helppoo aina (0.5) aina ookaan <sup>o</sup>mutta<sup>o</sup>,  
*it really is not always (0.5) easy <sup>o</sup>but<sup>o</sup>,*
- 35 (1.5)
- 36 N: mut kyl sä oot hienosti niinku (0.5) pärjänny (0.5) nyt et et niinku toi  
*but you have been doing like (0.5) really well (0.5) now like the the*
- 37 ateriasuunnitelmanki (0.7) nostaminen ni (0.5) se ei varmaa ollu sitte  
*increasing(?)(0.7) the meal plan so (0.5) it mustn't've been*
- 38 (0.7) ihan [helppoa (0.2) helppo päätös mutta,  
*(0.7) that [easy (0.2) an easy decision but,*
- 39 P: [ei: no (.) siis itseasias se oli,  
*[no: well (.) actually it was,*
- 40 P: >no en mä tiiä se< päätös >mut oli se sit niinku< iha (0.5) helppo kotona ku,

*>well I don't know the <decision> but it was like< really (0.5) easy at home,*

41 N: nii et sitte ruveta vaa,

*so just do it,*

42 P: nii ja sit [perjaattees ku,

*yes and then actually when,*

43 N: [et sit ku oli tehny sen päätök[sen.

*[when you had made the decis[ion.*

44 P: [nii ja sit per[jaattees,

*[yes and then ac[tually,*

45 N: [joo.

[yes.

46 P: ku oli viel miettinyt sitä et (0.5) n- sinne oli jo (.) asennoitunu siihen sit @mä

*when you had thought about it (0.5) so t- you had-(.) already oriented to it*

47 otan sen@ leikkeleen sit leivänpäälle ni sit sen vaan otti.

*@I'll take? that @piece of sausage on the bread so you just did.*

As seen in the prior extract, the nurse has produced an educative turn, a long explanation of how and why it is important at the moment for her to be present when the patient takes food on her plate. She has stated that although it might be annoying, it is important because the patient might easily slip into eating less if she does not have support. She describes the possible pitfalls related to the illness as well as the principles regarding the treatment. In lines 12-15 and 17 the patient produces a turn, which accepts the nurses turn. She has already started this in line 9, overlapping the nurse with an agreeing “yes”. Now she begins her turn in line 12 with “and at home it also has to be quite much” following up this from the nurse’s description. He then gives a description that confirms the nurse’s view and displays that she is able to see that side

in herself which might slip into eating less, also when the nurse is not present (at home). She gives an example of this kind of situation, which concludes with the patient stating in lines 17 that usually (0 person) does overcome the urge to take less food or drink. In line 18 the nurse receives it with a “nii”. After a pause the patient continues her turn in line 20-21 by returning to the reasons the nurse stated for her presence when the patient is taking food. She says: (0 people) has to think about it that (0 person) really takes the right amount”. She displays that she agrees to offer a perception of herself as a patient who is aware of her illness, and willing to work for recovery.

In line 22 the nurse receives the patient’s turn with an agreeing “yes” and then follows up on the patient’s description in lines 22-24, 26-28 and 30. She continues with an educative turn from the end of the patient’s previous turn extending the patient’s statement about having to think about the food amounts: “yes and contemplate it. ”. She then continues with a description of the contemplation. She designs this in the 1<sup>st</sup> person, as being the patient’s thoughts: “which way do I take, do I give myself the permission to take less or do I stay firm” in lines 22-24 and 26-27. She then continues in line 28 by describing the right way to contemplate: “No I’ll stay with this.” She continues in line

30 by explicating the reason why one should stick to the meal plan, keeping to the same turn design: it all takes one forward and makes one better. She again describes to the patient the nature of the illness and the challenges that come with it.

After a pause she continues in line 32, now moving away from the 1<sup>st</sup> person and designing the turn with herself as the speaker. The continuance is now a formulation of the previous description of the patient’s contemplation. She says in lines 32 and 34 that this is not easy and it takes firmness. After a pause in lines 36-38 she

Concludes the turn by stating that nevertheless the patient has done well even though adding food to the meal plan must not have been easy. In line 39 the patient receives this by stating that it actually was easy and in line 40 corrects herself by continuing that perhaps the decision was not easy but at home it was, cutting the turn off. In line 41 the nurse produces an aligning turn, a candidate understanding of the patient’s turn, which she cut off: to just begin doing it (the meal plan). In line 42 the patient

receives this, agreeing with it, and continues her turn by beginning an elaboration which the nurse overlaps with her elaboration on her candidate understanding in line 43: (it was easy) having made the decision. In lines 44, 46 and 47 the patient again receives this, agreeing with it, and continues with a description of how after pondering on the decision and orienting to it, the action itself was not difficult.

Continuing from the patient's turn, the nurse's turn design displays acknowledgement of the perception the patient offered: she recognizes the challenges of the illness and wants to work with them. At the same time the nurse describes the challenges of the illness to the patient without misaligning with her. At the end of her turn she also displays understanding towards the patient's position stating that this (recovery process) takes courage and is not easy. She displays acknowledgement of the patient's will to work for her recovery stating that she has done very well even though it must have not have been easy. When the patient receives the educative turn by bringing up how easy it actually was, the nurse aligns with this. The nurse has thus conveyed psycho-educative information about the illness and its treatment to the patient in an interactional environment, which emphasizes their co-operation and presupposes the patient as a person who wants to get better. She has also included interactional elements which deliver this turn in an understanding and supportive context.

In the next extract a pediatrician delivers a psycho-educative turn after a short step-wise move. The pediatrician is doing a physical examination of the patient. Before the examination they have had a short discussion (with the nurse present) on the patient's recent weight loss.

### **Extract 8.**

1 D: °onks sul° ollu oksentamisen (0.5) halua tai semmost tunnetta et pitäs  
oksen°taa°,

*°have you had a desire to (0.5) throw up or the kind of feeling that you need  
to throw up°,*

- 2 P: #no (0.2) <kyl> s<sup>o</sup>i<sup>o</sup>tä# (.) aika paljon aattelin,  
*#well (0.2) <i did> think# (.) about it quite a lot,*
- 3 (0.2)
- 4 D: mmm,
- 5 P: jossain vaihees mut sit (0.2) <sup>o</sup>e<sup>o</sup>- emmä jotenki vaa (.) <sup>o</sup>uskalla<sup>o</sup>,  
*at some point but then (0.2) <sup>o</sup>i<sup>o</sup>- i just don't (.) <sup>o</sup>dare<sup>o</sup>,*
- 6 D: joo se olis kyl,  
*yes that really would be,*
- 7 (0.3)
- 8 P: [<sup>o</sup>nii<sup>o</sup>],  
*[<sup>o</sup>yes<sup>o</sup>],*
- 9 D: [se o]n hyvä että et oksenna et et se on hi[rveen],  
*[it i]s good that you don't vomit so so it's a ter[ribly],*
- 10 P: [joo ],  
 [yes ],
- 11 D: se on semmonen <sup>o</sup>m-m<sup>o</sup>- miten mä nyt sanosin se on <sup>o</sup>ni<sup>o</sup>- (.) oire jolla sä  
 voit (0.2)  
*it is that kind of a <sup>o</sup>h-h<sup>o</sup>- how should i put it it is <sup>o</sup>s<sup>o</sup>- (.) a symptom with  
 which you can (0.2)*
- 12 voit semmosen elimistön tasapainotilanteen sotkee hirveen .hhh herkästi  
 ja sitä  
*can mess up the balance in the body terribly .hhh easily and in addition*
- 13 paitsi se on myös niinkun .hhh painon hallintaa ajatellen ni se on  
 #huono#,

*to that it's also like .hhh considering weight loss it is a #bad#,*

14 P: joo,

yes,

15 D: *ei sillä oikeestaan niinkun (.)tee mitään muuta ku haittaa it<sup>o</sup>selleen<sup>o</sup>,*

*one really doesn't do like (.) anything but harm to oneself with it<sup>o</sup>,*

16 D: .hhh avaaksä suuta.

*.hhh can you open your mouth.*

17 (1.0)

18 D: jo- sanos aaa,'

*ye- say aaa,*

While going through the examination (without the nurse present) the pediatrician continues the topic with questions covering the patient's current situation. In line 1 she initiates the topic of the upcoming educative turn by asking if the patient has had the urge to throw up or has had the feeling she has to do so. She designs the question in a way that does not mark the possible vomiting as something the patient would willingly do (have you wanted to throw up) but as possible symptoms which the patient might have: have you had the urge/ have you had a feeling. In line 2 the patient states that she has thought about it quite a lot, and after a short pause and the pediatrician's minimal response in lines 3 and 4, she continues in line 5 by adding "at some point" and states that she hasn't had the courage to do so. In line 6 the pediatrician begins her turn by stating "that really would be," which can be interpreted as a beginning of what will be the educative turn a bit later. She repairs herself and after a short pause produces an educative turn in which she comments that it is very good that the patient does not vomit and continues the turn by beginning to state the reason for why it is good: "for it is so terribly." After the patient's overlapping "yes" in line 7

the pediatrician corrects herself and continues to give the reason in lines 11-13. The turn contains an information delivery: vomiting can disturb the metabolism and it is also a poor way of controlling weight. She designs the turn to emphasize the symptomatic nature of vomiting: “it is a symptom with which,” giving the patient information on the symptoms related to the illness. She also informs the patient about vomiting as a way of controlling one’s weight. After the patient’s “yes” in line 14 the pediatrician continues with an elaboration in line 15, and sums up by saying that the patient only harms herself and nothing else. After this the pediatrician moves on with the examination.

Although the pediatrician did not take any longer stepwise move to the educative turn, she created a context for it with her initial question. She also added an encouraging acknowledgement before moving on to the information delivery by stating how good it was the patient did not vomit although she had thought about it. This acknowledgement also continued to create the context for the educative turn as the positive acknowledgement could be elaborated on with reasons.

#### **4.5. Summary**

In this chapter I have shown that as in many institutional situations, when delivering psycho educative turns professionals take a stepwise move into the informing turn. Also, in line with the previous findings of advice giving, especially concerning the patient’s lifestyle, eating habits and weight issues in relation to their health problems and their treatment, the professionals design the steps as well as the actual educative turn in line with the patient, not in confrontation with her.

I have shown that professionals create a context for their psycho educative turns by producing prior turns that initiate the topic and keep the discussion on the topic while directing it closer to the educative turn. The prior turns are designed to display understanding of and alignment with the patient, while acknowledging the patient’s position. Thus they work to create a supportive, co-operational interactional environment in which the patient’s co-operational side, which is aiming for recovery, is presupposed and emphasized. Because the educative turn follows up on the prior conversation it becomes part of the dialog between the patient and the professional. By

displaying understanding and alignment and pre-supposing a co-operative patient in the turn design, the professional has also created a co-operative, supporting interactional environment for the educative turn.

Patients receive these educative turns with turns that display agreement with the professionals. When receiving turns that suggest a problem in the patients' way of thinking, they display resistance and ambivalence. Educative turns are thus received with more agreement. The receiving turns can nevertheless be quite minimal responses such as a quiet "yes".

During the same discussion professionals confront the patient and suggest problems, as illustrated in the previous chapter, as well as present their views and information in alignment with the patient in a more guiding context, as in this chapter. Although both interactional methods occur in every professional's discussions (meaning they all do interactional work to deal with the various challenges of the treatment), it is clear that psychiatric nurses mostly keep the discussion within a guiding context, in alignment with the patient. Pursuing and suggesting a problem is clearly more the work of the psychiatrist. This might very well be because the nurses are in charge of the patients' "everyday" treatment. They are with them on the ward and are present as the patients go through everyday routines such as treatment and meal times. The psycho-educative work is therefore clearly their field. As the psychiatrist says to a patient on one of the tapes: "My task is to find some psychological factors underlying your illness." It would seem very natural that this kind of task involves a great deal of confrontation, while everyday treatment and supporting it would demand a more concrete, co-operational relationship; hence the aim for alignment. It is as if the psychiatrist's task is to confront the side that does not recognize the illness and is thus keen on resisting recovery. In contrast, the nurses' task would be to support the side that wants to recover.

In the two previous chapters I have focused on professionals' interaction in free form discussions. In the next chapter I will look at the methods professionals use during a half-structured diagnostic interview.



## **5. Between professional theory and patient individuality:**

The professional's ways of creating an alliance with the patient in a semi-structured diagnostic interview

In this chapter my focus is on the interaction in semi-structured diagnostic interviews. These diagnostic interviews are done by a psychiatrist at the beginning of the patients' treatment period.

According to a psychiatric guide, during a psychiatric interview professionals must maintain a position in which on the one hand they take into account the individuality of the patient and on the other they remain on a reasonable theoretical level in order to gather the needed information on the patient's symptoms. Patients might feel intimidated if professionals distance themselves completely during the interview, and maintain the interaction on a solely general and theoretical level (Lönnqvist 2007).

In the context of treating eating disorders, trust and good contact between patient and professional are very important elements in the treatment, as it helps motivate a patient who lacks the will to get well. This motivational relationship should be established right from the beginning, also when assessing the patient (Lönnqvist 2007).

This chapter continues the theme of the professionals' challenge in treating eating disordered patients: to establish a co-operational alliance with patients who lack the recognition of illness and therefore are keen on resisting treatment. Because of the patient's own fear and resistance it is important that the relationship between patient and professional be based on trust and an understanding of the patient's situation. At the same time professionals must be strong and offer guidance in order for patients to be able to eventually give up their symptoms (Lönnqvist 2007). The professionals must also keep bringing up the illness if the patient is to confront it in herself, and do it without causing the patient to withdraw completely from the interaction (and the rest of the treatment).

In the third chapter on non-structured treatment discussions the professionals confronted the patient straightforwardly. They produced turns which did not align with the patient's turn but instead suggested that the patient's mind was not well yet and

thus her evaluations of her situation could be questioned. In the prior chapter we saw the professionals' interactional tools when delivering psycho educative turns. They worked with the challenge of being understanding and supportive by giving their professional input while acknowledging the patient's will to get well.

In this chapter on half-structured diagnostic interviews the psychiatrist creates and maintains a co-operational situation, which is basically instrumental and dictated by the diagnostic interview. By this I mean that in this interactional situation the professional must get answers to certain questions, even if he is not restricted by a strictly structured questionnaire. Still, each diagnostic area (disorder) has to be covered and graded on the 1-3 scale in the questionnaire. Yet, as this is not a structured interview, designing the questions and creating the interactional situation are in the psychiatrist's hands. This is actually true for the whole situation: the diagnosis, the epistemic position of the medical profession, the leadership of the whole situation as well as the actual questionnaire is all in the professional's hands. As noted above, the challenge is to create a situation in which the patient feels comfortable enough to answer the questions. At the same time the professional must adhere to the technical side of following and filling out the diagnostic questionnaire.

The psychiatrist works with this challenge by producing different turns which aim to set the patient and the psychiatrist on mutual ground when filling out the questionnaire: by explicating the shifts of topic, establishing a mutual understanding of the topic, using follow-up turns and referring to the questionnaire the psychiatrist constructs an interactional situation. He also goes through the technical diagnostic interview and conveys to the patient the information he has in order to establish a mutual understanding. The technical tool itself acts as a vehicle for creating an alliance: by referring to the questionnaire in his turns the psychiatrist distances himself from the diagnostic interview. This also sets the patient and psychiatrist on more mutual ground.

## **5.1. Data**

The data of this chapter consists of five videotaped diagnostic interviews between one psychiatrist and five different patients. The duration of the interviews is approximately 35 minutes. The whole questionnaire is not covered during the sessions in the data because the time reserved for the interviews ran out. Also, the number of symptoms/disorders covered with each patient varies. As my focus is not on specific disorders but on the interactional methods the psychiatrist uses to construct a shared situation, I do not consider this a problem for the analysis.

### **5.1.1. The Kiddie – Sads – Present and Lifetime diagnostic interview**

The KIDDIE-SADS-Present and Lifetime questionnaire is a child and adolescent psychiatric interview method developed by Joan Kaufman et al. from Yale University. It is a half-structured tool for a diagnostic interview which is used to assess child and adolescent patients' current and prior psychopathologic episodes based on criteria defined in the classification systems for mental illnesses: DSM-III- R and DSM-IV. In more layman language the questionnaire aims to assess all mood disorders, eating disorders and schizophrenia. The diagnostic interview is a tool for assessing the patient's situation, present and past. This interviewing method contains questions and objective criteria for assessing individual symptoms. The questionnaire contains specific questions and criteria for each symptom/disorder. The questions are meant to show how the information needed to assess each symptom can be gathered. This means that each symptom/disorder has a set of questions. The questions do not have to be asked word for word. Rather the interviewer is allowed to freely adapt and apply the questions to the situation, taking into account, for example, the child's level of development. Not all of the questions in the questionnaire have to be asked; only the number of questions needed to grade each section. Nor do all of the symptoms concerning the disorder have to be covered in the order set in the questionnaire: the interviewer can, for example, start from the symptoms that are the reason for the patient's hospitalization. Still, all of the topics have to be covered, the questions have to be as neutral as possible, and leading questions must be avoided.

When the primary symptoms of each disorder have been covered, the interviewer defines the grading of the ruling out criteria given in the questionnaire regarding the current and past episodes of the disorder. The sections are graded on a scale of 0-3, [0] meaning that no information is available, [1] meaning that there is no indication of symptoms, [2] meaning mild symptoms that do not fulfill the criteria and [3] meaning symptoms that fulfill or exceed the criteria. The interviewer grades each topic three times. As the questionnaire is also filled out with the patient's parent (regarding the patient), one grade is based on the parent's perception, the other on the child's subjective perception and the third on the clinician's perception based on the information she has gained from asking the questions.

## **5.2. Half-structured interview as a focus of research**

The aim of a psychiatric interview is to evaluate and assess the patient's psychiatric condition. The patient has the ownership of her inner experience, the individual information which the interviewer is interested in. The interviewer is a psychiatric professional with expertise in diagnostic knowledge and a general knowledge of diagnostic criteria.

In his comparative study Rogers (2001) has looked at structured and half-structured psychiatric interviews. In contrast to strictly defined and outlined structured interviews, in half-structured interviews professionals can pose questions of their own in addition to those in the questionnaire. They can, for example, produce turns that ask for patients' clarification on what they have answered, or pick up on and ask more about an issue they consider relevant to the diagnosis. They are also able to verbalize the patient's confusion during the interview if they feel the patient is confused.

This lack of standardization and the possibility of a wider range of turns and topics have also been seen as the central challenge of the half-structured interviews. For example, as the affective dimensions of the patient's experience is emphasized, the significance of the patient's and the professional's rapport has been considered to increase in the half-structured interview (Trull 2005, 162; Bögels 1994, Garb 1998, Karon 2000). The interviewers should be able to respond to affectivity but at the same

time maintain their objectivity and distance. The actions of the interviewer thus have a very central role in half-structured interviews.

### **5.2.1. Conversation analysis and institutional interaction in interview situations**

When studying interaction in interview situations, the focus of CA research has mostly been on research rather than clinical interviews.

According to Ruusuvuori & Tiittula (2005) an (research) interview is always an interactional situation in which the interviewer and the interviewee act in relation to one another, and all interview material is verbal material produced in the interaction between the participants. The interviewee is usually considered to have the epistemic ownership of the information gathered in the interview. Then again, the question – answer – acknowledgement structure of the interview gives the interviewer the guiding and controlling role in the situation. The interviewer's role in the formulation of the interviewees' speech and the representations produced can be very significant.

In the field of interaction research the different forms of the structured interview include survey interviews (Suchman & Jordan 1990, Houtkoop – Steenstra 1995, 1996, 1997, 2000, Maynard & Schaeffer 1997, 2000, Nuolijärvi 1998) and psychometric questionnaire interviews (Antaki 1999, Antaki & Rapley 1996, Antaki, Houtkoop – Steenstra & Rapley 2000, Rapley & Antaki 1998), and interaction in psychological tests (Marlaire & Maynard 1990, Schegloff 1999b) has been widely studied.

The half-structured or non-structured interview has not been deeply studied in the field of conversation analysis. Leena-Maria Ehrling (2006) has studied interviewers' actions and the structure of a half-structured interview in a psychotherapy outcome research. Also, Tim Rapley (2001) has studied the actions and turns of both the interviewer and the interviewee in non-structured research interviews. Non-interviews are unstructured and unrestricted by a question-answer format (Ruusuvuori & Tiittula 2005). They are still similar to half-structured interviews such as the data of this chapter, as the interviewer can guide the interview, design the turns and ask questions which are not on the questionnaire. In his work Rapley notes that in open inter-

views the interviewer has a central, active and in many ways effective role in the outcome of the interview.

In this chapter I am also interested in the actions of the interviewer, the psychiatrist, and the interactional ways in which the psychiatrist creates a shared and co-operational situation in a psychiatric diagnostic interview. The central challenges are to avoid giving the patient the feeling of being put into a box and at the same time to remain objective and gather the necessary information. The challenges are the same in treating eating disordered patients: professionals must understand enough to gain patients' trust, but strict supportive and professional enough to motivate patients to give up their illness.

### **5.2.2. Professional theory and patient individuality**

As in an interview situation in general, in this diagnostic interview the patient has the primary access to the information the psychiatrist needs to be able to complete the interview. On the other hand, the psychiatrist is in charge of the diagnostic interview; as a medical professional doing a diagnostic interview and diagnosis of the patient, he holds the questionnaire in his hands and is the only one who sees it. He therefore has primary control over the management of interaction, and has primary access to the diagnostic knowledge that the interview is based upon.

The situation is the same in any kind of therapeutic situation. Labov and Fanshel (1977) have described this as interaction between A- and B situation. In an A-situation one speaker (participant A) has access to information that participant B does not have. A B-situation is vice versa: participant B has information that A does not have. An AB-situation is therefore one in which both A and B have access to the same information. In this diagnostic interview A, the patient, has information that B, the psychiatrist, needs to complete the interview. But B has information on the whole situation: the questionnaire, the related questions and themes, and of course the psychiatric knowledge the situation is based on, as the aim is to do a diagnosis of the patient. So B needs the information A has and A is asked to give the information to B without having the information of what her information is being used for. The chal-

lenge for the psychiatrist is to create an AB-situation out of an A-situation and a B-situation.

As noted before, the challenge in psychiatric interviews in general is to maintain a position where the professional on one hand takes into account the individuality of the patient and on the other remains on a reasonable theoretical level to be able to gather the needed information on the patient's symptoms. To avoid the patient's feeling of being "put into a box" without her *individual story being really listened to*, the professional must transform the half-structured questionnaire with thematic questions into a conversation that is about this particular patient and her situation.

Studying the half-structured interviews in the psychotherapy outcome projects, which aimed to assess the effects of psychotherapy, Leena-Maria Ehrling (2006) noted that when beginning the interview, interviewers tell the patients what kind of an interactional situation they are beginning and invite the patients to participate in? Certain kinds of actions along with certain choice of words. The interviewers thus set the participants on "mutual ground" (80, 2006). She also noted that the interviewers use delicate and elaborative turn-design and soften their choice of words to continue on this mutual ground and diminish the research interview frame in the interactional situation.

In this data the psychiatrist also uses different interactional ways to establish mutual ground and balance between the theoretical, research-like side and the individual. For example, when moving to the next theme he explicates the shift in his turn. Also, when coming to the end of a theme currently under scrutiny, he explicates it, referring to the questionnaire and the outcome of the segment. In this way he lets the patient in on the theoretical side of the situation: the patient does not have the questionnaire and she is the one being questioned in the diagnostic interview. Thus at the beginning and at the end the psychiatrist makes the questionnaire more transparent in order to create a situation in which the patient's feeling of being overruled can be avoided and their alliance and co-operation enforced.

### **5.3. Balancing between professional theory and patient individuality:**

The professional's ways to create a co-operational situation

The psychiatrist works to create a co-operational situation by establishing mutual ground, adapting instrumental grading to an individual conversation and establishing an alliance with the patient. These all contribute to the challenge of half-structured interviews: avoiding the patient's feeling of being overruled and generalized and at the same time keeping to the instrumental aim? Of the situation, which is to carry out a diagnostic interview. On the one hand, the psychiatrist works to turn the instrumental situation into a more individualized one by creating an AB-situation and fitting? The technical grading options as follow up turns of the patient's turns. On the other hand, he also uses the technical, generalizing side– the questionnaire – to display alliance with the patient.

I found four different interactional ways used by the professional to establish mutual ground for the patient and himself:

- 1) Making the questionnaire visible in the discussion by explicating the shift to the next theme and closing summary turn
- 2) Establishing a mutual understanding of the theme
- 3) Follow-up turns related to ranking of answer options
- 4) Referring to the questionnaire

#### **5.3.1. Explicating the questionnaire**

The psychiatrist most commonly moves on to the next theme by making the questionnaire visible in his talk. With a summary turn of the closing topic and an explication of the shift to the next topic he both shows the patient that the prior theme is closed and displays the shift to the next one. This makes the A-situation (the psychiatrist has the knowledge concerning the questionnaire) into more of an AB-situation: the patient is also made aware of the current theme. Usually the psychiatrist not only notes that the theme is closing but explicates to the patient the outcome of the questions regarding the disorder which has been under scrutiny. This opens the questionnaire to the



patient even more, involving the patient in filling out the questionnaire and setting the patient and the psychiatrist on mutual ground.

In the next extract the psychiatrist makes the shift to the next theme visible to the patient by explicating it.

### Extract 1.

1 Ps: ja sun mielestä ennen sitä eikä sen jälkeen ei oo ollu,

*and in your opinion you haven't had it before or after,*

2 Pa: ei o[o ollu sellasia °jaksoja°] ei,

*no [not those kinds of °periods°]no,*

3 Ps: [noin (.) rankkaah, ]

*[that (.) rough hh,]*

4 (1.0)

5 Ps: mm-↑m (0.2) et yks kolmonen sulle t↑äytyy mut se näyttää liittyvän tohon (0.5)

*mm↑m (0.2) so you g↑et one grade three but it seems to be connected to (0.5)*

6 tilantee°seen.° [.hhh]

*that situa°tion.°[.hhh]*

7 Pa: [joo,]

*[yes,]*

8 Ps: nyt me kysytään (0.8) sun ↑ärtyneisyydestäs ja £[suuttumuksestas£],

*now we'll ask (0.8) about your↑irritableness and/ £anger£],*

9 Pa: [£.hmm hmmhm£]

10 Ps: *£sua huvittaa.£*

*£you're amused£.*

11 (0.2)

12 Pa: *£joo£,*

*£yes£,*

13 Ps: *£mikäss sua huvittaa .hh£,*

*£what is it that amuses you .hh£,*

14 Pa: *£nnnoku tollanen kysymys£,*

*£well that sort of a question£,*

15 Ps: *joo (0.2) se on myös MAsennuksen oire,*

*yes (0.2) that's also a symptom of DEpression,*

The topic of the interview is depression. The disorder “depression” consists of three different fields in the questionnaire: sad feelings (dysforia), anger and irritableness and lack of interest and the capability to enjoy things (anhedonia). The psychiatrist has covered the first field of symptoms in lines 5-6, closing the topic by explicating the grading (the result) of the theme. In line 8 the psychiatrist makes the shift to a new theme. He starts his turn: “now we’ll ask about...” The word “now” orients the discussion to the present and also to a change of topic. The psychiatrist uses the word “we” although in reality it is of course he who is asking the questions. By using “we” when referring to himself and the patient the psychiatrist creates the feeling of a mutually shared situation: the patient is not just an object who is being questioned but rather they are discussing and thinking about the questions together. The word “we” could also refer to the psychiatrist and the rest of the “psychiatric field,” which is represented by the questionnaire. It has been noted that when a person acts as a representative of an organization or an institution, the use of the self-referring “we” instead of “I” invokes an institutional identity over a personal one. That functions as

an indication of the person speaking as a representative, not as an individual (Drew & Heritage 1992, 30). Still, considering other extracts in which the psychiatrist uses “we,” the first interpretation mentioned is much more likely.

The patient receives this turn and displays amusement in line 9. The psychiatrist picks up on this in lines 10 and 13. In line 13 he asks the patient for an account of her amusement. When the patient states in line 14 that the question amuses her, the psychiatrist produces an account for the question in line 15, positioning it as tied to his prior question and talk: it is also a symptom of depression.

In the following extract the psychiatrist also makes the shift to the next topic visible by explicating it to the patient.

### **Extract 2.**

1 Ps: °juu° mut sul on semmonen £<tunne> että et sä rasitat joitaki sillä °että°.hh et sä£

*°yes° but you have £ < the feeling > that you annoy some people °by° .hh saying£*

2 sanot suoraa °asioita°,

*°things° bluntly,*

3 Pa: se voi olla et k↑aikki ei siit tykkä[ä kyl]lä,

*it may be that not e↑verybody li[kes it y]es,*

4 Ps: [ joo. ]

*[yes.]*

5 Ps: °.hjooh° .hhhhhhh #joo# mut ilmeisesti sulla ei- (0.4) ei <tällästä>

*°.hyes h° .hhhhhh #yes# but apparently you don't- (0.4) not this <kind>*

6 ärtyneisyys- ↑no entäs sitte mielen- (0.3) me siirrymme kolmanteen

*of irritableness- ↑well what about intere- (0.3) we will move on to the third*

7 **£masennuksen osa-alueeseen£ joka on <kiinnostuksen puu<sup>o</sup>te> (0.2)**

*£part of depression£ which is <loss<sup>o</sup> of interest> (0.2)*

8 **kaiken <nautinnollisuuden> menettäminen >et ei-<**

*losing the capability to feel any <pleasure> >so n-<*

9 Pa: aa,

10 Ps: **=mikään asia ei tuota <iloa> (0.2)** tunnistatko itsess näistä sanoista,

*=nothing brings <joy> (0.2) do you recognize yourself in these words,*

The psychiatrist has covered the second set of questions regarding depression. The symptoms under scrutiny have been anger and irritableness. The patient has told the psychiatrist that sometimes people may find her annoying because she is very blunt and straightforward in her opinions. In lines 1-2 the psychiatrist produces a formulation of the patient's turn, suggesting she feels she irritates some people with her behavior. In line 4 the psychiatrist receives the patient's turn with a closing "yes" and continues his turn in line 5 by repeating this "yes." After this he moves on to give a summary /closing comment on the theme covered. He does this by explicating his perception/the outcome of the answers the patient has given. He begins this with the same "yes" he has used previously and moves on to the summary saying "but apparently you don't have this kind of irritableness." The word "but" in the psychiatrist's turn refers to his formulation, displaying that despite this and taking this into consideration his upcoming perception is valid. The psychiatrist does not quite finish his closing sentence lexically, but corrects himself and moves to make the shift to the next theme. The prior theme is nevertheless closed.

After the psychiatrist has closed the second theme he moves on to the next theme, the third section of symptoms covering depression. The symptom(s) is anhedony, the loss of interest and capability to feel pleasure. He begins the shift with rising prosody, thus indicating a new beginning. The turn begins with "so what about intere-," which orients the turn to begin a new topic. The psychiatrist is about to explicate the next

theme right away (so what about interest) but repairs himself and designs the turn more to “announce” the next topic. First he explicates the shift: now we will move on to the third part of depression.” After this he elaborates on what this third part is: the loss of interest and the incapability to feel any pleasure. The psychiatrist not only makes the shift to a new topic, but also makes the questionnaire visible to the patient with his turn design. By explicating the move to the next theme he lets the patient in on what is “happening” in the questionnaire at the moment.

In the following extract the psychiatrist again makes visible the shift from his general description of the interview to the first topic by explicating it in his turn.

The psychiatrist is beginning the diagnostic interview with the patient. In lines 1-3 he explicates what he is about to do (“so today I will go through this questionnaire with you Elina”) and summarizes the purpose and aim of the questionnaire in lines 2-3. In lines 6-7 he continues to elaborate briefly on how they are going to go through the interview.

### Extract 3.

1 Ps: .hhh eli mä teen tänään sulle (0.7) elina >semmosen< (0.4)

*.hhh so today I will go through (0.7) >this< ques<tio↑nnaire*

2 kysely<lomakk↑een> jossa käydään kaikk↓i .hhhh (0.3) psyykkiset

*with you Elina which covers al↓l .hhhh (0.3) the mental*

3 sairaudet mit↓äähhhhh (0.2) me tiedetään?

*illnesses wh↓ich hhhh (0.2) we know?*

4 (0.2)

5 Pa: okei,

*okay,*

- 6 Ps: .hhh nopeesti läpi =nopeesti jos ei sul oo mitään sen oireita ni sit siirrytään  
*.hhh quickly through =quickly if you don't have any symptoms of that illness*  
*so*
- 7 seur°aa[vaan°.]  
*then we'll move on to the ne°xt [one°.]*
- 8 Pa: [£mmh£,]
- 9 Ps: **.hhh ensimmäinen on <masennus> hnfffff .mhhhhh ja (0.4) masennus (0.2)**  
*.hhh the first is <depression> hnfffff .mhhhhh and (0.4) depression (0.2)*
- 10 °niinku° sairaut°en↓a° eli mä tutkin nyt tän kyselylomakkeen avulla et onks  
*°like° as an ill°ne↓ss° so with the help of this questionnaire I'll be studying*
- 11 sulla masentuneis°uutt[a°.]  
*if you have depress°io[n°.]*

In line 9 the psychiatrist makes the shift to the first topic, which is depression. He explicates it by beginning with “the first is depression.” He then moves on to elaborate on the topic in lines 9-10 with “like as an illness”. After doing so he still continues his turn with a re-formulation “so” which explicates to the patient once more the aim of the following questions, “with the help of this questionnaire I’ll be studying if you have depression.” With this re-formulation the psychiatrist makes the shift to the start of the interview visible to the patient and brings the questionnaire more in line with an AB-situation by giving the patient information on the purpose of the questions. This again helps to create a situation in which the patient’s feeling of “being put into a box” or being generalized can be minimized as it becomes clear that the questions and topics covered arise from this questionnaire. With this re-formulation the

psychiatrist also positions the questionnaire as a tool or a diagnostic aid, not as a decision maker on his behalf.

When the end of the theme is reached the psychiatrist generally refers again to the questionnaire by explicating the outcome of the questions to the patient; for example: it seems that you don't have so much of a problem with anger. In a couple of cases he also makes the diagnostic criteria more transparent for the patient by explicating it when producing the closing turn. These closing summaries aim to get an answer that can be adapted to the ranking in the questionnaire. They also display to the patient that the topic is closed, again making the patient aware of the questionnaire and setting the professional and patient on mutual ground, as in this following extract.

#### Extract 4.

1 Ps: #sä et oo mikään >semmonen< (0.3) m.hhh poika joka- jonka pitää seee- ajaa

*#you're not > that sort of a < (0.3) m .hhh boy who – who has to eee- ride*

2 >fillarilla< kaite<sup>o</sup>elle<sup>o</sup> k- öö- öö- lii- liian# läh-hehe-lähellä £si-sillan khaidettah£,

*> the bike< on the r<sup>o</sup>ail<sup>o</sup> r- aaa-aaa- to- too #cl- o-o- close to £the r (h)ail) of the br-bridge h£,*

3 Pa: =£ssheh[ehheehh] e-eeeh£,

*=£shnooh[hohhh]o-oooh£,*

4 Ps: [£sheheeh£,]

*[£shnoohooh£,]*

5 Ps: £ssul ei tuu mitään tämmösiä[h eh£,]

*£y-you don't have any of these [h eh£,]*

6 Pa: [fɛeiɬ,]

[ɬnooɬ,]

7 Ps: ɬtälläsiä mie°leen°ɬ.

*ɬkinds of id°eas°ɬ.*

8 Pa: fɛeiɬ,

*ɬnooɬ,*

9 Ps: eikä sulle satu paljon onnettomuu°ksia°.

*And you don't have a lot of acci°ents°.*

10 Pa: ei,

*no,*

11 Ps: =jo↓o (0.3) siit Masennuksest me voitaa ö-ö- varmaan sanoo näin että se on

*=y↓es (0.3) about the Depression we could a-a- probably say that it has at*

12 (0.2)korkeintaan sellanen (1.0) yks ö- sellanen reaktiovaihe missä sä

*(0.2) most been a sort of (1.0) one a- a kind of a reaction phase which*

13 [°oot ollu°.]

*[°you've had°.]*

14 Pa: [vieraileva]

*[a visiting]*

15 tekijä,

*factor,*

16 Ps: **vieraileva teki°jä°** .hhhh mut sit Vastaavasti m-m-mikä vois olla masennuksen



*a visiting factor* .hhhh but then Respectively w-w-what could be the oppo<sup>o</sup>site<sup>o</sup>

17 vasstakoh<sup>o</sup>hta<sup>o</sup> (0.4) s-siis sillon ku mennään jo vähän yli m.hhh,  
*of depression (0.4) m-meaning when one goes a little bit overboard m .hhh*

18 (0.8)

19 Pa: emmä [tiedä.]

*I don't [know.]*

20 Ps: [ no sit]ä kutsutaann maniaks onks[e su]lle- <maaninen>,  
*[well i]t's called mania are you [fam-] <manic>,*

21 Pa: [aha,]

*[okay,]*

In line 11 the psychiatrist receives the patient's declining answer with a rapid "yes" and after a pause continues his turn by making a reference to the illness under scrutiny (depression): "about the depression." In this way he returns from the more individual level questions for gathering information from the patient to the general level of sharing with the patient the illness they are going through in the questionnaire. He continues his turn "we could probably say," now very explicitly marking both himself and the patient as the executors of the questionnaire and as actors whose views are considered important. He continues with the outcome or conclusion of the patient's answers stating that depression has been a reaction phase. The patient adds a formulation, "a visiting factor," overlapping the psychiatrist. The psychiatrist picks up on this and continues his turn, overlapping and repeating the patient's formulation. He takes a breath and makes the shift to the next topic with "but then," which implicates a shift and a continuance for his turn and the interview.

In the next extract the psychiatrist refers to the questionnaire in his closing summary turn and explicates the grading he is going to choose.

### Extract 5.

1 Ps: ja yli kolme tuntii kerralla mh suuttumusta,

*and mh anger over three hours at a time,*

2 (0.2)

3 Pa: £ eee[iih]£,

£nnn[ooh]£,

4 Ps: [£ei]£ (0.2) eli .hh se ois toi ö-ö- tässä- tältä pohjalta tää tää

*[£no£] (0.2) so .hh it would be the a-a- here- based on this the the*

5 v↑ihasuusproblematiikkaa ei oo sullakoh- ilmeisesti tää dee harvemmin  
kuin

*you don't have problems with a↑nger- apparently this d less than*

6 kerran viiko£°ssa£°.

*Once a w£°eek°£.*

The psychiatrist has covered the second set of questions about depression. The theme has been anger and irritableness. In lines 4-6 he produces a summary of the questions covered, explicating the outcome/ his perception regarding the patient. He first explicates the grounds on which the perception is based, referring to the questionnaire and the patient's answers: "so here- based on this...." He displays to the patient the basis for the grading and thus makes the situation a shared one. In lines 4-6 he continues his turn by summarizing the outcome of this section and explicating the grading for the section and its criteria: "this d, less than once a week." The psychiatrist makes the questionnaire visible to the patient, who does not have a questionnaire herself, and thus makes the decision making regarding her more transparent.

In his closing summary turn in the following extract the psychiatrist not only explicates the criteria of depression in the questionnaire but elaborates on it.

**Extract 6.**

1 Ps: .hnff (0.4) no onks sul sit sellasia (0.5) <kausia> >jollon< kaikki tuntuu

*.hnff (0.4) well do you have those kinds of (0.5) <periods> >when< everything*

2 pitkästyttävältä ikävältä (0.2) tylsä<sup>o</sup>ltä<sup>o</sup>.

*Feels dull sad (0.2) boring<sup>o</sup>.*

3 (0.2)

4 Pa: aaaa no n£hh£ (0.6) no silloin kyllä oli (0.4) mutta aina keksii [£sit jotain£ ]

*aaaa well n£hh£ (0.6) well I did have then (0.4) but then you a[lways think £of]*

5 Ps: [mmm mm]

6 Pa: [£tekemistä khyllä£],

*[£something to do£],*

7 Ps: [mmm mmm, ]

8 Ps: **.hnfff no siis et sul on k- aina säilyny se että jotkut asiat tuottaa**

*.hnfff well then you have a- always had some things that bring*

**9 sulle iloa.**

*You joy.*

10 Pa: = mm kyll[ä],

*=mm ye[s],*

11 Ps: [jo]↓o (.) tän sairauden aikanaki,

[ye]↓s (.) also during this illness,

12 Pa: =mm,

13 (1.5)

14 Ps: .mth et luultavasti se e- voi sanoa että .hhh (1.0) että niinku tätä tämmöst

*.mth so probably it's n- one can say that .hhh (1.0) that this kind of  
anhedony*

15 mielenkiinnon puutetta on o- et sitäkään ei oo muutku korkeintaan

*you have h- that you don't have it either but maybe at most in its <mild  
form>*

16 <lievänä> jo sitäkään,

*if even that,*

17 Pa: joo.

*Yes.*

18 Ps: joo.

*Yes.*

The psychiatrist is going through questions on the symptoms of depression. The theme under scrutiny is anhedony. In line 1 the psychiatrist asks the patient if she has periods when everything feels boring and dull. The patient replies in lines 4 and 6 that sometimes she does, but then she always comes up with something to do. The psychiatrist follows up on this in line 8 with a candidate understanding of the patient's turn suggesting that the patient has always maintained a capability to feel joy. When the patient accepts this in line 10 the psychiatrist continues and follows up with an elaboration of the candidate understanding, clarifying that also during the illness (anorexia) this has been the case. The patient agrees again. The first follow-up question

functions clearly as a candidate understanding without challenging the patient. In the second follow-up asking for specification in line 11, a subtle challenge can be heard as the psychiatrist does not leave the topic after having received the first answer in line 10. Instead he continues with a specification of the candidate understanding regarding the patient's anorexia. In lines 14-16 the psychiatrist continues to formulate what the patient has previously stated giving a closing summary of the theme which is also based on the criteria in the questionnaire.

### 5.3.2. Establishing a mutual understanding of the theme

After explicating the shift the psychiatrist establishes a mutual understanding of the theme/disorder in question. He makes sure that the patient is aware of the symptoms of the disorder that the questions aim to make an assessment of. He establishes this mutual understanding (again changing an A-situation into more of an AB one) in the next extract by asking the patient if she knows what the disorder they are moving to is.

#### Extract 7.

1 Ps: =jo↓o (0.3) siit Masennuksest me voitaa ö-ö- varmaan sanoo näin että se on  
(0.2)

=y↓es (0.3) *about the Depression we could a-a- probably say that it has at*  
(0.2)

2 korkeintaan sellanen (1.0) yks ö- sellanen reaktiovaihe missä sä [°oot ollu°.]  
*most been a sort of (1.0) one a- a kind of a reaction phase which [°you've had°.]*

3 Pa: [vieraileva]  
*[a visiting]*

4 tekijä,

*factor,*

5 Ps: vieraileva teki<sup>o</sup>jä<sup>o</sup> .hhhh mut sit Vastaavasti m-m-mikä vois olla masennuksen

*a visiting fac<sup>o</sup>tor<sup>o</sup> .hhhh but then Respectively w-w-what could be the oppo<sup>o</sup>site<sup>o</sup>*

6 vasstakoh<sup>o</sup>hta<sup>o</sup> (0.4) s-siis sillon ku mennään jo vähän yli m.hhh,

*of depression (0.4) m-meaning when one goes a little bit overboard m .hhh*

7 (0.8)

8 Pa: emmä [tiedä.]

*I don't [know.]*

9 Ps: [ no sit]ä kutsutaann maniaks onks[e su]lle- <maaninen>,

*[well i]t's called mania are you [fam-] <manic>,*

10 Pa: [aha,]

*[okay,]*

11 Ps: onks nää sanat (0.3) vieraita <sup>o</sup>sulle<sup>o</sup>,

*are these words (0.3) strange <sup>o</sup>to you<sup>o</sup>,*

12 Pa: no on,

*well yes,*

13 Ps: joo no mut ne on kohonnu mieliala.

*Yes well they are elevated mood.*

14 (0.2)

15 Pa: okei,

*okay,*

16 Ps: .hh (.)eeli jos masentunu (.) ajattelee et @must ei oo mihinkään mä oon nii

*.hh (.) so: if one is depressed (.) one thinks that @I can't do anything I'm*

17 huono,@ [.hh]

*no good@, [.hh)*

18 Pa: [mm,]

19 (0.2)

20 Ps: ajatteleks↑ä muuten n°äin°,

*do you th↑ink like t°his° by the way,*

21 (0.4)

22 Pa: een yleensä,

*n:ot usually,*

23 (0.3)

24 P: jo↓o mut (0.2) me- me voidaan tätä masennuspuolta käyttää sen takii ku ssiel  
on

*y↓es but (0.2) we- we can use the depression part because the questions about*

25 nää itsetuntokysymykset [sitä] voidaan joskus .hnffff

*self esteem are there [we] can come back to them .hnfff*

26 Pa: [joo,]

*[yes,]*

27 Ps: joskus palata niihin .hhhh **mut maniassa tuntee** °itte°- **£MÄ** pystyn mihin

*at some point .hhhh but a manic person feels £I can do anything£*

28 vaan£ >mä oon< Kova jätkä [tai kova tytt]ö ja (.) ja ja,

*>I'm a< Tough guy [or a tough girl] and (.) and and,*

29 Pa: [£hihihi joo£,]

[£ehehh yes£,]

30 Ps: °ja° kokoajan on vauhti päällä (0.3) tunnistatsä itseäs tällasest kuvauk°se[sta]°.

*°and° is constantly on the move (0.3) do you recognize yourself from this des°cript[ion]°.*

31 Pa: [en]

[no]

32 (0.3)

33 Pa: mä en usko pystyväni kaikkee,

*I don't believe I can do anything,*

After the psychiatrist has made the shift to the next theme in lines 5, 6 and 9 he establishes a mutual understanding of the disorder by asking the patient if she knows what the disorder, mania, and means. He starts in line 9 by asking if the patient knows the word “manic” but corrects himself and asks instead in line 10 if the words are strange to the patient. He takes into account the situation in which he is the professional and has the knowledge of the themes they are discussing and recognizes that the patient does not necessarily have this information. After the patient has agreed that the words are strange the psychiatrist continues his turn and gives a definition of the word “mania” in line 13. He then continues to elaborate on this definition in line 16, beginning with the word “so” (Eli), which orients the turn to be heard as an explanation/elaboration. He first takes as an example the disorder they have covered and is therefore already familiar (depression) and then elaborates on mania by comparing



and contrasting it with depression. He first briefly describes depression in lines 16 and 17 and then describes mania in lines 27, 28 and 30.

In the next extract the psychiatrist is beginning to go through the questionnaire with the patient. Before the extract the psychiatrist has explained what the interview is about and they have gone briefly through the situation.

### Extract 8.

1 Ps: ja sit sä v<sup>↑</sup>astaa taval<sup>°</sup> ja sit me vähän yhes tuumitaan et .hhh nyt me

*and then you <sup>↑</sup>answer °like that° and then we'll ponder a little together so .hhh*

2 puhutaan masentuneisuudes<sup>°</sup>tah<sup>°</sup>.

*now we'll talk about depressi°ion h°.*

3 Pa: =mm[<sup>↑</sup>m,]

4 Ps: .hhh (0.2) **miten sä ymmärrät semmosen** °sanan ku masentuneisuus°.

*.hhh (0.2) **what is your understanding of the** °word depression°.*

5 Pa: .hh ööö no se on sellanen jos on ollu (0.4) just (.) ongelmia,

*.hh umm well it's like if one has had (0.4) like (.) problems,*

6 Ps: joo.

*yes.*

7 Pa: =nii sitten tulee (0.3) masennukseen,

*=so then one gets (0.3) depressed,*

8 Ps: jo<sup>↑</sup>o,

*y<sup>↑</sup>es,*

9 Pa: ja yleensä se on just ettei .hh jaksa herätä aamusinnn ja .h (0.2) just ettei jaksa

*and usually it's like .hh one can't get up in the mornings and .h (0.2) doesn't*

10 tehdä mitään et se on sellanen, .hh

*have the energy to do anything so it's like that .hh,*

In line 1 the psychiatrist is finishing his description of the interview situation and in lines 1-2 makes the shift to the first disorder by stating; “Now we’ll talk about depression.” After the patient has received this in line 3 the psychiatrist establishes a mutual understanding of the upcoming disorder in line 4 before moving on to the actual questions. He does this by asking the patient to explain her perception of the concept of “depression.” In lines 5, 7 and 9-10 the patient gives her description of a depressed person.

In the next extract the psychiatrist establishes a mutual understanding of the topic by giving the patient a description of the symptoms before moving on to the actual questions.

### **Extract 9.**

1 Pa: <ei>,

<no>,

2 Ps: e↓i .thh no sul eii oo paniikkihäir°iöö°.

*n↓o .hhh well you don't have panic disor°der°.*

3 Pa: £k↑iva£.

*£n↑ice£.*

4 Ps: £thhh.hhh sen voi sanoof£.

*£thhh .hhh one can say that£.*

5 Ps: no sit tulee <↑eroahdistushäiriö> =jo se nimiki jo vähän sanoo et mihin se  
*so then comes <↑separation anxiety disorder> =the name itself already says*

6 <viitt↓°aa°> ja siin on neljä oirett↑a .mhh (0.2) pelkää <onnettomuutta>  
joka

*something about what it's <related↓° to°> and there's four sympt↑oms .mhh  
(0.2) fear*

7 voi aiheuttaa eron .mhh pelkää että kiintymyksen kohteelle tapahtuu  
jotain

*of an accident which can cause the separation .hh fear of something bad*

8 pahaa (0.4) kouluhaluttomuus ja pelkää nukkua (.) poissa kotoa tai  
yks°in°

*happening to the object of affection (0.4) unwillingness to go to school and  
fear*

*of sleeping (.) away from home or al°one°.*

9 [.mhh]

10 Pa: [m-hm,]

11 Ps: #ja pelkää yksin olla kotona siin on niinku viis ko#ht°aah° (0.2) .mhhh ja  
nyt

*#and fear of being alone at home there are like five po#i°nts h° (0.2) .mhhh  
and*

12 ja nyt sä voit miettii myös sun koko elämä↓ä koska tää on aika usein (0.4)  
*now and now you can also think about your whole l↓ife because this is quite*

13 aika tavallista pienillä laps°illa°.

*often (0.4) quite common for little chil°dren°.*

14 Pa: okei,

*okay,*

15 Ps: .mhhh mut ehkä tähän i- .hhh et nyt otetaan ihan kohta kerrallaan.

*.mhhh but maybe in this- .hhh so now we'll take one point at a time.*

In lines 2 and 4 the psychiatrist closes the previous topic and in line 5 makes the shift to the next topic by explicating it “so then comes” and naming the disorder under scrutiny as “separation anxiety disorder.” He immediately continues with an elaboration of the disorder by continuing his turn with “the name itself already says something” in lines 5-6. He then moves on to explicate the criteria of the separation anxiety disorder reading the symptoms out loud from the questionnaire to the patient in lines 6-8 and 11. He then continues to establish a mutual understanding by giving the patient advice on how to think and look at the topic in lines 11-13. He explicates that the patient can consider the symptoms described in terms of her whole life since they are quite common for small children. As opposed to the prior extract the psychiatrist now clearly refers to the questionnaire reading straight from it and in this way giving the “official version” on the subject.

In all of the three extracts we saw how the psychiatrist contributes to creating a shared situation, balancing between the theoretical and the individual, by establishing a mutual understanding of the topic under scrutiny. In the two previous extracts the psychiatrist established a mutual understanding through giving the patient a more active role by asking questions and commenting on her answers. In extract 8 before asking the questions in the questionnaire, the psychiatrist asked the patient for her perception of depression on a general level. In extract 7 the psychiatrist asked the patient if she knew what “mania” meant, thus giving her a role in defining the disorder under scrutiny. When the patient told the psychiatrist that she did not know the psychiatrist followed up with an explanation. In extract 9 he does it in a statement format, explaining the meaning of the disorder to the patient.

### 5.3.3. Follow-up turns related to ranking of answer options

The questionnaire contains three answer options for each theme. Each option receives a ranking, which indicates the possible diagnosis. For each section the psychiatrist must get one of the three answers in the questionnaire. When the psychiatrist asks questions related to the ranking options, he designs them on the basis of these answer options. Yet, they are also designed so that they conform to the specific conversation. The psychiatrist would not ask, for example: “which of these options would you say is the right one?”

In this next extract the psychiatrist’s follow-up questions are designed to get the ranking concerning depression.

#### Extract 10.

1 Ps: .hh ajatteleksä et sul ei oo k↑oskaan oll semmosta ajatusta et sä tappa°sit ittes°,

*.hh do you think that you h↑ave never thought about killi°ng yourself,*

2 (0.4)

3 Ps: tai onkse niin et sul, ((potilas nyökkäilee))

*or is it so that you, ((patient nodding))*

4 Pa: jjooh,

*yyes h,*

5 Ps: ↑**onks niin.**

*↑is it so.*

6 (0.3)

7 Pa: joo emmä kyl (0.2) em- ei emmä mun mielest oo ku emmä pystyis tehdä itelleni

*yes I couldn't (0.2) I- I think I haven't because I couldn't do anything to*

8 mit[ään].

*my[self].*

9 Ps: [mm.]

10 (0.8)

11 Pa: ainaki >se ois< t↑osi pelottavaa jo[s py]styis,

*at least >it would be< r↑eally scary i[[f I c]ould,*

12 Ps: [joo.]

*[yes.]*

13 Ps: .hhh (0.2) °joo° sit ei oo- et- et oo ajatellu että .hhhh se tuntuis- jo

**AJatuski**

*.hhh (0.2) °yes° then there isn't- you haven't thought that .hhhh it would feel-*

14 **tuntuu pelottaval°tah°,**

*even the THought feels frighten°ingh°,*

15 Pa: joo,

*yes,*

The psychiatrist is asking questions covering depression. The current theme is on thoughts of death/ suicidal thoughts. The grading is again from 1 to 3 with 1 being “has not had suicidal thoughts.” When the psychiatrist made the shift to the theme and introduced it, the patient stated straight away that she had not had such thoughts (data not shown). The psychiatrist has covered the questions despite this. In line 1 the psychiatrist returns to the initial question of the patient ever having suicidal thoughts.

He asks a closed question: does the patient think that she has never thought about killing herself; the patient confirms this in line 4. The psychiatrist follows up on this in line 5 with a short question calling for confirmation on what the patient has just agreed on: “is it so?” The follow up turn calls for the patient’s elaboration after her one word answer in line 4. It also subtly challenges the patient, as the psychiatrist does not leave the topic after the patient’s prior answer but still does not offer any problematic views or in other ways misalign clearly with the patient’s stance. The patient also hears it as a request for elaboration as she continues her turn in lines 7-8 and 11 by reflecting on her “yes” answer about not having suicidal thoughts. She confirms the stance about suicidal thoughts and then continues with an explanation for this: she could not do anything to herself or at least it would be very frightening if she could. The psychiatrist now receives this in line 12 with an overlapping “yes” and follows up on the patient’s turn with a candidate understanding. He now designs the turn to receive the information from the patient and display and confirm that he has understood correctly: He begins with another “yes” and then goes on to state: “then there isn’t– you haven’t thought that,” which fits the grading in the questionnaire: “hasn’t thought about suicide.” He continues with a repetition of the patient’s explanation: the idea seems frightening. The patient confirms this in line 15.

In the next extract the psychiatrist designs the clarifying formulation based on the ranking in the questionnaire.

### Extract 11.

1 Ps: °et sä et°- m↑iten sä yleensä suhtaudut (.) kuole>maan< onkss se sunn (0.2)

°so you don’t°- h↑ow do you generally relate (.) to de>ath< iss it for you (0.2)

2 >sellanen< °että se° .[hh],

> the kind of< °that it° [hh],

3 Pa: [mu]st se on luonnollinen asia.

*[I th]ink it's a natural thing.*

4 Ps: N↑II s- et se ei pyöri sun mieless[ä e]t #kauhee mä kuolen joskus#.

*Y↑ES i- so it's not going through [you]r mind that #terrible I'm going to die someday#.*

5 Pa: [ei,]

*[no,]*

6 Pa: ei,

*no,*

The psychiatrist is asking questions about suicidal thoughts or thoughts related to death, possible symptoms of depression. The psychiatrist asks the patient in lines 1-2 how she generally feels about death and dying. In line 3 the patient replies, overlapping the psychiatrist, that she thinks it's a natural thing. In line 4 the psychiatrist follows up on the patient's turn and produces a candidate understanding/ formulation of the patient's turn. He begins it with a "yes" (Finnish receiving particle "nii"), receiving the patient's answer and displaying understanding of it, and then continues with "so," orienting the turn to continue the patient's words. He then produces a candidate understanding of the patient's answer in which she stated that death is a natural thing by confirming? That the patient does not have the thought "oh my, I'm going to die someday" going on and on in her head. One of the answer options in the questionnaire is: "has thought about death constantly," and it is ranked as a strong symptom. The psychiatrist's follow-up – even though suggesting a possible symptom – aligns with the patient's turn as it is designed to enforce and confirm what the patient has said. Also, after the patient has confirmed the follow-up turn in lines 5-6 the psychiatrist leaves the topic and moves on to the next question.

In the next extract the psychiatrist makes a formulation of the patient's turn, again based on the answer options in the form.



**Extract 12.**

1 Ps: kuinka usein sä ajattelet et sulle tämmösii ajatuksii tulee m[iel]e<sup>o</sup>en<sup>o</sup>,

*how often do you think these kinds of thoughts come into yo[ur m]<sup>o</sup>ind<sup>o</sup>,*

2 Pa: [mth]

3 Pa: tosi harrvoin kylläki onneks >mut et< (0.7) °mhäh° (0.8) emmä nyt tiedä edes

*actually fortunately really seldom >but< (0.7)° mhm° (0.8) I don't know not*

4 kerran kuussa [hhh],

*even once a month [hhh],*

5 Ps: [jo↓o] (0.4) et voi sanoo et sä ajattelet kuolemaa  
oh↑imennen.

*[y↓es] (0.4) so it can be said that you think about death*

*p↑assingly.*

6 Pa: joo,

*yes,*

7 Ps: m.hhhhh [j-]

*m.hhhhh[a-]*

8 Pa: [fs]illee ehkäh£,

*[£m]aybe like that h£,*

9 Ps: ja se tuntuu liittyvän tämmöseen tunnetil<sup>o</sup>aan<sup>o</sup>.

*and it seems to be related to this kind of a fee<sup>o</sup>ling<sup>o</sup>.*

10 Pa: joo,

*yes,*

The psychiatrist is asking questions that aim to gather information on the symptoms of depression. The current theme is suicidal thoughts or thoughts about death. In her previous turn the patient has answered when asked that yes, sometimes when she is angry she thinks that it would be better if she was dead. In line 1 the psychiatrist asks for the patient's assessment of how often she has these kinds of thoughts. The patient replies in lines 3-4 that these thoughts are quite rare, but she is unsure of the correct frequency. In line 5 the psychiatrist follows up on this and produces a formulation of the patient's turn suggesting a definition of the frequency of the thoughts: the patient thinks about death "passingly". The definition is one of the three options in the ranking for this section. He begins the turn by receiving the patient's answer, overlaps her and continues with "so it can be said," which relates his turn to the patient's turn and is? A formulation/candidate understanding of it. The choice of the passive form is less confrontational than the direct form: "so you think about..." which would be more of a claim. By designing the turn in the passive "one can say" (Finnish zero person) the psychiatrist's follow up turn does not challenge the patient's words but includes her in deciding the definition and asks for her confirmation of it.

The patient confirms the psychiatrist's formulation with hesitation in lines 6 and 8. The psychiatrist again follows with a confirmative turn referring to what the patient has stated: these thoughts seem to be related to a particular mood/feeling. The turn is again designed not to challenge the patient but calls for the patient's confirmation: "and it seems it is related..." The patient accepts this in line 10.

In these previous extracts we saw again how the psychiatrist balances between the instrumental nature of the situation (executing a diagnostic interview) and the individuality of the patient during the diagnostic interview. The psychiatrist picks up on the patient's own words and follows up with a turn based on both the patient's words and the response options in the questionnaire.

### 5.3.4. Referring to the questionnaire

Referring to the questionnaire is also the psychiatrist's way of displaying to the patient that the questions that follow are not claims about the patient and her individual situation but questions that are general and asked from everyone. This is similar to the use of the self-referring "we" instead of "I" that invokes an institutional identity over a personal one (Drew & Heritage 1992, 30). Referring to the questionnaire also indicates that the person is speaking as a representative, not as an individual.

#### Extract 13. (extract 2 reproduced)

1 Ps: °juu° mut sul on semmonen £<tunne> että et sä rasitat joitaki sillä °että°.hh et sä£

*°yes° but you have £ <a feeling> that you annoy some people °by° .hh saying£*

2 sanot suoraa °asioita°,

*°things° bluntly,*

3 Pa: se voi olla et k↑aikki ei siit tykkä[ä kyl]lä,

*it is possible that e↑verybody doesn't li[ke it y]es,*

4 Ps: [ joo. ]

*[yes.]*

5 Ps: °.hjoo° .hhhhhhh #joo# mut ilmeisesti sulla ei- (0.4) ei <tällästä>

*°.hyes h° .hhhhhh #yes# but apparently you don't- (0.4) not this <kind>*

6 ärtyneisyys- ↑no entäs sitte mielen- (0.3) me siirrymme kolmanteen

*of irritableness- ↑well what about intere- (0.3) we will move on to the third*

7 £masennuksen osa- alueeseen£ joka on <kiinnostuksen puu°te> (0.2)

*£part of depression£ which is <lo°ss° of interest> (0.2)*

8 **kaiken <nautinnollisuuden> menettäminen >et ei<**

*losing the capability to feel any <pleasure> >so n-<*

9 Pa: aa,

10 Ps: **=mikään asia ei tuota <iloa> (0.2)** tunnistatko itsess näistä sanoista,

*=nothing brings <joy> (0.2) do you recognize yourself from these words,*

The psychiatrist has covered the second set of questions regarding depression.

After the psychiatrist has closed the second theme he moves on to the next theme in line 6, the third section of symptoms covering depression. The symptom(s) is anhedony, the loss of interest and capability to feel pleasure. The turn begins with “so how about intere-” which is more of a conversation like design, as though it would be something the psychiatrist has thought about and wants to ask about. He corrects himself and re-designs the beginning as more of a statement of changing the topic, marking both himself and the patient as the actors: “we will? Move on to the third part of depression” in lines 6-7. He continues to elaborate on this by stating what the next area is in lines 7-8 and 10. By referring to the questionnaire, by explicating the move to the next theme or set of questions, the psychiatrist distances himself from the questions he is asking: the questions arise from the questionnaire, they are not something the psychiatrist is claiming about the patient. The questionnaire is thus a kind of a third party in the situation, which the patient and the psychiatrist are looking at together. As the psychiatrist does this he also uses “we” in the turn design, marking both himself and the patient as the ones moving on. He sets them on mutual ground by letting the patient know what is in the questionnaire, by distancing himself from the questionnaire through referring to it and by emphasizing togetherness with “we”. The psychiatrist does this in the next extract as well. Now he also refers to the questionnaire lexically, making it even more concretely a third party in the situation.

**Extract 14.**

1 Pa: kyl se lukituss tilas pitäis säily[ttää,]

*it really should be kept in a locked s[pace],*

2 Ps: [joo ]just nii .thhhh °mut° sitte (0.2)

KUOlemaan

*[yes]exactly .thhh °but° then (0.2) thoughts*

*related*

3 liittyviä ajatuksia itsemurha-ajatuksia °ja° itsemurhayrityksiä se on meidän

*to DEAth suicidal thoughts °and° suicide attempts that's our*

4 <teem↑a> mhh,

<th↑eme> mhh,

5 (0.6)

6 Pa: ↓en o koskaan kokeillu (0.2) mitään tehdä enkä .hhh (0.2) oo ajatellukkaa

*↓I have never tried (0.2) to do anything and .hhh (0.2) haven't thought*

7 tekevänihh,

*about doing eitherhh,*

8 Ps: mm .hhh no onks sulla niinko u-useilla ihmisillä et tulee- voi tulla sellanen

*mm .hhh well do you get like m-most people that you get- one can get a*

*f↓eeling*

9 t↑unne joskus että tota (0.2) m.hh (0.2) et #parempi# ku olisin kuollu #tai#

*sometimes that umm (0.2) m .hh (0.2) that it would be #better# if I was dead*

10 (0.2) [mt.h,]

*#or# (0.2) [mt.h,]*

- 11 Pa: [välill]ä,  
[occa]sionally,
- 12 Ps: jo↓o (0.3) no puhutaan siitä koska ne on ne- ne on sit todennäkösempiä  
kuin  
*yes (0.3) well let's talk about that because they are the- with you they are more*
- 13 sulla itsemurha-ajatukset °mut° .hh ni tota mhhhh mth niin <tota> (0.2)  
*likely than suicidal thoughts °but° .hh so umm mhhh mth so <umm> (0.2)*
- 14 katotaampa sillä tavalla että (0.6) tässä annetaan semmonen johdanto et  
*let's look at this like (0.6) there's an introduction here which says that*
- 15 jotkut <nuoret> on niin pois tolaltaan et he toivoisivat olevansa kuolleita  
tai  
*some <youngsters> are so devastated that they wish they were dead or*
- 16 kuoleu-°via° (0.2) tu- tuntuuko tutulta,  
*dyi°ng° (0.2) do- does this feel familiar,*
- 17 Pa: mmm no emmä ehkä poissa t↑olaltaan mut sillee ehkä ↑onneton et jos ei  
mikään  
*mmm well maybe not d↑evastated but like maybe ↑unhappy like if nothing*
- 18 niinku .hhh (0.2) huvita eikä tulnu sillei ki#v↓alta# ni .hhh (0.2) m-mitä varten  
*interests.hhh (0.2) me and nothing like feels n↑i#ce# so .hhh (0.2)w-why*
- 19 (0.8) £ssit olis£.  
*would (0.8) £I then be£.*
- 20 Ps: mmm.

The psychiatrist is asking the patient questions covering “anhedony”, loss of all interest, which is an area of symptoms related to depression. They have been talking about the patient playing the violin and the possibility of doing that also while in the hospital. In line 2 the psychiatrist receives the patient’s prior turn with “yes, exactly” and then moves on to change the subject. The next topic is related to the following set of questions covering an area of symptoms related to depression. He displays the change of topic by saying “but then” and continues in lines 2-3 to elaborate on the next topic: “thoughts related to death, suicidal thoughts and suicide attempts.” He produces this elaboration in a statement format, reading it from the questionnaire. He ends his turn in lines 3-4 by clarifying that this is the next theme. He designs this as involving both of them together by saying: “that is our theme”. After a pause the patient produces an answer in lines 6-7, which straightforwardly turns down both suicidal thoughts and actual attempts. The psychiatrist follows up on these in lines 8-9 asking now about the third subject he mentioned, thoughts related to death. He designs the question so that it is not a direct claim or question exclusively about the patient, but speaks in generalities by stating that most people sometimes think it would be better if they were dead. The patient’s answer is in partial agreement in line 11.

The psychiatrist receives this with an acknowledging “yes” in line 12 and then continues to redefine their next topic by stating: “well let’s talk about that. ” He continues with an explanation to this in line 13. In lines 13-14 he hesitates a bit and then continues his turn by moving on with the questionnaire. He includes the questionnaire explicitly in his turn design by referring to it as he introduces the next question. First, in line 14 he marks both himself and the patient as those going through the questionnaire together (even though the psychiatrist alone can see the questionnaire) and then explicitly refers to the questionnaire by saying: “there is an introduction here which states that some youngsters are so devastated that they wish they were dead.” The psychiatrist now distances himself from these claims by referring to the questionnaire and its pre-set questions and themes; he displays that these are not his personal claims about the patient. Thus he first marks himself and the patient as being together, both outsiders of the questionnaire and both investigating it, and then explicates that the theme arises directly from the questionnaire.

In this next extract the psychiatrist also very specifically refers to the questionnaire when introducing the topic about to be discussed.

**Extract 15.** (extract 3 re-produced)

1 Ps: **.hhh eli mä teen tänään sulle (0.7) elina >semmosen< (0.4)**

*.hhh so today I will go through (0.7) >this< ques<tio↑nnaire*

2 kysely<lomakk↑een> jossa käydään kaikk↓i .hhhh (0.3) psyykkiset

*with you Elina which covers al↓l .hhhh (0.3) the mental*

3 sairaudet mit↓äähhhhh (0.2) me tiedetään?

*illnesses wh↓ich hhhh (0.2) we know?*

4 (0.2)

5 Pa: okei,

*okay,*

6 Ps: **.hhh nopeesti läpi =nopeesti jos ei sul oo mitään sen oireita ni sit siirrytään**

*hhh quickly through =quickly if you don't have any symptoms of that illness*

*so*

7 seur°aa[vaan°.]

*then we'll move on to the ne°xt [one°.]*

8 Pa: [£mmh£,]

9 Ps: .hhh ensimmäinen on <masennus> hnfffff .mhhhhh ja (0.4) masennuss (0.2)



.hhh the first is <depression> hnfffff .mhhhhh and (0.4) depression (0.2)

10 °niinku° sairaut°en↓a° **eli mä tutkin nyt tän kyselylomakkeen avulla et onks**  
°like° as an ill°ne↓ss° **so with the help of this questionnaire I'll be studying**

11 **sulla masentuneis°uutt[a°.]**

***if you have depress°io[n°.]***

The extract is from the beginning of the diagnostic interview. In line 1 he begins the interview by explicating the purpose of their meeting: the diagnostic interview. In lines 1-3 the psychiatrist refers to the questionnaire by saying that he will go through a questionnaire in which all the known mental illnesses are covered. The psychiatrist displays that the upcoming themes are based on the questionnaire and the pre-set questions in it, not on his opinions or views about the patient. After a short pause he adds “quickly” in line 6, and continues to elaborate in lines 6-7 that each theme will be covered quickly if the patient does not have any related symptoms and they will move on to the next theme. In lines 9-10 the psychiatrist then moves on to the first theme and explicates his to the patient. In lines 10-11 he again refers to the questionnaire by clarifying that he will use the questionnaire to examine whether the patient is suffering from depression. By referring to the questionnaire the psychiatrist displays that he is not claiming the patient is suffering from these symptoms, but he is going through a set of questions in co-operation with the patient. He is asking questions and the patient is answering them based on her own evaluation.

## **5.4. Summary**

In this chapter I have focused on the psychiatrist’s interactional ways to maintain a position where on the one hand he takes into account the individuality of the patient and on the other remains on a reasonable theoretical level to be able to gather the needed information of the patient’s symptoms. The psychiatrist attempts to turn an

instrumental situation into a more individual one by creating an AB-situation and adapting the technical response options to function as follow-up turns to the patient's turns. He also uses the technical, generalizing element, the questionnaire, to display alliance with the patient.

I have shown four different interactional ways the professional uses to establish mutual ground for the patient and himself. First, he makes the questionnaire visible in the discussion by explicating the shift to the next theme and producing closing summary turns. Second, he establishes a mutual understanding of the theme by producing turns that clarify the theme for the patient. Third, he produces follow-up turns related to ranking options in the questionnaire and fourth, he refers to the questionnaire as a kind of third party.

There are no rules or guidelines concerning how the questions should be asked. The basic sequential format of this half-structured diagnostic interview is the same as in the non-structured discussions: question-answer. The follow-up turns function as clarifications, which then function as ways of constructing the right "answer" to the theme and display to the patient that she is the one who has the information needed for the answer. The 1<sup>st</sup> position questions (as the follow-up turns) are also very often designed to ask for the patient's opinion: "would you say...is this exaggerated to say..." These questions help to maintain co-operation: the information is needed and asked for, but at the same time the patient's individuality is emphasized. The emphasis on the child's experience in the turn design is also relevant because the responses to the questions in the questionnaires are based on three different evaluations, the psychiatrist's, the parent's and on the child's subjective perception.

A half-structured questionnaire necessitates answers, which can be adapted to the ranking/criteria already defined in the questionnaire. This easily leads to the closed questions, clarifications and summary turns described in this analysis. This is the theoretical side, which the professional has to consider in the situation. At the same time these turns also act as acknowledgements of the patient's individuality, as they are formulated to emphasize the patient's epistemic position regarding her or otherwise include the patient in the theoretical part of the situation, in which the professional has the epistemic upper hand. This helps to create the necessary co-operational situation.

As the information the psychiatrist aims to gather with his questions has already been defined in the questionnaire (although the formulation of the questions is left to the executer of the questionnaire as it is a half-structured one), the psychiatrist needs an answer that can somehow be adapted to the ranking of the response options. This easily leads to “fishing” for the answers or asking closed questions that might contribute to the patient’s feeling of being defined from the outside and not being heard. This again might disrupt the efforts to maintain a co-operational situation between the theoretical and the individual. By explicating the purpose of the questions to the patient, the psychiatrist is able to create a shared situation with the patient since they now both know and are aware of this “third party,” the diagnostic questionnaire which these generalizing questions are based on.

Using the questionnaire as a third party helps the professional to balance between the theoretical and the individual. It also helps him to create an alliance with the patient. This is possible by explicating the topics and questions in the questionnaire, and approaching the questions not as claims by the professional about the patient but as general questions, which are asked of everyone going through the questionnaire. Thus the mutual sharing and talk related to the questionnaire, the third party, can help create an alliance between the other two, the patient and the professional. As the challenge in treating eating disordered patients is their strong resistance, professionals must balance between being supportive and being confrontative. In this case the third party, the questionnaire, helps the professional distance his questions from the patient, which in turn might help to establish the needed co-operational situation.

It is also a fact that during the interview the psychiatrist needs to make notes. This brings up the theoretical, distant side of the situation and emphasizes that the patient is being assessed. The different types of interaction are needed to emphasize the patient’s individuality and create a sense of a shared situation in which the assessment does not overrule the patient’s epistemic stance of being the person knowing the answers to the questions regarding her.

In the previous three chapters I have focused on professionals’ turns to see how the challenges of treating anorexic patients become visible in the interaction and interactional methods professionals use. In the next chapter I will look at these challenges from the patients’ angle: patients’ resisting turns.

## **6. Patients' resisting turns: The turn initial "I don't know" (*emmä tiä*)**

This chapter focuses on the patients' position in discussions between eating disordered patients and professionals involved in their treatment, as well as on the actions that distance the patients' response from the professionals' questions. As I will show, one of these actions is the use of the phrase "I don't know" at the beginning of the patients' turns. The patients frequently begin their turn with "I don't know" and after this produce the actual response to the professional's question. These turns always include the common features of a misaligning turn such as a pause before taking the turn, delays during the turn, self-corrections, and usually a delaying particle as the first word of the response.

As mentioned, resistance is a central feature of eating disorders and a central challenge in their treatment. It is interesting that patients at the same time co-operate in the institutional situation by producing responses, but when looked at more closely, several turns include misaligning features, which take a distance from the same situation. This co-existence of co-operation and resistance is especially interesting in the context of treating eating disorders. According to clinicians, eating disordered patients have a need to please the counterpart and avoid expressing their own views directly. This is a challenge for the treatment as patients may express acceptance and alignment towards the treatment but still continue their hazardous behavior (Kuusinen 2001, 218).

In this chapter I use the frequently occurring turn-initial "I don't know" as a window through which we can look at the misaligning turns and actions more closely as a whole. In these data patients always produce a response after beginning the turn with "I don't know." This must mean that the phrase has another function in addition to displaying lack of knowledge or inability to answer the question. I will show that the turn-initial "I don't know" in collaboration with the other features mentioned above act as a vehicle for the patients to create turns that display resistance towards the line offered in the professional's turn. In these turns the patients display resistance to the professional's agenda and the context of the situation. I will also show that in addition

to the misaligning actions that relate to the immediate sequential situation the patients display misalignment with the institutional situation more broadly.

## **6.1. Prior research**

In CA research, as in this study, the interest on the phrase “I don’t know” has been on the functions of the phrase that it might have besides displaying cognitive inability. The general perception is that in second position “I don’t know” can be used in its literal sense but its actions are broader than that (Beach & Metzger 1997, Grant 2010, Tsui 1991).

Hutchby has explored the phrase in rather similar institutional settings as the data of this study. He focuses on discussions of a six-year-old child and his counselor. In the data the child frequently answers “I don’t know” to the counselor’s questions and sometimes even interrupts the counselor’s turn with the phrase. Usually the “I don’t know” is the child’s complete turn; nothing else is added to it. Hutchby sees these “I don’t knows” as a vehicle for strong resistance as the child tries to interrupt the subject offered by the counselor. On the other hand, Hutchby’s view is that the cognitive function should not be excluded when exploring the functions of this phrase. In his data, for example, it is also clear that the child sometimes cannot give an answer to the counselor’s question.

Potter (1996) on the other hand has explored the uses of “I don’t know” as part of a broader turn. In this context they are related to the “I don’t knows” of this study as the phrases in this data are also part of a broader turn, not complete turns. Potter has focused on these phrases in various kinds of naturally occurring talk such as TV interviews. The phrases in Potter’s data are added, “Tagged”, at the end of the turn when the turn could already be completed: “I think the restaurant was a disappointment, I don’t know.” Potter sees the function of these tagged phrases to be “stake inoculators,” ways of preparing for negative input from the interlocutor. According to Potter every turn is oriented to evaluation, so by tagging this stake inoculator the speaker prepares for a negative evaluation by lightening the turn beforehand.

As the phrases in Hutchby's data were complete turns and not part of a longer turn, and in Potter's data they were tagged to the end of the turn and not the beginning, it is Ann Weatherall's (2011) study on "I don't know" which comes closest to the focus of this study. Weatherall's focus has been on "I don't know" that are pre-positioned or preliminary to the next element within a turn. Unlike in this data they were all in first position, while those in focus here are all responses to the professionals' turns. Weatherall found that these "I don't knows" functioned as a pre-positioned hedge, a forward looking stance marker which displays that the speaker is not fully committed to what follows in their turn of talk (Weatherall 2011, 2). Although the "I don't knows" in this data are preliminary to what comes next in a responsive turn, I will show that they also function similarly in the patients' turns.

## **6.2. "I don't know" in the data**

In this data "I don't know" occurs frequently in the patients' turns in various places. They can be imbedded in a broader syntactical unit in which case the completion and the comprehensibility of the turn are dependent on the phrase; for example: "they say it's true but I don't know if I believe them or not".

The phrase occurs also as an independent, added element that is not part of a broader sentence. This means that the "I don't know" is not, at least directly, related to the rest of the turn and the turn could be very well completed and understood without it; for example: "I liked the restaurant, I don't know, there was a nice atmosphere." This raises the interest about the function of the phrase. Why is it added in the turn and what is the action it performs?

These independent "I don't know" can occur as additions in the middle of the turn such as in the example above. They can also be tagged to the end of the turn as expansions. One of the most common places for these independent phrases is at the beginning of the turn; for example: "I don't know, it is not that hard I guess". These turn-initial "I don't knows" are the focus of this chapter.

This data has 32 turn-initial "I don't know" in all. A particle is usually added at the beginning, most commonly the particle "well" (particle "no" in Finnish). Sometimes a

particle is added somewhere else in the phrase, such as: I don't know now." These particles are also common features in a turn design of a misaligning turn. For example, the particle "well" in a turn-initial position in response to "wh" – questions is found to function as an alert to a non-straightforward response (Schegloff & Lerner 2009).

As I will show, the turn-initial "I don't know" occurs in turns which contain features of a misaligning turn, also other than the fore mentioned particles. Next I will look at this more closely.

### **6.2.1. Turn-initial "I don't know" as part of a resisting turn**

In this data the turn-initial "I don't know" is usually part of a resisting turn, an element of a dispreferred turn design. I call these turns "resisting" because they are examples of the ways the patients display resistance towards the professionals' turn, and patients' resistance is a central challenge in the treatment of anorexic patients. The turns are not all clearly misaligning as understood in CA-terms. Still, they contain elements of misaligning responses, and resisting turns are always misaligned with some element of the professional's turn.

In this chapter I use the terms "preference" and "misalignment" alongside each other, acknowledging that they are different interactional actions. Their relationship is complex: if a response is a "dispreferred second pair part" it contains misalignment; but all misaligning turns are not dispreferred. Still, in this chapter I need both of these terms. Therefore I see it as important to look at the elements of misalignment and preference before going to the analysis.

Alignment and misalignment can be looked at in the sequences of a conversation from two different angles (Schegloff 1988). First, it is central to look at the adjacency pair as a type of action (structure-based use of "preference"). What is the action the first pair part calls for and is this what the second pair part does, in other words, aligns with? At its simplest this can mean a quite clear action such as an invitation. Alignment to an invitation is to accept it; this is the preferred second pair part. To decline is to misalign with the first pair part; this is the dispreferred second pair part. But the action

the first pair part calls for can also be more complex, not so “black or white.” In our data, for example, the professionals’ first pair parts are commonly questions or suggestions, which can be quite complex and include presuppositions. Often there is not a single “preferred” answer (e.g. to accept a suggestion) as such, but there are still actions in the professionals’ turns that are called for. I will show for example that an action, a question which calls for the patient’s subjective answer, can get a misaligning dispreferred second pair part by not performing the sought after action specifically: a response is given but the actual question is not answered.

The second angle central to investigating alignment and misalignment is to look at the turn design of the second pair part, how the response is produced (practice-based use of “preference”) (Schegloff 1988). There are several features common to a dispreferred second pair part whereas preferred responses go fairly “unnoticed.” Preferred responses are straightforward while dispreferred responses include elements that distance the second pair part from the first. Characteristics common to dispreferred turn design are delays such as a pause before taking a turn, and pauses and self-corrections in the middle. Also, a particle at the beginning of a turn delays the response. An example is “no” (well) in the Finnish language (Sorjonen 1989), a feature very common for the patients’ turns focused on in this article. All the turns in this data which begin with the turn-initial “I don’t know” include several of these features; thus the turn-initial “I don’t know” is always part of a misaligning turn design.

Sometimes however the turn-initial “I don’t know” is truly an “I don’t know,” a part of producing a complex and difficult answer. I will show an example of this function of “I don’t know” before concentrating on resisting responses.

Before the next extract the nurse and the patient have been talking about the patient’s weight and the fact that it has gone down despite the treatment and the new meal plan. The nurse has been asking the patient about her feelings towards eating and the weight gain that is obligatory. In the next extract the nurse poses a question which calls for the patient’s assessment of her feelings about the fact that she has been able to eat sweets a few times. The nurse starts the turn in line 1 taking up a new topic “how about now,” and then states that the patient has eaten sweets and gives an example of a situation in line 2. The nurse uses the verb “have been able to,” which displays the nurse’s view and the presupposition of the question that eating sweets is



difficult for the patient. The nurse ends the turn in line 2 with an open question which now calls more specifically for the patient's feelings about the situation in which she ate the sweets.

### Extract 1.

- 1 N: mitäs nyt ku sä oot muutaman kerran pystyny makeetaki syömään  
*what about now when you've even been able to eat sweets a few*
- 2 (0.2) esimerkiks eilen leffassa?(.) hh. ni miltä se tuntu.  
*times hh (0.2) for example yesterday at the film ? (.)hh so how did that feel.*
- 3 (1.8)
- 4 P: °no°(0.8) **emmä tiitä**(.) eilen alus- siin alussa oli semmonen  
*°well° (0.8) I don't know(.) yesterday at fir- at first there was a*
- 5 (0.4)heti (0.2) sillai ku mä: söin sen ensimmäisen kar-(0.2) karkin  
*kind of(0.4) like(0.2) right after I ate the first can- (0.2) candy*
- 6 niin sit tuntu et on lihonnu £kilon jo:£ (0.2) sillai(0.2) so  
*then I felt I had £already gained a kilogram£ (0.2) like*
- 7 mut sit(0.5) kyl(0.8) sit sen pystyy niinku joten-(.)ki (1.0) ku  
*>but then<(0.5) <yes> I'm able to like some- (.) how(1.0)'cause*
- 8 (1.0) sit aattelemaan et(.) ei nyt fyhest karkist voi sillai£  
*(1.0) to think that (.) from one candy £it's not possible like£,*
- 9 (0.2)

10 N: mmm, ((nyökkää))  
 11 (0.8)  
 12 P: lihoo,  
*to gain weight,*

The patient delays the turn with the pause in line 3 and takes the turn in line 4 beginning it with the particle “well.” After another pause she adds “I don’t know” and after that begins to produce a response. The patient gives a two-part answer in which she first in lines 4-6 refers to the situation the nurse brought up and her immediate feelings after eating the sweets: at first she felt like she had gained weight right away. She pauses five times in lines 4-6 during this description and corrects herself twice in lines 4 and 5. After this she moves on to the second part of her answer in line 6 with “but then” and in lines 6-8 and 12 voluntarily expands her turn by telling how she then coped with the feelings: she was able to be rational and realized that the weight gain was not possible. Again the patient pauses five times in lines 6-7, 9 and 11 and corrects herself three times in lines 7-8. The patient produces the response the nurse has called for. The “I don’t know” along with the pauses and self corrections display difficulty in producing the answer; the question is not something the patient has a straightforward answer to.

As mentioned, in this chapter I will focus on the turn-initial “I don’t know” as part of a resisting turn. I will look at these turns on two levels. First I will look at the immediate action the patient’s turn misaligns with. I use the turn-initial “I don’t know” as a window for investigating this misalignment and how it is produced by looking at the function of the phrase in the turn. By this I mean that I want to know about the structure-based use of “preference”: there is an action, which the professional’s turn calls for. A response is given, but with a dispreferred turn design. What is the action in the patient’s turn that makes it a misaligning answer according to the practice-based use of “preference”?

Second, I also will look at patients’ misalignment in light of the institutional situation and the professional’s agenda for the conversation, concentrating on talk about the

illness. There is misalignment towards the immediate action in the professional's first pair part, but also towards the agenda of the conversation. I begin by concentrating on the immediate actions.

### **6.3. Function of the turn-initial "I don't know" in a resisting turn**

I found that the turn-initial "I don't know" functions in the resisting turn in two different ways. In the evasive turns the phrase works as a way for the patient to receive the professional's turn and the action it calls for. After receiving this with the "I don't know" the patient is able to produce a second pair part, which on the surface is aligning, a response is given, but which bypasses? The actual subject sought after in the professional's turn.

Also, in the turns which transform the frame of the conversation, the turn-initial "I don't know" works as an initial acknowledgement. The difference is that before giving the actual response the patient transforms the frame (often problematic) or presupposition included in the professional's turn before producing the sought after action of giving a response.

#### **6.3.1. Evasive**

The evasive turn-initial "I don't know" function as a way for the patient to acknowledge the presupposition or outline offered in the professional's turn and then begin to produce the response. By doing this, the patient evades the subject sought after in the professional's turn and gives a response which is "beside the point." Usually this means that the patient's response is on a more superficial level than the agenda in the professional's turn. In the turns for which these evasive responses are given the professional usually calls for the patient's assessment of her feelings concerning a difficult situation or inner conflict. The patient most commonly begins her response with the particle "well" and then adds "I don't know." After this the patient produces the evasive response.

Before the next extract the psychiatrist has started a topic that was orienting the conversation to pondering the patient's inner world of her thoughts and feelings. The focus the psychiatrist has offered is thoughts about weight loss and food. The patient has stated that the loss of friends is mostly on her mind at the moment. The psychiatrist picks up on this and produces a turn in lines 1-2, which is related to this statement. He begins the turn with "how does it" but corrects himself and rephrases it; he ends up asking the patient what she feels are the reasons she does not have friends at the moment. At the end of his turn in line 2 the psychiatrist suggests a possible reason: "have you somehow lost friends," but leaves the question open with "or what."

The patient takes the turn without a delay and accepts the psychiatrist's suggestion (with slight hesitation) and starts an expansion of the turn "and then." She gives an aligned answer to the psychiatrist's question: the action the psychiatrist called for was giving reasons and she answers in lines 3-6 and 8: when her friends tried to contact her in the spring she rejected them and now they are annoyed with her. Even though this turn also includes pauses that are typical features for misaligning turns, the action of the response is aligned with the psychiatrist's turn.

## Extract 2.

1 Ps: miltä se (.) mitä sä ajattelet miten (0.3) mikä se (.) <on se siinä et> sä et saa

*how does it(.) what do you think how(0.3) what is(.)<is it that> you don't*

2 nyt ystäviä aa- (0.6) ooksä jotenki menettänyt ystäviä °tai mikä. °

*get friends now aa-(0.6) have you somehow lost friends °or what.°*

3 P: n- ka:i ja sit (.) varmaan se et (1.6) et (.) silloin varmaan pari (0.4) niin

*i guess so and then(.)probably that(1.6)that(.)then probably a couple(0.4)so*

- 4 ku(.) jossai vaiheessa ehkä maaliskuut tai (.) sillai (.) ku ne yritti olla  
sillai  
*when(.) at some point probably march or(.)like that(.) when they tried*
- 5 (.) koko ajan kanssani ja >sillai mut sit mä< jotenki koko ajan  
*(.)like to be with me all the time and >like that but then i<somehow all  
the*
- 6 vaa torjuin niitä,  
*time just rejected them,*
- 7 Ps: mm.
- 8 P: ja sit kai ne nyt (0.4) jotenki (0.2) ei vaa jaksa mua enää.  
*and then i guess now(0.4)somehow(0.2) they are just fed up ↓with me.*
- 9 (5.0)

After quite a long pause the psychiatrist poses a question related to the patient's turn. He calls for the patient's assessment of her feelings: how does losing friends make her feel. The question projects a "feeling" answer.

- 10 Ps: milt se tuntuu.  
*how does that feel.*
- 11 (2.2)
- 12 P: no (2.6) **en mä tiiä** (0.2) kyl se (.) kyl mä jollai tavalla (.) ymmärrän niit.  
*well (2.6) **i don't know** (0.2) it does(.) I do somehow(.) understand them.*
- 13 Ps: mm.

14 P: sit ku ei oo nähny niinku kuukausiin nii sit (1.0) °kyl siin (0.2)  
vieraantuu.°

*when you haven't met like for months so then(1.0)°you  
get(0.2)alienated°.*

15 Ps: mm.

This time the patient delays the response with the pause in line 11. Then she takes the turn and begins it with the particle “well.” She still delays the answer with another pause and then adds, “I don’t know.” A short pause follows and after this the patient starts to produce an expansion. She begins it with “it does” but corrects herself and produces a response in line 12 in which she tells that she somehow understands her friends. After the psychiatrist’s minimal response in line 13 she expands her turn in line 14 with an elaboration on why the behavior of her friends is understandable. The turn has pauses and a self-correction in addition to the delay before taking the turn and the turn-initial “I don’t know” preceded by the particle “well,” all features common to a misaligning answer. The misalignment is also visible in the action the psychiatrist’s turn calls for and the action in the patient’s answer. In his turn the psychiatrist calls for the patient’s assessment of how she feels about losing friends. In her answer the patient does not answer this but instead states that she understands them. She orients the discussion to assessing her friends instead of expressing her own inner feelings. With the turn-initial “I don’t know” she receives the psychiatrist’s turn and the action it calls for and with the phrase and the other delays mentioned above she bypasses/evades the action and gives a response but a misaligning one.

Before the next extract the patient and the psychiatrist have been talking about yesterday’s treatment discussion and the patient’s experience of being blamed. The patient has also mentioned that she never brings up her negative thoughts and feelings. At the beginning of his turn in line 1 the psychiatrist first marks the patient’s previous turn as an important subject, “It is important what you’re saying” and orients the discussion to the patient’s inner world: “what you’re saying and how you understand it yourself.” After this in lines 1-2 he poses a question which is related to what the patient has told about herself in her turn. The question calls for the patient’s own assess-

ment of the reason she has to suppress her feelings. At the end of the turn in lines 2-3 the psychiatrist suggests one possible reason but leaves the question open with “or what are you thinking.”

### Extract 3.

1 Ps: tärkeä asia mitä sä kerrot ja (1.3) miten sä ite ymmärrät sitä et miksi sä tu- mitä se

*It is important what you're saying and (1.3) how you understand it*

2 on et sä °joudut° tukauduttamaan tun°teitas° (.) pelkäätsä

*yourself that why you fe- why is it that you °have to° suppress your*

3 jotenkin seuraamuksia tai mitä sä ajat°telet°.

*fee°lings°(.) are you afraid of the consequences or what are you thi°nking°.*

4 (2.2)

5 P: °en mä tiiä° ( ) must vaan tuntuu et mä en saisi (0.5) olla vihainen tai (0.5)

*°i don' know°(.) i just feel that i shouldn't (0.5) be angry or (0.5)*

6 kellekään tai (0.5) et en mä saisi niinku arvostella ketään muita tai sillai,

*at anyone or (0.5) that i shouldn't criticize anyone else or like that,*

7 Ps: mm-m.

The patient delays her response with the pause in line 4 and then begins her turn with “I don't know.” The patient expands her turn by repeating what she has stated in her previous turn, the turn following up on the psychiatrist's question. Three pauses in the patient's turn make it misaligning and hesitant. The word “just” in line 5 inhib-

its the response from reaching the level the psychiatrist calls for: the reasons *behind* her feeling of not being allowed to be angry. Instead, she communicates that she cannot answer in the frame the psychiatrist offers in his turn and receives the turn with “I don’t know.” As she expands her turn she gives a response but it is not aligned with the action the professional calls for; she leaves it on the level of what she has stated before: “I just feel....” The psychiatrist’s turn calls for the patient’s thoughts on the reasons for why she has to suppress her feelings, that is, her own assessment on the matter. Instead, the patient produces a response in which what she says about her feelings is already known and the basis for the psychiatrist’s question.

The following extract is the next sequence from the same discussion, following the psychiatrist’s “mm-m” in line 7 of extract 3. In his prior turn the psychiatrist has asked for the patient’s assessment of why she has to suppress her feelings. When the patient does not produce an aligning response, but instead evades the action the psychiatrist calls for, the psychiatrist rephrases the question. He is pursuing an answer to his question but not by positioning the patient accountable. Instead, he is partly holding his own phrasing accountable as he rephrases his prior question.

The turn begins on lines 1-2 with an orientation to the rephrasal: “I was trying to say,” from which the psychiatrist continues to state a supposition that there are situations where the patient does display negative feelings and criticize other people. The patient agrees in line 3. From this agreement the psychiatrist expands his turn by asking the patient if she recalls such a situation and what kind of a situation it was. The psychiatrist’s turn is directing the discussion to pondering the reasons behind the patient’s guilt and suppression of feelings.

#### **Extract 4.**

1 Ps: .hh varmaan kuitenkin jos mä yritän- yritetään yhdessä ymmärtää nii mua->yritin

*.hh probably anyway if i try- we try to understand together so for me- > i was*



- 2 sanoo< varmaan kuitenkin semmosia tilanteita sattuu että sä arvostelet  
*trying to say< probably anyway there are situations when you do criticize*
- 3 eikö vaan.  
*isn't that so.*
- 4 P: joo.  
*yes.*
- 5 Ps: =mm niin mitä sillon (0.3) muistats sä jonkun tilanteen jossa sä oisit >oma-  
*=mm so what then (0.3) can you recall a situation where you would have*
- 6 aloitteisesti< arvostellu >esimerkiksi< vanhempias tai (0.5) mitä siitä niinku sit  
*>criticized< for example your >parents< or (0.5) what did it then like*
- 7 minkälainen tilanne siitä sit synty.  
*what kind of a situation did it become.*
- 8 (5.3)
- 9 P: no (0.5) en mä tiiä sen jälkeen mä vaan aattelen et (1.0) et ei mun ois niiku  
*well (0.5) **i don't know** after that i just think that (1.0) that i shouldn't have*
- 10 pitäny (1.25) ajatella noin,  
*like (1.25) been thinking like that,*

After a long pause the patient takes the turn in line 9 and begins it with a delaying “well”, a feature common for a response taking a distance from the first pair part. After this the patient still delays the answer with another pause, then adds “I don’t know” and begins to produce the actual answer. The patient does not answer the psychiatrist’s question that pursued the patient’s assessment of an actual situation

where she has been angry. Instead the patient designs an answer that resists the direction the psychiatrist offers in his turn and gives an answer in which she repeats what she has already brought up in the conversation: she feels she must not be angry. The psychiatrist's turn calls for a narrative on the fore mentioned situation but the patient does not give one. There are delaying pauses in the answer in lines 8-10. The "I don't know" at the beginning of the turn, in addition to the delaying particle and the pauses, allows the patient to produce an evasive answer by giving more time to the turn design. The answer would also be more clearly misaligned with the psychiatrist's question if the patient would immediately begin to produce an answer that clearly does not answer the question. Thus the turn initial "I don't know" functions as an initial response to the psychiatrist's question and together with the delaying particle "well" and the pauses help to produce a resisting evasive response.

As we have shown, these evasive turn-initial "I don't know" function as a way for the patient to acknowledge the presupposition or frame offered in the professional's turn. After doing so the patient can begin to produce a response to bypass the subject sought after in the professional's turn and gives a response that is "beside the point."

### **6.3.2. Transforming the frame of the conversation**

We have seen that the evasive turn-initial "I don't know" function in the patient's turn as an initial response to the professional's agenda and by doing so allow her to produce the evasive answer. This is also the way this phrase functions in responses that transform the frame of the conversation. The difference is that by doing so the patient is able to produce a misaligned response by transforming the frame of the professional's presupposition or suggestion and then give the actual answer. The professional's turns to which these transforming responses are given usually offer a problematic view of the conversation. They are also more likely to be closed yes/no questions. The response most commonly begins with the particle "well" and then "I don't know" is added. The turn-initial "I don't know" receives the presupposition/suggestion offered in the professional's turn without turning it down or accepting it. After having done so the patient starts to produce the actual response in which she

takes up the outline offered by the professional and comments on it before giving the actual response to the turn. Usually this comment transforms the professional's turn and the frame offered in it by normalizing the problematic view. When the patient has done this she produces the response. There seem to be fewer of the other features of a misaligning turn other than the particle and the turn-initial "I don't know" in the turn, which transforms the frame of the conversation. This is probably because the misalignment is already explicated in the turn by the commentary.

Before the next extract the patient and psychiatrist have been discussing the patient's thoughts about her eating disorder: when it started and what the first signs were. With his turn in line 1 the psychiatrist calls for the patient's assessment of the thoughts and feelings at the beginning of her illness, suggesting a possible symptom. The patient declines with a slight hesitation in line 3. The psychiatrist takes the turn and poses a question related to his prior turn. He makes another suggestion which is now more closed than the one in lines 1 and 2 ("or"). The question still calls for the patient's subjective thoughts about the beginning of her illness, this time suggesting a desire to just cut down on eating.

### **Extract 5.**

1 Ps: alkoks tulla jotain semmostah (0.8) et halus (0.2) välttää joitaki

*did you begin to hh(0.8) get the feeling(0.2) you wanted to avoid some*

2 asioita (.)<sup>o</sup>tai<sup>o</sup>,

*things(.)<sup>o</sup>or<sup>o</sup>.*

3 P: <sup>o</sup><mm ei oikeestaah.> <sup>o</sup>

◦<mm not really hh.>◦

4 Ps: olikse se vaa et halus (0.5) vähentää syömisen määrää.

*was it that you just wanted(0.5) to cut down on eating.*

5 P: no (0.2) **emmä ny tiiä**=mä halusin elää terveellisesti mut sit mä vähensin

well(0.2) **i don't know**=i wanted to live healthily but then I cut down on

6 samalla sitä syömisen määrää [°et ]kylhän se°,

eating at the same time [°so] yes°,

The patient takes the turn in line 5 and begins it with a particle “well,” and then after a short pause adds “I don’t know.” This receives the psychiatrist’s suggestion. She immediately continues her turn now adding her own input and subjective information about her thoughts and feelings. The patient does not accept the professional’s suggestion as such but comments on it by bringing her own normalizing view to the conversation: instead of *just* wanting to cut down on eating she wanted to live healthily and that was the reason she started to eat less. After transforming the problematic outline offered in the psychiatrist’s turn the patient shows a slight acceptance of the psychiatrist’s suggestion at the end of her turn in line 6. Along with the particle “well” the patient uses the turn-initial “I don’t know” to receive the professional’s suggestion without turning it down or accepting it. Instead, she communicates that she cannot answer in the framework given to her and uses these fore mentioned features to design a misaligned turn that resists the terms of the question by transforming it.

Before the next extract the psychiatrist and the patient have been discussing the treatment discussion they have had with the treatment staff and the patient’s parents. The patient has mentioned that she felt the adults were blaming her and based on this the psychiatrist has initiated a subject in which he talks about the patient’s feeling of self

blame and guilt in general. In his turn the psychiatrist asks a two-part question. In the first part in lines 1-3 he calls for the patient's assessment of her own self blame in the treatment discussion: whether the patient finds a reason to blame herself also in that situation. When the patient does not take the turn after the first question in line 4 the psychiatrist continues in lines 5-7, now giving an option: the patient thinks the adults blame her. The psychiatrist expands the question with an elaboration, a description of the situation that in a way accepts a "yes"-answer beforehand. All in all the presupposition in the psychiatrist's turn is that the patient has experienced the treatment discussion as very unpleasant and it has affected her and left her thinking about it. Furthermore the presupposition is that these thoughts are connected to the patient's feeling of guilt and self-blame.

#### **Extract 6.**

1 Ps: meneeks tää nyt tää menee liia- hoitoneuvotteluski et sä sit (.) miten

*does this get now this gets to- also in the treatment discussion that you(.) now*

2 ku sä oot nukkunu yhden yön ni meneeks seki sit nyt niin et se kääntyy jotenkin

*when you've slept through the night so does this also get like that that it turns somehow*

3 suoraan (0.3) et sä löydät sieltäkin nyt jonkun syyn sit syyttää itseäs.

*straight (0.3) that also in that situation you now find some reason to blame yourself.*

4 (1.3)

5 Ps: ta:i pidäk- ooks sä edelleen sitä mieltä et me niinkun me syytetään ja ja niinhän se

*:or do yo- do you still think that we are like blaming you and and it might have*

- 6 saatto ollakin °et se oli oli sellanen että sillälailailla° @aikuiset esitteli@  
semmosia  
*been so °that it was was like that in that way° @the adults showed you@ those*
- 7 kohtia mit- mitkä menee huonosti. .hh  
*things th- that are going poorly .hh*
- 8 (3.3)
- 9 P: **emmä tiä** (1.0) en mä ny (.) ei se nyt hoitoneuvottelu kauhee ollu  
*i don't know (1.0) i don't (.) the treatment discussion wasn't terrible*
- 10 mitenkää,  
*in any way,*
- 11 (0.8)
- 12 P: >et en mä< kauheesti sitä oo mie[ttiny] mut sillai,  
*> so i haven't< really thought ab[out it] but like,*
- 13 Ps: [mm. ]

After a long pause the patient takes the turn, begins it with "I don't know" and receives the suggestions in the psychiatrist's turn. After another pause the patient continues and begins a response, which seems to be misaligned with the professional's suggestions: "I don't". The patient continues by commenting on the psychiatrist's presupposition that the treatment discussion has been unpleasant for the patient: "the treatment discussion wasn't terrible in any way". This transforms the frame the professional was offering for the conversation: the supposed terrible thing is normalized to not terrible at all. After this comment and a pause the patient continues her answer by stating that because the treatment discussion was not as the psychiatrist suggested she has not really thought about it. With the turn-initial "I don't know" along with the pauses the patient designs a response which transforms the frame the psychiatrist offered in his turn and takes a distance from the presuppositions. The

questions in the psychiatrist's turn are thus left without the answer they were calling for.

As we have seen in the turns which transform the frame of the conversation, the turn – initial “I don't know” receives the presupposition/suggestion offered in the professional's turn without turning it down or accepting it. After this the patient is able to produce the actual response in which she takes up the frame/presupposition offered by the professional and comments on it, usually by normalizing the problematic presupposition before giving the actual response to the turn.

#### **6.4. Taking a distance from the professional's agenda**

So far I have shown that the turn-initial “I don't know” functions in the patient's turns as a vehicle for designing a resisting turn. The turns that include this phrase always include other common features for a turn that takes a distance from the first pair part: delays, mitigations, self-corrections and the particle “well.” The misalignment is visible not only through the turn design but also through the immediate actions of the first pair part and the second pair part: what action the first pair part calls for and whether the action of the second pair part is aligned with this. I showed that although patients always produce a second pair part, with the turn-initial “I don't know” and the other features mentioned above, they design turns which take a distance from the action the professional's first pair part called for. The misalignment can be with the question, as in the evasive turns, or with the frame/suggestion of the professional's turn as in the turns that transform the frame of the conversation.

The fore mentioned misaligning turns were investigated on the level of immediate actions: the relationship between the first pair part and the second pair part. I also want to look at this misalignment in the context of the institutional situation: what is the professional's agenda in the conversation, and in what direction is he aiming with the questions that the patient is taking a distance to when producing misaligning responses? At this point I want to return to the beginning of the chapter and the context of eating disorders and their treatment. As mentioned, eating disorders are difficult and complex illnesses and their treatment is challenging for both the professionals and the patients themselves. The denial of the sickness and resistance towards the treat-

ment (fear of losing the eating disorder) are common features. So the frame of a conversation in which the treatment and the illness are discussed, for example, by talking about the first signs of the eating disorder can easily raise resistance in the patient. It is this point of view from which I want to look at this resistance more closely on the interactional level by investigating the misaligning turn of this data also in light of the professional's aim in the conversation.

#### **6.4.1. Talking about the illness**

In these sequences the professional's turns orient the discussion to looking at the patient's illness more explicitly. By this I mean that the turns call for the patient's assessment, for example, of the first symptoms of her illness or her feelings about weight gain or loss and the treatment in general. They also sometimes call for the patient's assessment of reasons her state has regressed. Then again the topic of possible progression can raise resistance as in extract 8. All in all in these sequences the fact of the illness is being brought up and examined.

The next extract is extract 4 reproduced. This is an example of a turn which transforms the frame of the conversation. Before the extract the patient and the psychiatrist have been discussing the early stages of the patient's eating disorder. In line 1 the psychiatrist for the first time orients the discussion to looking at the patient's illness by suggesting a possible symptom. When the patient does not pick up on the psychiatrist's topic and declines with a slight hesitation he poses another question related to the same topic, this time suggesting a desire to just cut down eating. Again the turn directs the discussion to the pathology of the patient.

#### **Extract 7. (ex.4 reproduced)**

1 Ps: alkoks tulla jotain semmostah (0.8) et halus (0.2) välttää joitaki

*did you begin to hh(0.8) get the feeling(0.2) you wanted to avoid some*



- 2 asioita (.)<sup>o</sup>tai<sup>o</sup>,  
*things(.)<sup>o</sup>or<sup>o</sup>.*
- 3 P: <sup>o</sup><mm ei oikeestaah.> <sup>o</sup>  
<sup>o</sup><mm not really hh.> <sup>o</sup>
- 4 Ps: oliks se vaa et halus (0.5) -vähentää syömisen määrää.  
*was it that you just wanted(0.5) to cut down on eating.*
- 5 P: no (0.2) **emmä ny tiiä**=mä halusin elää terveellisesti **mut** sit mä vähensin  
  
well(0.2) **i don't know**=i wanted to live healthily but then I cut down on the
- 6 samalla sitä syömisen määrää [<sup>o</sup>et ]kylhän se<sup>o</sup>,  
eating at the same time [<sup>o</sup>so] yes<sup>o</sup>,

In her response the patient does not go along with the orientation the psychiatrist is offering in his turns: looking at the patient's "dieting" as a pathological state. Instead, the patient produces an answer which transforms the frame of the conversation by bringing her own normalizing view into the conversation: instead of *just* wanting to cut down on eating she wanted to live healthily, and that was the reason she started to eat less. The patient does not pick up on the agenda in the psychiatrist's turn. Rather she shows resistance towards the orientation to the pathology by bringing the normalizing view into the discussion and pulling the orientation away from the pathology of her state.

In this next extract the patient also takes a distance from the professional's agenda. This extract is rare in this data because the patient's turn not only takes a distance

from the action in the professional's turn but also explicates disagreement with the suggestion in the professional's first pair part.

Before the extract the nurse and the patient have been talking about the current situation of the patient's eating disorder. In his prior turn the nurse has asked if there are days now when the patient does not think about her weight and being fat. The nurse is directing the patient to looking at her illness and possible improvement. The patient has answered hesitantly that possibly her weight is not on her mind every day but her appearance surely is. In her turn she has taken a distance from the orientation of possible improvement in the nurse's turn. At the beginning of the next extract in line 1 the nurse poses a follow-up question linked to the patient's turn and asks a closed yes/no-question suggesting that the thoughts about her appearance are related to situations where the patient is alone. Again the nurse's agenda is to offer a view on improvement by asking whether these thoughts are related to certain situations; thus there is a supposition that in some situations she can forget her looks.

#### **Extract 8.**

1 N: mth .h liittyks se niihin tilanteisiin et ku on yksin.

*mth. h is it related to situations that when you're alone.*

(1.2)

2 P: no ei.

*well no.*

3 N: °ei,°

*°no°,*

4 (0.4)

5 P: #et vaikka metrossaki voi olla# (.) #ihan ku siin on ne

*#that for example also in the metro it can be#(.) like when the*

- 6           ikkunat nii sit aina näkee itsensä#,  
*windows are there so then you always see yourself#,*
- 7 N:       °mmm°.
- 8           (.)
- 9 P:       °nii°(1.2) °nii sit,°  
           °so° (1.2) °so then°,
- 10         (1.2)

After a pause the patient declines in line 2. When the nurse has received her turn in line 3 by repeating the "no" in the patient's turn the patient expands her turn after a short pause in lines 5-6 and elaborates on her negative response with an example of a situation which is like the nurse suggested: even in company (the underground) she is still anxious about her appearance.

After a pause the nurse takes the turn in line 11 and picks up on the example which was the elaboration on the patient's disagreement and offers his agenda again, first by stating that the example the patient gave is not an example of a situation he meant, and then by describing what he meant by not being alone in lines 12-14. The nurse expands on his turn in lines 16-18 with an elaboration, a description of the patient's mind and refers to what the patient has said about still thinking of her looks by minimizing it with: "so it can then come up for a moment when you notice yourself again somewhere..." The nurse is orienting the discussion to acknowledging the improvement in the illness.

- 11 N:       m.hhhh mut onk- mä aattelin sitä et (.) periaattees metrossaki sä oo  
           *m.hhhh but is-i was thinking that(.)basically also in the metro you're*
- 12         yksin.hh ja sit ku sul on jotain <tekemistä> tai joku ystävä kenen kaa  
           alone.hh and when you have something <to do>or a friend with whom

- 13 sä niinku juttelet ni tavallaan .hhh sit pystyy unohtaa  
*you're like talking to so in a way.hhhthen you're able to forget about*
- 14 sen painon,  
*the weight,*
- 15 (1.0)
- 16 N: et se saattaa °sit° tulla hetkeks sillai >ku niinku< (0.2) taas huomaa  
ittensä  
*that it can then come up for a moment like when(0.2) you notice  
yourself*
- 17 jostain (.) näkee .hhh et °sitte° jää miettimään °sitä että  
*again somewhere(.) see.hhh so °then° you're left thinking° about*
- 18 miltä näyt°tääh°.  
*what you look like°.*
- 19 (2.2)
- 20 P: no emmä tiä,  
*well i don't know,*
- 21 (0.6)
- 22 P: kyl (.) jos mä vaik (.) jonkun muun kanssaki ni ky:l (0.6) >just siin<  
(0.6)  
*it's(.) if i'm like (.) with somebody else so it is (0.6) >just when< (0.6)*
- 23 niinku (.) s- vaik nyt (.) sunnuntaina ku mä olin mun kaverin kaa nii  
sit,  
*like (.) t- for example now (.) on Sunday when i was with my friend so,*
- 24 (1.0)

- 25 P: sit ku me käytiin kaupassa nii sit sielläki oli <peilejä> nii sit  
*then when we went to the store so there were also mirrors there so  
then*
- 26 (0.7) jotenki (0.6) sit siinä tilantees ku ei- (.) ei oo ihan yksin  
*(0.7) somehow (0.6) in the situation when no-(.) not completely alone*
- 27 nii (0.7) kyl siinäki rupee miettimää:,  
*so (0.7) you start to think as well.;*
- 28 N: mm,

After quite a long pause the patient takes the turn and produces a response in which she still takes a distance from the nurse's agenda. First she clearly disagrees in line 22 by stating that even in company the thoughts are there and then moves on to an example of this kind of a situation in lines 23-25. She ends her turn in lines 26-27 by again stating that it is also in situations where she is not completely alone that the thoughts of her looks can come to mind. The patient has persistently resisted the nurse's agenda of looking at her illness and any possible improvement by producing misaligning turns to all three of the nurse's turns offering this frame for the conversation.

As we have seen, it is not only the immediate action in the professional's turns the patients distance themselves from with the resisting turns. There is also the broader agenda related to the institutional situation the patients interact with. As it is central to the nature of eating disorders to deny the pathology, it would be expected that the sequences where the professional's agenda is to examine this pathology would receive misaligning responses as in extract 9. On the other hand, another central feature for eating disorders is to resist treatment, probably because one denies being sick in the first place, and because treatment aims at recovery, which means giving up the eating disorder. As we have shown, sequences such as in extract 7, in which the professional's agenda is to direct the patient to look at herself, understand her conflicts and

then understand her eating disorder also received misaligning turns. Extract 9 also relates to this even though the illness is talked about directly and therefore is categorized under “the illness” in this analysis. The professional’s agenda is to direct the patient to look at her possible improvement, the side in her which is possibly the “healthy” side, but the patient clearly disagrees with the professional and distances herself from his agenda with her resisting turn.

## **6.5. Summary**

In this chapter my focus has been on the patient’s position in discussions between eating disordered patients and professionals involved in their treatment. Central to this chapter has been the resistance in the patients’ turns, more specifically, the actions that display resistance to the professionals’ first pair part. I have used the turn-initial phrase “I don’t know” as a central feature, a vehicle for examining the resisting turns and actions more closely. The patients frequently begin their turn with “I don’t know” and after this produce the actual response to the professional’s first pair part. These turns always include common features of a misaligning turn, such as a pause before taking the turn, delays during the turn, self-corrections and usually a delaying particle as the first word of the response.

I have shown that the turns display resistance in two different ways. In evasive turns the phrase functions as a way for the patient to receive the professional’s turn and the action it calls for. After receiving this with the “I don’t know” the patient is able to produce a second pair part, which on the surface is aligning, a response is given, but which bypasses the actual subject sought after in the professional’s turn.

In turns, which transform the frame of the conversation, the turn-initial “I don’t know” also functions as an initial acknowledgement. The difference is that before giving the actual response the patient transforms the frame (often problematic) or presupposition included in the professional’s turn before producing the sought after action, giving a response.

I have also shown that in addition to resisting the action called for in the professional’s turn, the turn-initial “I don’t know” is also used to resist the agenda in the

professional's question. The agenda, which came up in the analysis was "talking about the illness." In these sequences the professionals' turns orient the discussion to looking at the patient's illness more explicitly. The turns call for the patient's assessment, for example, of the first symptoms of her illness, or her feelings about weight gain or loss and the treatment in general, or the reasons her state has regressed. In these sequences the fact of the illness is being brought up and examined.

An interesting question is why "I don't know" provides such good possibilities for resistance and challenging the agenda of the conversation. Weatherall (2011) found that "I don't know" can work as a pre-positioned epistemic hedge which shows the speaker is not fully committed to the epistemic status of what immediately follows it in the turn (Weatherall 2011, 18). This point is also relevant concerning this data. Using "I don't know" before responding allows the patients are able to display co-operation by producing a response to the professionals' questions, but it also displays less commitment to the response. "I don't know" functions as a response to the professional's question, but what the patient produces after that is more up to her. If she began her turn with another phrase such as a delaying "well" and then continued directly to the response, the answer produced would be "tied" more closely to the professional's question. If the response then somehow resisted the action or agenda the professional called for in his turn, the resistance would be more visible.

As this is the last empirical chapter of this study, the next chapter will present the conclusions on the research.

## 7. Discussion

In this chapter I will present conclusions about my research and go through the setting of my research before I move on to the results.

This study has focused on interaction in the treatment of anorexic patients. During the past decades eating disorders have become common especially among young women. Within the medical field eating disorders are considered difficult and complex illnesses and their treatment is a challenge for professionals as well as patients. According to textbooks, eating disorders are serious and difficult mental and somatic illnesses. A key aspect of the psychiatric side of the illness is denial of the illness and resistance to treatment (Suokas & Rissanen 2007). These are the main obstacles to therapeutic engagement for many patients, and clinicians are often placed in the position of having to constantly attempt to persuade reluctant patients to change their behavior (Guarda & Coughlin 2009, 171-172). The relationship between the professional and the patient must be based on trust and understanding if the treatment is to be successful. In addition, the professionals must be supportive and firm mentors/guides who can motivate patients to give up their symptoms (Suokas & Rissanen 2007, 362). Psycho-education is also very important and the professional's role is often like a trainer's, constantly encouraging the practice of healthy behaviors (Guarda & Coughlin 2009, 173).

The right kind of interactional approach to patients is important during the treatment process and crucial to the success of the treatment. In other words, the professional must educate the patient about her illness and its symptoms, and how the illness creates skewed perceptions of eating and body image. Thus the central aim of the treatment is to get the patient to see her/his illness. Since interaction and its special features have a crucial role in realizing this aim, these should be given more attention. In response to this need, this study has focused on the interaction between professionals and patients in an institutional setting. The methodological and theoretical tools of this research arise from conversation analysis, especially the conversation analytical study of institutional interaction, the interaction between a professional and a client.



The aim of this research has been to describe how these challenges of the treatment of adolescent eating disordered patients are visible in the interaction of the treatment discussions between the professionals and the patients. The challenges are mentioned in the literature and standard care guidelines but they are not elaborated on to any great extent. This study has aimed to show how these different challenges and central concepts are visible in the interaction, how they are manifested by interactional choices and how the challenges are thus reproduced in the interaction.

I have also tried to explicate how, in their spoken interaction, patients avoid recognizing their illness and resist treatment, and how the professionals deal with that resistance and avoidance. I have also looked at the challenge of creating a co-operational situation during the treatment process with patients who are considered to be reluctant towards treatment.

In the four empirical chapters I have looked at the professionals' interactional ways of pursuing the patient's recognition of illness, confronting her by suggesting a problem in the treatment and producing psycho educative turns using a supportive, understanding approach. I have also looked at the psychiatrist's ways of creating a co-operational, shared situation in a half-structured diagnostic interview. In the last empirical chapter I have focused on the notion of resistance from the patient's perspective: the patient's ways of producing resisting turns using the turn-initial "I don't know."

The video recorded data of this study came from the day treatment unit for eating disordered adolescent patients at The Helsinki University Hospital for Children and Adolescents. The data consists of one-on-one discussions between the patients and professionals involved in the treatment. All the patients in this data suffer from anorexia nervosa and are 13-17-year-old girls in the fairly early stages of this treatment program.

## **7.1. Results**

The results of this study are based on four empirical chapters. The main result is that the central challenges considered by the professionals involved in the treatment can be clearly pinpointed in the interaction. The treatment situation as it is described in the

textbooks and guidelines is maintained and reproduced in the interaction. The textbooks describe the central challenges in the treatment of anorexic patients and the approach professionals should use to work with these challenges. There are no guidelines or advice, however, on how to do this on the level of immediate interaction, that is, what to say and how to approach specific topics. The analysis of this study shows that professionals use specific interactional ways to work with the different challenges and to implement an approach.

One central finding of this study is that professionals use the patients' own words to carry out their interactional projects, be it suggesting a problem in the patient's thoughts and desires or producing psycho educative turns. They do this by basing their key turns on the patients' turns, by following up their turns on the patients' previous turns. The study shows on the level of immediate interaction how professionals direct the discussion towards showing patients their relation to the illness, its symptoms, and the actions they take due to the illness. This result relates strongly to results found in conversation analytical studies on psychotherapeutic interaction and interaction concerning the treatment of addictions.

The study also shows how patients carry out the resistance mentioned in the textbooks. I have shown that on the level of immediate interaction, resistance is not by any means limited to a clear denial of the illness or unco-operative behavior. The sixth chapter shows how this resistance is also embedded in the patients' turns in the discussions. In other words, patients do co-operate by producing answers to the professionals' questions (compared to clearly refusing to answer) but in reality resist what the professional is offering in his/her turn.

Another result is that on an interactional level, the treatment discussions in this study are truly challenging for both the patients and professionals. The professionals' turns are challenging from an interactional point of view: broad questions and suggestions, often with quite strong presuppositions and many closed questions, frame the discussion as a question – answer structured conversation leaving less room for the patient to produce talk. This also leaves less room for the patients' own “part” in their treatment (discussions) although the aim is to get the patients to see their relation to their illness. Presuppositions and suggestions can raise resistance on the interactional level in general. In the treatment of anorexia, these interactional features double the

possibility of resistance from patients that suffer from an illness of which a central symptom is denial of the illness and resistance towards treatment.

## **7.2. Study of institutional interaction and the treatment of anorexic patients**

Interaction in the treatment of anorexic patients is similar to interaction in other types of institutional settings, and is therefore a mix of various interactional approaches. On the one hand, the interaction of the professionals is designed to confront resistance and work with a patient who is presupposed against the treatment and not in touch with her illness. As seen in chapter 3, the methods of pursuing the recognition of illness among anorexic adolescent patients are quite similar to the interactional ways used in Myllyhoito to help clients form a perception of their relationship with alcohol (Halonen 2000). In a way this is not surprising at all as both conditions are known for the fact that individuals suffering from them do not necessarily recognize them as problematic, and even if they do, do not want to give them up because of the addiction and ego-syntonic reasons. Also, the misalignment displayed by the patients in chapter 6 shows from another perspective how these pursuing turns are received. As is common for questions or suggestions with strong suppositions, they are met with misalignment and distancing by the recipient.

On the other hand, professionals do interactional work to create a co-operational situation with patients, and some interactional methods are very similar to the actions in many health care institutional settings. As seen in chapter 4, delivering psychoeducative turns is similar to delivering advice in general, be it about life style issues (Peräkylä et al. 2001), weight issues (Pyörälä 2006) or advice to new mothers (Heritage & Sefi 1992).

As mentioned earlier, institutional interaction is connected to the roles of the participants specific to that institution. It is clear that the participants of this data are thus in the roles of a doctor, a nurse and a patient and their interaction is framed by that role. It is also interesting to look at the different roles from the point of view of the challenges of the treatment and see if there is role divide in the interactional ways in relation to the challenges. Since the central challenge in treating anorexic patients is the

lack of recognition of the illness, and reluctance and resistance towards treatment, the key to recovery is to get the patients to see their illness, their skewed thoughts and unhealthy behavior. Psycho education is considered a very important part of this treatment process. Informing the patients of the illness and its symptoms as well as educating them about the right kind of nutrition are seen to play an important role in the recovery process.

According to the textbooks and guidelines, the type of interaction leading to good results is based on an attitude of understanding, support and firmness. The roles are clearly divided in this respect as well: the psychiatrist's role is that of pursuing the recognition of the illness. The nurse's role is that of a psycho educator. The psychiatrist's role is to confront the patient, as we saw in chapter 3, clearly misaligning with the patient's stance and questioning her will to recover. Although some misaligning turns were also produced by the nurses, their approach, as seen in chapter 4, was much more aligning and supportive. In this data the discussions of these two chapters are from the same time period, so the patients' situations are the same in the discussions with the nurses, the pediatrician and the psychiatrist. This gives the opportunity to see what kind of interactional methods different professionals use to approach the situation.

I have now examined the results of this study in relation to institutional interaction. Next I will ponder on the use of these results and possible topics for further research.

### **7.3. Use of the results and possible topics for further research**

As the fore mentioned challenges in the treatment of anorexic patients are considered by the professionals themselves as central and crucial issues for the success of the treatment, it is of prime importance to study these more closely . The challenges are mentioned in the literature and standard care guidelines but not elaborated on to any great extent. This study has shown how these different challenges and central concepts are visible in interaction, how they are manifested by interactional choices and how the challenges are thus reproduced in the interaction. The analysis and the results of this study offer the professionals involved in treating anorexic patients enhanced ways of evaluating their work by showing how the different, central challenges docu-

mented in the textbooks and guidelines are produced and displayed in the interaction, that is, the actual treatment. Professionals can thus evaluate their interaction and interactional choices in relation to their concepts of the central challenges and how they should be managed. The study of institutional interaction can therefore produce information about central issues in the treatment of anorexic patients.

In the future, the same themes of research could be applied to a broader set of data on professionals in the same field and in different fields. Studies could be carried out in different hospitals; for example, in those with a special unit for eating disordered patients and in those without such a unit. In my view this study is only the first step in research on interaction in the treatment of eating disordered patients.

## References

- ANTAKI, C. (1999): *Assessing quality of life of persons with a learning disability: how setting lower standards may inflate well-being scores*. *Qualitative Health Research*, 9, 437-457.
- ANTAKI, C. & RAPLEY, M. (1996): "Quality of life" talk: the liberal paradox of psychological testing. *Discourse and Society*, 7(3), 293-316.
- ANTAKI, C., HOUTKOOP-STEENSTRA, H. & RAPLEY, M. (2000): "Brilliant, next question..." High-grade assessment sequences in the completion of interactional units. *Research on Language and Social Interaction*, 33, 235-262.
- ANTAKI, C., BARNES, R., & LEUDAR, I. (2005): *Diagnostic formulations in psychotherapy*. *Discourse Studies* 7(6): 627-647.
- ANTAKI, C. (2008): *Formulations in psychotherapy*. In Peräkylä, A., Antaki, C., Vehviläinen, S. & Leudar, I. (ed.) (2008): *Conversation Analysis and Psychotherapy*. Cambridge: Cambridge University Press. 26-42.
- ARMINEN, I (1998): *Therapeutic Interaction. A Study of Mutual Help in the Meetings of Alcoholics Anonymous*. The Finnish Foundation for Alcohol Studies, Helsinki.
- ARMINEN, I. (2001): *Kokemusten jakaminen nimettömien alkoholistien (AA) palaverissa*. In J. Ruusuvaori, M. Haakana & I. Raevaara (ed.): *Institutionaalinen vuorovaikutus. Keskusteluanalyttisiä tutkimuksia*. Suomalaisen Kirjallisuuden Seura, Helsinki. 82-103.
- ARMINEN, I. (2005): *Institutional Interaction: Studies of Talk at Work*. Ashgate, Hampshire.
- ATKINSON, M.J. & HERITAGE, J. (ed.) (1984): *Structures of Social Action. Studies in Conversation Analysis*. Cambridge University Press, Cambridge.
- ATKINSON, J.: (1992): *Displaying neutrality: formal aspects of informal court proceedings*. In P. Drew & J. Heritage (ed.) *Talk at Work*. Cambridge University Press, Cambridge. 199-211.
- BOYD, E. & HERITAGE, J. (2006): *Taking the history: questioning during comprehensive history-taking*. In Heritage, J. & Maynard, D. (ed.): *Communication in Medical Care: Interaction between primary care physicians and patients*. Cambridge University Press, Cambridge. 151-184.
- BEACH, W. (1996): *Conversations About Illness: Family Preoccupations With Bulimia*. Lawrence Erlbaum Associates, Mahwah, New Jersey.
- BEACH, W. & METZGER, TR. (1997): *Claiming insufficient knowledge*. *Human Communications Research*, 23, 562-588.

- BEACH, W. & ANDERSON, J. (2003): “*Communication and cancer? Part two: Conversation analysis.*” *Journal of Psychosocial Oncology*. Vol. 21(4) 2003, The Haworth Press.
- BERCELLI, F., ROSSANO, F. & VIARO, M. (2008): *Clients’ responses to therapists’ reinterpretations*. In Peräkylä, A., Antaki, C., Vehviläinen, S. & Leudar, I. (ed.) (2008): *Conversation Analysis and Psychotherapy*. Cambridge: Cambridge University Press. 43-61.
- BERG, M. (2001): *Vallan vahtikoira haukkuu mutta ei pure. Poliitikkoo syyllistävät toimittajan kysymykset televisiokeskustelussa*. In J. Ruusuvuori, M. Haakana & I. Raevaara (ed.): *Institutionaalinen vuorovaikutus. Keskustelunanalyttisiä tutkimuksia*. Suomalaisen Kirjallisuuden Seura, Helsinki. 121-137.
- BERGMANN, J. (1992): *Veiled morality: notes on discretion in psychiatry*. In P. Drew & J. Heritage (ed.) *Talk at Work*. Cambridge University Press, Cambridge. 137-162.
- BERGNES, M. & BJORK, I. (2012): *Entry into Nursing: An Ethnographic Study of Newly Qualified Nurses Taking on the Nursing Role in a Hospital Setting*. *Nursing Research and Practice*, Volume 2012 (2012), Article ID 690348, 7 pages doi:10.1155/2012/690348
- BORDO, S. (1993): *Unbearable weight: Feminism, Western culture and The Body*. University of California Press, Berkeley and Los Angeles, California.
- BRUMBERG, J. (2000): *Fasting Girls: The History of Anorexia Nervosa*. Vintage.
- BÖGELS, S.M. (1994): *A structured-training approach to teaching diagnostic interviews*. *Teaching of Psychology*, 12, 144-150.
- CLAYMAN, S. (1992): *Footing in the achievement of neutrality: the case of news-interview discourse*. In P. Drew & J. Heritage (ed.) *Talk at Work*. Cambridge University Press, Cambridge. 163-198.
- CRISP, A.H., JOUGHIN, N., HALEK, C. & BOWYER, C. (1996): *Anorexia Nervosa: The Wish to Change*. Psychology Press, East Sussex.
- DANCYGER, I.F. & FORNARI, V.M. (ed.) (2009): *Evidence Based Treatments for Eating Disorders: Children, Adolescents and Adults*. Nova Science Publishers, New York.
- DANCYGER, I.F., FORNARI, V.M. & KATZ, J.L. (2009): *Day Treatment for Anorexia Nervosa*. In Dancyger, I.F. & Fornari, V.M. (ed.) (2009): *Evidence Based Treatments for Eating Disorders: Children, Adolescents and Adults*. Nova Science Publishers, New York. 101-118.
- DREW, P. (1992): *Contested evidence in courtroom cross-examination: the case of a trial for rape*. In P. Drew & J. Heritage (ed.) *Talk at Work*. Cambridge University Press, Cambridge. 470-520.
- DREW, P. & HERITAGE, J. (ed.) (1992): *Talk at Work*. Cambridge University Press, Cambridge.

- DREW, P. & HERITAGE, J. (1992): *Analysing talk at work: an introduction*. In P. Drew & J. Heritage (ed.) *Talk at Work*. Cambridge University Press, Cambridge. 3-65.
- DREW, P. (2006): *Misalignments in "after-hours" calls to a British GP's practice: a study in telephone medicine*. In Heritage, J. & Maynard, D. (ed.): *Communication in Medical Care: Interaction between primary care physicians and patients*. Cambridge University Press, Cambridge. 416-444.
- EHRLING, L-M. (2006): *Psykoterapian vaikutusten arvioiminen: Keskusteluanalyttinen tutkimus arviointihaastattelun käytänteistä*. Helsingin yliopiston sosiaalipsykologian laitos, Helsinki.
- FEDERICI, A. & KAPLAN, A.S. (2009): *Overview of the Biopsychosocial Risk Factors Underlying Anorexia Nervosa*. In Dancyger, I.F. & Fornari, F.M. (ed.) (2009): *Evidence Based Treatments for Eating Disorders: Children, Adolescents and Adults*. Nova Science Publishers, New York. 1-18.
- FORRESTER, M. & REASON, D. (2006): *Conversation analysis and psychoanalytic psychotherapy research: questions, issues, problems and challenges*. *Psychoanalytic Psychotherapy* 20(1): 40-64.
- GALE, J. (1991): *Conversation Analysis of Therapeutic Discourse: The pursuit of a therapeutic agenda*. Ablex Publishing Corporation, Norwood, New Jersey.
- GARB, H.N. (1998): *Studying the clinician: judgement research and psychological assessment*. American Psychological Association, Washington DC.
- GOODWIN, C. & HERITAGE, J. (1990): *Conversation Analysis*. *Annual Review of Anthropology* 19, 283-307.
- GORDON, R. (1990): *Anorexia and Bulimia: Anatomy of a Social Epidemic*. Basil Blackwell, Oxford and Cambridge.
- GRANT, L.E. (2010): *A corpus comparison of the use of "I don't know" by British and New Zealand speakers*. *Journal of Pragmatics*, 42, 2282-2296.
- GREATBATCH, D. (1992): *On the management of disagreements between news interviewees*. In P. Drew & J. Heritage (ed.) *Talk at Work*. Cambridge University Press, Cambridge. 268-301.
- GUARDA, A.S. & COUGHLIN, J.W. (2009): *Treatment Resistance: Persuasion, Perceived Coercion and Compulsion*. In Dancyger, I.F. & Fornari, F.M. (ed.) (2009): *Evidence Based Treatments for Eating Disorders: Children, Adolescents and Adults*. Nova Science Publishers, New York. 171-186.
- HAKULINEN, A. (1998): *Johdanto*. In L. Tainio (ed.): *Keskusteluanalyysin perusteet*. Vastapaino, Tampere. 13-17.
- HALONEN, M. (2002): *Kertominen terapian välineenä: tutkimus vuorovaikutuksesta myllyhoidon ryhmäterapiassa*. Suomalaisen Kirjallisuuden Seura, Helsinki



- HAVE, P. & PSATHAS, G. (ed.) (1995): *Situated order. Studies in the social organization of talk and embodied activities*. University Press of America, Washington DC.
- HEATH, C. (1992): *The delivery and reception of diagnosis in general-practice consultation*. In P. Drew & J. Heritage (ed.) *Talk at Work*. Cambridge University Press, Cambridge. 235-267.
- HEPWORTH, J. (1999): *The Social Construction of Anorexia Nervosa*. Sage, London.
- HERITAGE, J. & SEFI, S. (1992): *Dilemmas of advice: aspects of the delivery and reception of advice in interactions between Health Visitors and first-time mothers*. In P. Drew & J. Heritage (ed.) *Talk at Work*. Cambridge University Press, Cambridge. 359-417.
- HERITAGE, J. (1996 [1984]): *Harold Garfinkel ja Etnometodologia*. Finnish translation Arminen, I., Paloposki, O., Peräkylä, A., Vehviläinen, S. & Veijola, S. Gaudeamus, Helsinki.
- HERITAGE, J. & MAYNARD, D. (2006): *Introduction: Analyzing interaction between doctors and patients in primary care encounters*. In Heritage, J. & Maynard, D. (ed.): *Communication in Medical Care: Interaction between primary care physicians and patients*. Cambridge University Press, Cambridge. 1-21.
- HERITAGE, J. & MAYNARD, D. (ed.) (2006): *Communication in Medical Care: Interaction between primary care physicians and patients*. Cambridge University Press, Cambridge.
- HIGHTOWER, R. (2010): *"Doing Ethnography In An Urban Hospital Emergency Department Setting: Understanding How Culture Was Related To Emergency Physician Habitus"*. Wayne State University Dissertations. Paper 167. [http://digitalcommons.wayne.edu/oa\\_dissertations/167](http://digitalcommons.wayne.edu/oa_dissertations/167)
- HOUTKOOP-STEENSTRA, H. (1995): *Meeting both ends: standardization and recipient design in telephone survey interviews*. In ten Have, P. & Psathas, G. (ed.): *Situated order. Studies in the social organization of talk and embodied activities*. University Press of America, Washington DC.
- HOUTKOOP-STEENSTRA, H. (1996): *Probing behavior of interviewers in the standardized semi-open research interview*. *Quality & Quantity*, 30, 205-230.
- HOUTKOOP-STEENSTRA, H. (1997): *Being friendly in survey interviews*. *Journal of Pragmatics*, 28, 591-623.
- HOUTKOOP-STEENSTRA, H. (2000): *Interaction and the Standardized Survey Interview. The living questionnaire*. Cambridge University Press, Cambridge.
- HUTCHBY, I. (2002): *Resisting the incitement to talk in child counselling: aspects of the utterance "I don't know"*. *Dicourse Studies*, 4, 147-168.
- IJÄS-KALLIO, T. (2011): *Patient participation in Decision Making Process in Primary Care: A conversation analytic study*. Tampere University Press, Tampere.

- JOKINEN, A. & SUONINEN, E. (ed.) (2000): *Auttamistyö keskusteluna. Tutkimuksia sosiaali- ja terapiatyön arjesta*. Vastapaino, Tampere.
- JUHILA, K. (2000): *Neuvot ja pulmat lastensuojelukeskusteluissa*. In Jokinen, A. & Suoninen, E. (ed.): *Auttamistyö keskusteluna. Tutkimuksia sosiaali- ja terapiatyön arjesta*. Vastapaino, Tampere. 105-130.
- KARON, B.P. (2000): *The clinical interpretation of the Thematic Apperception Test, Rorschach and other clinical data: a re-examination of statistical versus clinical prediction*. *Professional psychology*, 31, 230-233.
- KOSKINEN, I. (2001): *Työpaikan organisaatio ja tekstit jäsentämässä johtajien kokouspuhetta*. In J. Ruusuvuori, M. Haakana & I. Raevaara (ed.): *Institutionaalinen vuorovaikutus. Keskustelunanalyttisiä tutkimuksia*. Suomalaisen Kirjallisuuden Seura, Helsinki. 104-120.
- KURRI, K. (2005): *The Invisible Moral Order: Agency, Accountability and Responsibility in Therapy Talk*. Jyväskylä University Printing House, Jyväskylä.
- KUUSINEN (2008): *Syömishäiriöt*. In Kähkönen, S., Karila, I. & Holmberg, N. (ed.): *Kognitiivinen psykoterapia*. Duodecim, Helsinki.
- KÄHKÖNEN, S., KARILA, I. & HOLMBERG, N. (ed.) 2008: *Kognitiivinen psykoterapia*. Duodecim. Helsinki.
- LABOV, W. & FANSHEL, D. (1977): *Therapeutic Discourse: Psychotherapy as Conversation*. Academic Press, New York.
- LERNER, G.H. (2004): *Introductory remarks*. In Lerner G.H. (ed.): *Conversation Analysis: Studies from the first generation*. John Benjamins, Amsterdam/Philadelphia. 1-11.
- LERNER G.H. (ed.) (2004): *Conversation Analysis: Studies from the first generation*. John Benjamins, Amsterdam/Philadelphia.
- LINDFORS, P. (2005): *Homeopaatin vastaanotolla: Tutkimus vuorovaikutuksesta ja päätöksenteosta*. Tampere University Press, Tampere.
- LIVESLEY, J. & LONG, A.J. (2013): *'Children's experiences as hospital in-patients: voice, competence and work. Messages for nursing from a critical ethnographic study'*, *International Journal of Nursing Studies*. (In Press)
- LÖNNQVIST, J. et al. (ed.) (2007): *Psykiatria*. Duodecim, Helsinki.
- MACMARTIN, C. (2008): *Resisting optimistic questions in narrative and solution focused therapies*. In Peräkylä, A., Antaki, C., Vehviläinen, S. & Leudar, I. (ed.) (2008): *Conversation Analysis and Psychotherapy*. Cambridge: Cambridge University Press. 80-99.
- MACSWEEN, M. (1993): *Anorexic Bodies. A Feminist and Sociological Perspective on Anorexia Nervosa*. Routledge, London.
- MARLAIRE, C. & MAYNARD, D. (1990): *Standardized testing as an interactional phenomenon*. *Sociology of Education*, 63, 83-101.

MAYNARD, D. (1992): *On clinicians co-implicating recipients' perspective in the delivery of diagnostic news*. In P. Drew & J. Heritage (ed.) *Talk at Work*. Cambridge University Press, Cambridge. 331-358.

MAYNARD, D. & SCHAEFFER, N.C. (1997): *Keeping the gate: declinations of the request to participate in a telephone survey interview*. *Sociological Methods and Research*, 26, 34-79.

MAYNARD, D. & SCHAEFFER, N.C. (2000): *Toward sociology of social scientific knowledge: Survey research and ethnomethodology's asymmetric alternates*. *Social Studies of Science*, 30, 323-370.

MAYNARD, D. (2003): *Bad News, Good News: Conversational Order and Everyday Talk and Clinical Settings*. University of Chicago Press, Chicago.

MAYNARD, D. & FRANKEL, R. (2006): *On diagnostic rationality: bad news, good news and the symptom residue*. Teoksessa J. Heritage & D. Maynard (toim.): *Communication in Medical Care: Interaction between primary care physicians and patients*. Cambridge University Press, Cambridge. 248-278.

MURPHY, R., STRAEBLER, S., COOPER, Z. & FAIRBURN, C.G. (2009): *Interpersonal Psychotherapy (IPT) for Eating Disorders*. In Dancyger, I.F. & Fornari, V.M. (ed.) (2009): *Evidence Based Treatments for Eating Disorders: Children, Adolescents and Adults*. Nova Science Publishers, New York. 257-274.

**NOMURA, N. (1987): *Ethnography of interaction at a Japanese mental hospital*. Stanford University**

NUOLIJÄRVI, P. (1998): *Surveyhaastattelu vuorovaikutustilanteena*. In Paananen, s., Juntto, A. & Sauli, H. (ed.) *Faktajuttu. Tilastollisen sosiaalitutkimuksen käytännöt*. Vastapaino, Tampere.

ORBACH, S. (1986): *Hunger Strike: The anorectic's struggle as a metaphor for our age*. Faber & Faber, London.

PERÄKYLÄ, A. (1995): *AIDS Counselling: Institutional interaction and clinical practice*. Cambridge University Press, Cambridge.

PERÄKYLÄ, A. (1995): *Institutionaalinen keskustelu*. Teoksessa L. Tainio (toim.) *Keskustelunanalyysin perusteet*. Vastapaino, Tampere. 177-203.

PERÄKYLÄ, A. (2001): *Diagnoosin kertominen ja vastaanottaminen*. In M. Sorjonen, A. Peräkylä & K. Eskola (ed.) (2001): *Keskustelu lääkärin vastaanotolla..* Tampere: Vastapaino. 71-88.

PERÄKYLÄ, A., SORJONEN, M-L., TAMMI, T., RAEVAARA, L. & HAAKANA, M. (2001): *Potilaan elämäntavoista keskusteleminen*. In . Sorjonen, A. Peräkylä & K. Eskola (ed.) (2001): *Keskustelu lääkärin vastaanotolla..* Tampere: Vastapaino. 161-182.

PERÄKYLÄ, A. & VEHVILÄINEN, S. (2003): *Conversation analysis and the professional stocks of interactional knowledge*. *Discourse & Society* 14(3):727-750.

- PERÄKYLÄ, A. (2004): *Making links in psychoanalytic interpretations: a conversation analytic view*. *Psychotherapy Research* 14(3):289-307.
- PERÄKYLÄ, A., ANTAKI, C., VEHVILÄINEN, S. & LEUDAR, I. (ed.) (2008): *Conversation Analysis and Psychotherapy*. Cambridge: Cambridge University Press.
- PERÄKYLÄ, A., ANTAKI, C., VEHVILÄINEN, S. & LEUDAR, I. (2008): *Analysing psychotherapy in practice*. In Peräkylä, A., Antaki, C., Vehviläinen, S. & Leudar, I. (ed.) (2008): *Conversation Analysis and Psychotherapy*. Cambridge: Cambridge University Press. 5-25.
- PIKE, K.M. & YAMANO, M.A. (2009): *Cognitive Behavioral Therapy for Anorexia Nervosa*. In Dancyger, I.F. & Fornari, V.M. (ed.) (2009): *Evidence Based Treatments for Eating Disorders: Children, Adolescents and Adults*. Nova Science Publishers, New York. 187-206.
- POMERANTZ, A. (1984): *Agreeing and disagreeing with assessments: some features of preferred/dispreferred turn shapes*. In Atkinson, M.J. & Heritage, J. (ed.): *Structures of Social Action. Studies in Conversation Analysis*. Cambridge University Press, Cambridge. 57-102.
- POMPILI, M., GIRARDI, P., RUBERTO, A. & TATARELLI, R. (2006): *Suicide in Anorexia Nervosa and Bulimia Nervosa*. In Swain, P.I. (ed.): *Anorexia Nervosa and Bulimia Nervosa: New Research*. Nova Science Publishers, New York. 1-26.
- POTTER, J. (2004): *Discourse analysis as a way of analyzing naturally occurring talk*. In D. Silverman (Ed.), *Qualitative analysis: Issues of theory and method* (2<sup>nd</sup> ed.), London, Sage. 200-221.
- PUURONEN, A. (2004): *Rasvan tyttäret. Etnografinen tutkimus anorektisen kokemustiedon kulttuurisesta jäsentymisestä*. Nuorisotutkimusseura, Helsinki.
- PYÖRÄLÄ, E. (2006): *Interaction in dietary counseling of diabetic children and adolescents*. University of Helsinki, Helsinki.
- RAE, J. (2008): *Lexical substitution as a therapeutic resource*. In Peräkylä, A., Antaki, C., Vehviläinen, S. & Leudar, I. (ed.) (2008): *Conversation Analysis and Psychotherapy*. Cambridge: Cambridge University Press. 62-79.
- RAEVAARA, L., RUUSUVUORI, J. & HAAKANA, M. (2001): *Institutionaalinen vuorovaikutus ja sen tutkiminen*. In J. Ruusuvoori, M. Haakana & L. Raevaara (ed.) (2001): *Institutionaalinen vuorovaikutus. Keskustelunanalyttisiä tutkimuksia*. Suomalaisen Kirjallisuuden Seura, Helsinki. 11-38.
- RAEVAARA, L. (2001): *Potilaan diagnoosiehdotukset lääkärin vastaanotolla*. In M. Sorjonen, A. Peräkylä & K. Eskola (ed.) (2001): *Keskustelu lääkärin vastaanotolla*. Tampere: Vastapaino. 113-134.
- RANKIN, J. & CAMPBELL, M. (2009): *Institutional Ethnography (IE), Nursing Work and Hospital Reform: IE's Cautionary Analysis [41 paragraphs]*. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 10(2), Art. 8, <http://nbn-resolving.de/urn:nbn:de:0114-fqs090287>.

- RAPLEY, M. & ANTAKI, C. (1998): "What do you think about...?": generating views in an interview. *Text*, 18 (4), 587-608.
- RAPLEY, T. (2001): *Accounting for recreational drug use: the lived practice of qualitative interviews*. An unpublished dissertation.
- RAPLEY, T. (2003): *Qualitative Interviews*. In Seale, C., Gobo, G., Gubrium, J. & Silverman, D. (ed.) *Qualitative Research Practice*. Sage, London.
- RAYMOND, G (2003): *Grammar and Social Organization. Yes/No Interrogatives and the Structure of Responding*. *American Sociological Review* 68, 939-967.
- ROGERS, R. (2001): *The Handbook of Diagnostic and Structured interviewing*. Guilford Press, New York.
- RUUSUVUORI, J., HAAKANA, M., RAEVAARA, L. (ed.) (2001): *Institutionaalinen vuorovaikutus. Keskustelunanalyttisiä tutkimuksia*. Suomalaisen Kirjallisuuden Seura, Helsinki.
- RUUSUVUORI, J. (2001): *Miten vastaanotto aloitetaan?* In M. Sorjonen, A. Peräkylä & K. Eskola (ed.) (2001): *Keskustelu lääkärin vastaanotolla*. Tampere: Vastapaino. 27-48.
- RUUSUVUORI, J. & TIITTULA, L. (2005): *Tutkimushaastattelu ja vuorovaikutus*. In Ruusuvuori, J. & Tiittula, L. (ed.) (2005): *Haastattelu. Tutkimus, tilanteet ja vuorovaikutus*. Vastapaino, Tampere. 22-56.
- RUUSUVUORI, J. & TIITTULA, L. (ed.) (2005): *Haastattelu. Tutkimus, tilanteet ja vuorovaikutus*. Vastapaino, Tampere.
- SACKS, H., SCHEGLOFF, E. & JEFFERSON, G. (1974): *A Simplest Systematics for the Organization of Turn Taking for Conversation*. In J. Schenkein (ed.): *Studies in the organization of conversational interaction*. New York: Academic.
- SACKS, H. (1992): *Lectures on Conversation*. Blackwell, Oxford.
- SCHEGLOFF, E.A. & SACKS, H. (1973): *Opening Up Closings*. *Semiotica* 8, 289-327.
- SCHEGLOFF, E.A., JEFFERSON, G. & SACKS, H. (1977): *The preference for self-correction in the organization of repair in conversation*. *Language* 53, 361-382.
- SCHEGLOFF, E.A. (1979): *Identification and recognition in telephone conversation openings*. In Psathas, G. (ed.): *Everyday language: studies in ethnomethodology*. Irving, New York. 23-78.
- SCHEGLOFF, E.A. (1999): *Discourse, pragmatics, conversation analysis*. *Discourse Studies*, 1, 405-436.
- SCHEGLOFF E.A. (2007): *Sequence Organization in Interaction. A Primer in Conversation Analysis. Volume I*. Cambridge University Press, Cambridge.
- SEALE, C., GOBO, G., GUBRIUM, J. & SILVERMAN, D. (ed.) *Qualitative Research Practice*. Sage, London.

- SORJONEN, M-L., PERÄKYLÄ, A., ESKOLA, K. (ed.) (2001): *Keskustelu lääkärin vastaanotolla..* Tampere: Vastapaino.
- SORJONEN, M. (2001): *Lääkärin ohjeet*. In M. Sorjonen, A. Peräkylä & K. Eskola (ed.) (2001): *Keskustelu lääkärin vastaanotolla..* Tampere: Vastapaino. 89-112.
- STIVERS, T (2006): *Treatment decisions: negotiations between doctors and patients in acute care encounters*. In Heritage, J. & Maynard, D. (ed.): *Communication in Medical Care: Interaction between primary care physicians and patients*. Cambridge University Press, Cambridge. 279-312.
- SUCHMANN, L. & JORDAN, B. (1990): *Interactional troubles in face-to-face survey interviews*. Journal of American Statistical Association 85, 409, 232-241.
- SUOKAS, J. & RISSANEN, A. (2007): *Syömishäiriöt*. In Lönnqvist, J. et al. (ed.) (2007): *Psykiatria*. Duodecim, Helsinki.
- SWAIN, P.I. (ed.) (2006): *Anorexia Nervosa and Bulimia Nervosa: New Research*. Nova Science Publishers, New York.
- TAINIO, L. (ed.) (1998) *Keskustelunanalyysin perusteet*. Tampere: Vastapaino
- TRULL, T. (2005): *Clinical Psychology. 7th ed.* Thomson, Wadsworth.
- TSUI, B.M. (1991): *The pragmatic functions of "I don't know"*. *TEXT An Interdisciplinary Journal for the Study of Discourse*, 11, 607-622.
- VEHVILÄINEN, S. (2001): *Ohjaus vuorovaikutuksena*. Gaudeamus, Helsinki.
- VEHVILÄINEN, S. (2003) *Preparing and delivering interpretations in psychoanalytic interaction*. *Text* 23(4): 573–606.
- VEHVILÄINEN, S (2008): *Identifying and managing resistance in psychoanalytic interaction*. In Peräkylä, A., Antaki, C., Vehviläinen, S. & Leudar, I. (ed.) (2008): *Conversation Analysis and Psychotherapy*. Cambridge: Cambridge University Press. 120-138.
- VOUTILAINEN, L., PERÄKYLÄ, A. & RUUSUVUORI, J. (2010): *Misalignment as a therapeutic resource*. In Voutilainen, L: *Emotional Experience in Psychotherapeutic Interaction. Conversation analytical study on cognitive psychotherapy*. Helsinki University Print, Helsinki
- VOUTILAINEN, L (2010): *Emotional Experience in Psychotherapeutic Interaction. Conversation analytical study on cognitive psychotherapy*. Helsinki University Print, Helsinki
- WEATHERALL, A. (2011): *"I don't know" as a Turn Constructional Unit that Functions as a Pre-positioned Epistemic Hedge (under review)*.
- WEST, C. (2006): *Coordinate closings in primary care visits: producing continuity of care*. In J. Heritage & D. Maynard (ed.): *Communication in Medical Care: Interaction between primary care physicians and patients*. Cambridge University Press, Cambridge. 379-415.

WISNIEWSKI, L., BHATNAGAR, K. & WARREN, M. (2009): *Using Dialectical Behavioral Therapy for the Treatment of Eating Disorders: A Model for DBT Enhanced CBT*. In Dancyger, I.F. & Fornari, V.M. (ed.) (2009): *Evidence Based Treatments for Eating Disorders: Children, Adolescents and Adults*. Nova Science Publishers, New York. 275-290.

WOLF, Z. (1986): "NURSING RITUALS IN AN ADULT ACUTE CARE HOSPITAL: AN ETHNOGRAPHY" (January 1, 1986). *Dissertations available from ProQuest*. Paper AAI8614888.  
<http://repository.upenn.edu/dissertations/AAI8614888>