Conversations About Illness

Family Preoccupations With Bulimia

Wayne A. Beach
San Diego State University

M LAWRENCE ERLBAUM ASSOCIATES, PUBLISHERS 1996 Mahwah, New Jersey

Series Editors' Preface

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

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

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

the other the "avoidance of wrongdoing" by those denying that problematic health behaviors exist and merit the attention being given to them.

Although bulimia is the central focus of this monograph, the implications extend beyond this particular problem.

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

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

Wendy Leeds-Hurwitz Stuart J. Sigman

Introduction

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

This case study involves a single audiorecorded and transcribed conversation, nearly 13 minutes in length, as a point of departure for coming to grips with a limited but revealing set of interactional moments between a grand mother (G) and her granddaughter (S/Sissy). Understanding the nature and problematic consequences of family medical talk necessitates repeated inspection of the interactional organization of such occasions, involvements best preserved by naturally occurring recordings and carefully produced transcriptions. The availability of such materials affords researchers and clinicians alike the opportunity to describe and explain family members' orientations to

INTRODUCTION

bulimia, and by doing so to access what members themselves come to treat as meaningful throughout illness processes. By drawing attention to G and S's moment-by-moment, occasioned solutions to evolving courses of action, it becomes possible to reveal how these solutions reflect here-and-now relevancies of what these participants, for reasons often (but not always) explicitly provided in their conversation, acted upon as meaningful and thus in meaningful ways.

In most general terms, the focus of this book addresses why and how the study of social problems such as bulimia and "grandparent caregiving," often described in terms of the "social context" of health and illness, might be practically understood through an examination of language and social interaction. Attending to how family members rely on interaction to routinely order, produce, justify, and manage their daily affairs and understandings, engaging in

subtle and deceptively complex actions such as imposing and disregarding constraints regarding health behavior, reveals how families socially construct and in these ways make available their institutional orientations and priorities. More specifically, the focus rests predominantly with how G and S display contradictory preoccupations with bulimia: Just as G is persistent in her conviction that soon-to-be married S is consistently vomiting her food and therefore bulimic (e.g., as one means of losing weight to appear thinner and become more attractive), so does S consistently fail to directly admit, take ownership for, and agree to seek professional help in order to remedy alleged health problems put forth by G. It is the continuous and negotiated character of this interaction that the following analysis seeks to make clear, especially the curiously disaffiliative and at times conflicting resources G and S rely on throughout their conversation. However, certain actions can also be shown to display cooperative and even playful moments in the midst of otherwise serious matters involving an eating disorder.

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

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

The issues raised here give rise to basic questions:

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

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

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

The work presented herein is not a reflection of self-proclaimed expertise on eating disorders in general nor bulimia in particular, either as a researcher or resulting from direct personal or family experience with such an illness. In fact, the conversation between G and S was one of many volunteered recordings within the San Diego Conversation Library (SDCL) that, for some time, had remained unnoticed and thus gone unattended. For reasons long forgotten, several short segments of the recording were utilized in classes as evidence of what I then put forth as instances of "blaming," and a full transcription was only gradually produced and refined. It was at this point that a set of local, at times befuddling, observational problems arose: in the first few moments of the conversation, trying to figure out the rather curious

fashion in which G appeared to reject S's seemingly innocent invitation to go for a walk, first by questioning S's underlying motive for walking and eventually concluding "That's stupid." Through analysis, it did become increasingly clear that G's apparent attribution of motive, and possible wrongdoing toward S's walking, was designed in consideration of S's vomiting and generally poor eating habits. However, such eventual understandings in no way minimized or dismissed the analytic, here-and-now tasks of coming to grips with a

range of complex actions inherent to the moment-by-moment contingencies of this (and every) conversation. The methods or techniques recruited by G and S to coauthor this occasion, and what if anything such activities might reveal about the displayed character of family preoccupations with an eating disorder such as bulimia-not to mention the interactional organization of conversations about illness most generally-remained not only unarticulated but for a considerable period of time were simply not primary explanatory resources throughout a host of repeated listening sessions of the G-S audiorecording and inspections of the transcription.

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

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

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

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

Over the past few years I have, however, informally asked students, family members, and friends if they had participated in conversations about the

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

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

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

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

Relying on multiple resources for ensuring that S treats G as informed and takes her allegations seriously, thus laying grounds for reasonable assertion, chapter 3 addresses the interactional work of overcoming resistance:
attempts to solicit from S direct admittance via affirmation of responsibility, and commitment to seeking professional assistance for the "problems" S repeatedly fails to "own" (e.g., consistently vomiting her food as a means of becoming thinner for her upcoming wedding). In the ways G engages in a variety of actions-establishing, claiming, and imputing "knowledge," laying out consequences, citing sources, and offering evidence-the interactionally achieved character of "confrontation/insistence" is made apparent, as are routine and emergent difficulties in offering and receipting unasked for "advice."

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

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

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

alternatives by focusing on problems inherent in the social construction of illness (e.g., with contradictory and disaffiliative orientations such as withholdings of "commiseration" from persons struggling with an illness). The implications of this investigation extend well beyond bulimia to a vast array of inherently interconnected, casual and institutional involvements between family members, friends, and bureaucratic representatives (e.g., in long-term caregiving, dealing with cancer and Alzheimer's disease, during psychiatric interviews, and HIV/AIDS counseling sessions).

ACKNOWLEDGMENTS

From the inception of this project, I have benefited greatly from the comments of students, too numerous to mention here, and participants in unmotivated data sessions during Conversation Play Groups at San Diego State University and elsewhere. Several colleagues have offered generous insights and support as these materials were being developed-Greg Desilet, Rich Frankel, Phil Glenn, Chuck Goodwin, Char Jones, John Heritage, Robert Hopper, Michael Hyde, Jenny Mandelbaum, Doug Maynard, Mike Motley, Anita Pomerantz, Robert Sanders, and Manny Schegloff-at times incognito under the guise of anonymous reviewers, the upshots of which are hopefully conveyed throughout this analysis. Particular thanks to coeditors Stu Sigman and Wendy Leeds-Hurwitz, not just for careful readings and detailed comments but also for the inception of an "everyday communication" series.

Earlier versions of chapters 4 and 5 were published as "Avoiding ownership for alleged wrongdoings," *Research on Language and Social Interaction,* 24, 1990/1991, 1-36, and "The delicacy of preoccupation," *Text and Performance Quarterly,* 13, 299-312. Appreciation is extended to Boreal Scholarly Publishers and Distributors, Ltd. and the Speech Communication Association for permission to incorporate this work. The inclusion of the painting "Patterns of Behaviour," by Barry Kamen, is also made possible through his permission and Virgin Records Ltd. and UB40.

Patterns Of Behaviour (Artist: Barry Kamen)

1

Iyvvyy~y

Finding Bulimia

Those who are sated loathe honey; but to the hungry soul every bitter thing is sweet.
-Proverbs 27:7

Bulimia is an exceedingly common eating disorder approaching "social epidemic" (Gordon, 1990) proportions. The American Psychiatric Association (1987, 1993) offers both manuals and practice guidelines suggesting that

bulimia is diagnosed across a predominantly female population (approximately 90%) involving 1 % to 10% of middle to upper class adolescent and college-age women (see also Bemporad et al., 1992; Drenowski, Yee, & Krahn, 1988; Haller, 1992; Strober & Yager, 1988-1989; Yager, 1988);' approximately 1 out of every 200 teenage women suffer from starvation and binge disorders (Marx, 1991).[2]

Considerable attention has been given to biological, developmental, family dynamic, and related psychosocial causes and consequences of eating disorders-to symptoms, diagnosis, clinical treatment, and intervention methods

'A proportionate minority (5%10%) of eating disorders exist across diverse male populations, especially those preoccupied with obesity, sexual identity, and sports/exercise (see Farrow, 1992). There is, therefore, some irony in the original Proverb appearing at the outset of this chapter: the "He who is" in original text was purposefully altered to "Those who are" with these concerns in mind.

-There are notable similarities and distinctions between anorexia nervosa and bulimia that occupy a good portion of the research and therapeutic literature on eating disorders. Haller (1992), for example, reported that patients may alternate between illnesses; estimates suggest that 30% to 80% of bulimics have anorexic histories.

for anorexia and bulimia, on the one hand, and relatedly to cognitive, social, and cultural influences promoting bulimia that have been forwarded as negatively impacting not just health, but communication and relationships over time. Whether understood as an experienced illness, an explicit focus of clinical intervention, or a set of activities generating considerable biomedical and psychosocial research interest, bulimia in the very least reveals a complex interplay of mind, body, and social action.

But just how such an interplay gets worked out in social interaction is the focal concern of this and remaining chapters:

- What is known about the kinds of interactions bulimics routinely get involved in with family members or friends as a set of distinctive, interactionally organized practices?
- In what social activities is bulimia embedded, therefore readily apparent, and what evidence warrants such a claim?
- In short: Where is bulimia, what is the nature of its occurrence, and what activities and occasions comprise the social existence of this eating disorder?

These questions reveal a partial reconstruction of the issues guiding the latter course of this investigation: finding what is known about and put forth as "theories" seeking to explain bulimia, especially the social and thus communicative dimensions of this illness; and determining how such explanations might serve as grounds for attempting to show the relevance of prior research to subsequent analysis of the conversation between the grandmother (G) and her granddaughter (S/Sissy). It is shown to be a predominant feature of these diverse research efforts that, first, although priority is given to causes and consequences of illnesses such as bulimia, proportionately little is said about the details of social interaction constituting and encompassing actual processes of bulimic actions and relationships. And second, when interaction and social relationships do comprise the focus of empirical investigation, findings are almost exclusively rooted in perceptual data derived from selfreport measurement techniques, questionnaires, and interviews.

This chapter begins with a necessarily brief overview of research on bulimia as a backdrop for understanding inherent problems in discovering how family and friendship interactions are put forth as a cause and consequence of eating disorders. And as G and S comprise a grandparent-grandchild relationship, an overview is also provided of empirical investigations focusing on relatively recent concerns with *grandparent caregiving.* Overreliance on self-report methods and findings reveals the unequivocal need for direct examinations of family conversations about illness; individually based limitations of prior research give rise to the utility of conversation-analytic (CA) alternatives for coming to grips with real-time interactional involvements such as G and S, and ways prior

research on both casual and institutional talk-in-interaction can itself be shown to have bearing on the ensuing analysis.

OVERVIEW OF RESEARCH ON BULIMIA

Individuals displaying bulimic tendencies are routinely described by medical professionals and social scientists as preoccupied, even obsessed with food and thinness. Nearly universal agreement on diagnostic symptoms seems to exist:

> A diagnosis of bulimia nervosa is made when a person has recurrent episodes of binge eating, a feeling of lack of control over behavior during binges, regular use of self-induced vomiting, laxatives, diuretics, strict dieting, or vigorous exercise to prevent weight gain, a minimum of 2 binge episodes a week for at least 3 months, and persistent overconcern with body shape and weight.
> (Haller, 1992, p. 658)

This description stresses the utilization of abnormal, episodic methods for weight loss but also the feelings and concerns of bulimics (see also Halmi, 1985). In addition to a lack of control over binge eating and obsessive preoccupation with body shape and weight, specific additional personality attributes, mood states, and eating patterns (Davis, Freeman, & Solyom, 1985; Lambley & Scott, 1988; Rebert, Stanton, & Schwarz, 1991; Steiger, PuentesNeuman, & Leung, 1991; Steiner-Adair, 1991; Vitousek & Manke, 1994) have been identified as constituent features of the interpretive and consumptive world of bulimic persons: predictably low self-esteem; self-worth tied to low weight; extreme self-criticism; overwhelming and conforming need for others' approval; social isolation and distancing; affective instability due to overly anxious, depressed, tired, apathetic, embarrassed, irritable, hostile, and moody predispositions; individuals who not uncommonly eat alone, but are secretive about diet and self-indulgent eating habits as well as reliance on vomiting, laxatives, and diuretics for weight loss and general appearance management (see Herzog, 1982).

Taken together, such personality attributes reflect often serious psychiatric disorders, what Bemporad et al. (1992, p. 509) described as "profound underlying personality pathology" and thus "comorbidity" with bulimia (Yanovski, Nelson, Dubbert, & Spitzer, 1993), especially affective, substance, and obsessive-compulsive use disorders (Farrow, 1992; Woodside, 1993). And there are a host of additional problems, not the least of which are irrational and thus dysfunctional beliefs (Lohr & Parkinson, 1989), alcohol abuse (Goldbloom, Naranjo, Bremner, & Hicks, 1992), fear of psychosexual maturity with a general inability to develop age-appropriate sexual identities (Meades, 1993), and overall sexual dysfunction (Simpson & Ramberg, 1992).

Despite what appears to be overwhelming agreement on personality and eating-habit symptoms leading to diagnosis, alternative characterizations of bulimia are offered depending on the unit of analysis put forth. Rather than looking to personality profiles of the individual, consider a second depiction
by Haller (1992) regarding "medical complications":

> potential medical complications include electrolyte and fluid imbalances, hyperamylasemia, hypomagnesemia, gastric and esophageal irritation and bleeding, gastric dilation, large bowel abnormalities (due to laxative abuse), edema, and fatigue. Swelling of the parotid gland bilaterally, dental erosion, gingivitis, and knuckle calluses (from inducing vomiting using the fingers) are common physical symptoms of bulimic behavior. (p. 659)

Here, physical symptoms and thus bodily consequences are described, often in technical medical terminology, revealing quite clearly that bulimia typifies not just a potentially debilitating psychosocial illness, but also multisymptom organ abnormalities resulting in diseases across "the skeletal, gastrointestinal, pulmonary, endocrine, and cardiovascular systems" (Cerami, 1993, p. 165).'

Bulimic tendencies and complications are both diverse and complex (e.g., see Bulich, 1988-1989): Food imbalances and generally unhealthy dieting can affect thoughts, feelings, and actions in dramatic ways; numerous "bio
psychiatric" interrelationships have been posited (see Marx, 1991) linking the role of neurotransmitters and the brain to biological and psychological explanations for behavior; chemical deficiencies and imbalances have been forwarded as explanatory factors causing and influencing the progression of bulimia, and can be treated by means of "psychopharmaceuticals" in addition to therapeutic, behavioral, and "psychopathological" interventions involving the individual, group, and family (see Haller, 1992; Igoin-Apfelbaum, 1992; Labov & Fanshel, 1977; Leon, 1990).

Developmentally, as transitions from adolescence to adulthood occur and problems arise between children and parents (see Yates, 1990), the female child may identify primarily with the mother, resulting in traditional feminine qualities (Wurman, 1988-1989) but also a perception that the mother is frustrated and unhappy; this promotes a sacrifice of more autonomous capabilities, evident in a need for validation from yet general fear of

men, and thus the corollary obsession with body type and overall appearance (BoskindLodhal, 1976).

'The well-known distinction between illness and disease-for example, individuals' meaningful history, experience of, social interactions and stories about illness, on the one hand, and the evidence of disease via physical and thus bodily manifestations and consequences, on the other-can be recognized throughout literature on bulimia, is a microcosm of ongoing concerns with humane versus technical medicine (see Byrne & Long, 1976; Chenail, 1991; Engel, 1977; Frankel, 1984; Heath, 1986; Mishler, 1984; Silverman, 1987), and in general, the argument against biological reductionism (e.g., see Benoist & Cathebras, 1993) or what Cassell (1985) summarized succinctly in observing that "doctors treat patients, not diseases" (p. 1).

Sociocultural Influences

Sociocultural pressures on women to be thin, popularized and diffused through press and media, are perhaps the most commonly understood social causes of bulimia (Schwartz, Thompson, & Johnson, 1982). When considering epidemic proportions of eating disorders among women on college campuses (Carter & Eason, 1983; Drenowski et al., 1988), individuals rely on bulimic behaviors to manage stresses arising from what Gordon (1988-1989) described as historical shifts in both expectations and demands for thinness among females .[4] Binge eating and vomiting become imitated, learned, and are often normalized practices, at times having ritualized status for women attempting to maintain some control over their body image across an increasing variety of social groups. Given cultural overemphasis and socially critical evaluations of feminine beauty, ideally and predominantly by reliance on criteria of thinness and exercise (Nasser, 1988), bulimic-prone persons eventually treat themselves as constantly inspected and visually objectified (McLorg & Taub, 1987). Obtaining slenderness is therefore not just prerequisite for, but tantamount to social acceptance and the avoidance of stigma due to excessive weight.

As Yager (1992) observed, it is paradoxical that increasing preoccupations with "healthy lifestyles" may contribute signficantly to unhealthy and dysfunctional eating disorders. In reference to earlier surveys of female populations at UCLA, Yager reported that "surveys repeatedly show that about three quarters of women whose weights are fully in the normal range feel too fat and wish to lose weight: indeed, some studies have shown that they desire on average to weigh only slightly more than the weights in the anorexia nervosa range" (p. 679; see also Kurtzman, Yager, Landsverk, Wiesmeier, Bodurka, 1989). In compulsive cases of this sort, the body becomes the locus of conflict: "Bulimia is viewed as an effort to make up for the lack of inner sources of self-esteem by living up to external ideals of perfection" (Wurman, 1988-1989, p. 167; see also Benoist & Cathebras, 1993).[5]

°In late 1995, news headlines reported studies indicating that cigarette companies were directing their media campaigns to young women as the highest percentage category of new smokers: Increased smoking ensures the maintenance and/or loss of weight (e.g., Virginia Slims).

Questions remain, however, about the proportion of young women who smoke cigarettes and engage in bulimic behaviors. Similarly, if young women break the smoking habit, what proportion become bulimic to ward off weight gain?

'The inherent conflict between internal and external priorities is omnipresent in the literature on bulimia, and uniquely though coincidentally summarized as follows: "They saw the glory of the world displayed; they saw the bitter of it, and the sweet" (Dawson, 1867-1900); "From the heart of this fountain of delight wells up some bitter taste to choke them even amid the flowers" (Lucretius, 99-55 Bc). And regarding assumed relationships among family interactions and eating disorders, "Bitterness attracts bitterness and then multiplies by feeding on itself" (Brownlow, 1972).

Histories of disturbance in early and ongoing relationships promote what Bemporad et al. (1992) summarized as "a lack of security and pronounced difficulties in trusting others, and in simply being an authentic individual in the presence of others" (p. 509). This observation provides a foundation for raising more direct questions regarding the patterns and assumed problems bulimics have when interacting with family members and, more generally, social networks involving individuals concerned with and suspecting of their possible illness.

Interactions With **Family and Friends**

Rather than treating such factors as poor self-image, the overwhelming desire to please others, and excessive need for external approval as randomly occurring or self-imposed symptoms of bulimia, the research literature puts forth dysfunctional family environments as major causal forces, perhaps even the "root causes," of eating disorders (Bemporad et al., 1992).

Bulimic individuals are more likely to emerge from suburban family environments that are competitive, achievement-oriented, and appearance-centered (Harper & Shillito, 1991). A typical sketch involves middle to upper class, "high pressure" families (Siegel, Brisman, & Weinshel, 1988; Yager, 1992; Yager, Gwirtsman, & Edelstein, 1991) in which both parents work; owing to workaholic, passive, and/or frequently absent fathers, it is the mothers who are primary, often overly protective and involved caregivers. Parents tend to critically impose idealized models of weight and appearance on their children, just as parents and siblings may engage in such

activities as teasing others about eating, exercise, and habits consequential for achieving fat-free bodies. In terms of birth order, at least for small families, bulimics are highly likely to be the eldest or only daughter (Lacey, Gowers, & Bhat, 1991).

Studies relying on self-report measurement techniques have consistently evidenced a strong relationship between eating disorders and abnormal patterns of family interaction, although little or no self-reported differences across subject populations have been reported (e.g., see Kent & Clopton, 1992; Strober & Humphrey, 1987; Thienemann & Steiner, 1993). As with literature on social support and family functioning generally, the vast majority of findings have been generated from diverse self-report measures (Franks, Campbell, & Shields, 1992). Compared with repeat or nondieters, bulimics perceive their families to be dysfunctional due to such factors as low affective involvement and responsiveness, poor family communication, problem-solving skills, and behavior control (McNamara & Loveman, 1990). Binge eating activities have also been found to be more frequent when bulimic women perceive family members to have poor problem-solving skills rather than cohesive styles of interaction (Waller, 1994): Bulimics perceive their families as considerably more dysfunctional on dimensions of "cohesion, ex

pressiveness, conflict, recreational orientation, emotional support, communication, and need for counseling" (Schisslak, McKeon, & Crago, 1990, p. 185; see also Kog & Vandereycken, 1989). It thus appears "that eating-disordered behavior may be a symptom response and/or coping strategy for women in dysfunctional families" (Lundholm & Waters, 1991, p. 97). For example, through analysis of relationships among personality, family traits, and symptomatic behaviors it was revealed that high school girls' self-reports suggest symptomatic eaters are more likely to be moody, have obsessive concerns with the body, and be self-critical (Steiger et al., 1991). And among family members, bulimics display the most realistic perceptions and thus valid descriptions of interactional styles and overall problems with sufferer's family (Waller, Slade, & Calam, 1990).

Extending beyond the family, a recurrent and significant fear of intimate relationships has been confirmed across bulimics and control subjects responding to the Fear of Intimacy Scale (Descutner & Thelan, 1991; Pruitt, Kappius, & Gorman, 1992). Grissett and Norvell (1992) evidenced how bulimics perceive less social support from family and friends, enhanced negative interactions and conflict, and reduced social competence. Attention has also been drawn to bulimics' overall stress and their perceived changes over time in levels of satisfaction across other relationships (Meades, 1993; Thelan, Kanakis, Farmer, & Pruitt, 1990); ratings of female college students have been shown to be negatively correlated with satisfaction in relationships with males, with no significant differences in levels of satisfaction for same-sexed relationships (Thelan et al., 1993).

Overreliance on Self-Report Data

A substantial corpus of investigations relying on bulimics' and family members' perceptions of their family environments and social networks (see also Blouin et al., 1994) reveal the exceedingly common utilization and labeling of measurement scales. Findings such as "poor communication," "increased conflict," or "low cohesiveness" are generated from the correlation of variables rather than the inspection of socially organized, interactionally achieved activities.' Specific instances of just what poor communication and other findings look like in real-time conversational involvements are noticeably

6A somewhat parallel analysis is provided in Coulter's *(1973) Approaches to Insanity,* where an overview is provided of how "aetiologists" searching for the genesis of "schizophrenia" identify family interactions as primary social causations. Further, as related to inherent limitations of self-report data, there are fundamental problems in capturing "complex orders of human activity" *(p. 41)* by operationalizing social theories on the basis ofquantitative indices and variables (see also Atkinson, *1978;* Cicourel, *1964;* Coulter, *1979;* Sudnow, *1967),* just as there are limitations to phenomenological inquiries emphasizing the "context of self" (e.g., see Zaner, *1981).*

absent. These and related results, although inherently interesting and predictive across diverse respondents, remain indirect assessments of social interaction on its own merits; they are based on individual reports about interaction rather than examinations of actual behavior jointly produced by and for interactants themselves. There are also inherent problems when, in addition to the construction and validation of scaling measures (see Coker & Roger, 1990) and questionnaires (Rosen, Srebnik, Saltzberg, & Wendt, 1991), expert ratings and standardized interviews are employed for diagnosis and to determine family members' attitudes toward eating, psychiatric status, and overall social functioning (Collings & King, 1994; Cooper, Clark, & Fairburn, 1993; de Zwaan et al., 1993). For example, although trained coders employed two different behavioral observational systems to differentiate and reveal differences in bulimic-anorexic from control families in a study by Humphrey, Apple, and Kirschenbaum (1986), this coding of interaction by means of predetermined categories and schemes gives

priority to how each coding system contributes to the predictive power of the other, rather than to finely detailed examinations of bulimics' actual interaction practices and patterns (see W. Beach, 1990c; Garfinkel, 1967; Heritage & Roth, 1995). Similarly, when Grissett and Norvell (1992) reported that observers not aware of group membership still rated bulimics as "less socially effective" (p. 297), the constituent and interactive details of such a claim remain elusive.

Similar problems exist in field studies employing interviews. Promoting an agenda for naturalistic examinations of such activities as the "discourse of femininity," Hepworth (1993) accurately observed that just as "research on eating disorders has been dominated by a positivistic scientific model for over a century," so is it the case that "qualitative research has been marginalized by mainstream research and its dissemination" (p. 179; see also Spitzack, 1993). Nevertheless, as a means for understanding routine and ongoing problems faced by British health care workers managing anorexic patients in a state psychiatric hospital, Hepworth relied exclusively on interviews (only with workers) and a form of discourse analysis emphasizing recurring "themes" as the preferred method "to theorize relations between social processes and individual subjectivity" (p. 180). Unfortunately, although interviews can reveal rich information regarding individuals' lived experiences (e.g., see following discussion of Minkler & Roe,1993), interview-generated reconstructions of social processes offer only typified and overly generalized versions of possible connections between talk and social structure (see W. Beach & Lindstrom, 1992; Boden & Zimmerman, 1991; Drew & Heritage, 1992).

The upshot of this discussion might best be capsulized by Grissett and Norvell's (1992) prescription: "Results highlight the need for further investigation of the quality and type of *interactions* in bulimic women's lives" (p. 293; italics added).

GRANDPARENT CAREGIVING

The study of family caregiving has traditionally focused on the involvements of female spouses, parents, and adult children caring for chronic or terminally ill "elderly" family members (i.e., over 65 years of age), especially the normative yet stressful burdens, strains, and consequences of providing in-home, informal, long-term care (see D. Beach, 1993; Biegel & Blum, 1990; Brody, 1985; Brody, Johnsen, & Fulcomer, 1983; Cantor, 1983; Cicirelli, 1992; Clipp & George, 1990; Kane & Kane, 1981). Given an increasingly aging population, it is expected that continued research attention will be given to eldercare, although impacts of caregiving on young adults (D. Beach, 1994), including grandchildren (Creasey & Jarvis, 1994), is beginning to be recognized. But little is known about what might be described as the inverse of elder-care, namely, how older adults such as grandparents are more or less actively involved with or committed to facilitating the growth and development of their grandchildren.

Grandparent caregiving is on the rise, thus such caregiving processes are increasingly predominant as a research topic (see Bengston & Robertson, 1985; Homolova, Hoerning, & Schaeffer, 1984; Kornhaber & Woodword, 1981; Minkler & Roe, 1993). Yet, gaining direct access to grandparent caregiving remains a problem, as summarized by Hagestad and Burton (1986): "All too often we have looked at grandparenthood in isolation, not taking into account how it is embedded in a web of relationships and lives" (p. 471).

In their book entitled *Grandmothers as Caregivers,* Minkler and Roe (1993) took a significant step toward remedying this problem by seeking to understand the practical and situated consequences of grandparenting across social and cultural contexts within which African-American grandmothers care for grandchildren with drug-abusing parents (especially crack cocaine). Relying on two-part in-depth interviews with grandmother caregivers (as well as observations, field notes, and direct community involvments), priority was given to retaining the integrity of women's voices by transforming reported experiences into data. Although results offer a unique storified history and heuristic analysis of women's caregiving experiences and described incidents, family relationships were events reported about rather than directly examined (i.e., via recordings and transcriptions of actual caregiving occasions), and thus only minimal understandings of how grandmothers and grandchildren conversationally organize "caregiving" are offered. It is important to note that this is not a critique of Minkler and Roe's (1993) broad-reaching study, but an articulation of priorities and, consequently, the inevitable limitations

of types of questions that can be answered by interviews and participant observation data. For example, soliciting grandparents' lived experiences about a "typical day" (p. 213) through probing interview protocols-coping

styles for dealing with difficult situations, changes in marital relationship since the onset of caregiving, or how caregiving had altered relationships with adult children-reveals little about the communication activities implicated in the practical achievement of daily tasks and activities. By focusing on individuals' reconstructions of feelings, experiences, and levels of awareness (e.g., toward physical and emotional health status, work, grandchildren and their health), the relational and thus collaborative behavior contextualizing that subjectivity remains untapped and unnoticed, most notably, the conversational resources recruited and the patterns cogenerated by grandparents and grandchildren in the routine course of dealing with everyday life affairs. This by no means discounts ongoing concerns with ill persons' or caregivers' personal well-being (e.g., see George, 1979; George & Gwyther, 1986; Montgomery, Gonyea, & Hooyman, 1985; Morse & Johnson, 1991); it simply articulates the lack of cumulative knowledge regarding the omnipresence of interaction as a vehicle for accomplishing a vast amount of caregiving tasks and assumed responsibilities.

Overreliance on Self-Report Data

The overreliance on self-report data (especially measurement scales, questionnaires/surveys, and interviews) is evident throughout a limited corpus of grandparenting studies (see Bengston & Robertson, 1985; Downs, 1988; Schmidt, 1982; Troll, 1985). This is the case even though important matters such as "selective investment" (Cherlin & Furstenberg, 1985, p. 97) by grandparents toward their grandchildren are addressed, as are attempts to establish vital connections between grandparents and grandchildren by soliciting children's thoughts, for example, that grandparents are "mentors, caretakers, mediators between child and parents, same sex role models, and family historians" (p. 81). The problems and promises of self-report data have not been entirely overlooked, however, as Hagestad (1985) has observed:

> Several of us who have studied grandparents and grandchildren have been puzzled by some seeming paradoxes in our data. On one hand, interviews and questionnaires present an overall impression of grandparents as important forces in the lives of the grandchildren. On the other hand, it is hard to pinpoint what it is that grandparents do.... Our problem might be that we have concentrated too narrowly on concrete behavior and actions, and have not considered the wider family context. (pp. 37-38)

The initial conclusion regarding difficulties in determining what "grandparents *do"* appears aligned with the present discussion in two key ways: (a) what people report that they do is a different activity than doing the activities reported; and (b) there is a compelling need to move beyond exclusive reliance on self-report data and toward observation and analysis of situated (frequently social) actions. However, Hagestad's later speculation that the source

of the problem may stem from an overconcentration on "concrete behavior and actions" at the expense of understanding "the wider family context" is not consistent with concerns expressed herein. In marked contrast, research efforts have, thus far, universally failed to come to grips with the social organization of grandparenting behaviors and actions; because naturally occurring interactions have not themselves been treated as contextually rich sources of information, it is actually "the wider family context"-as constructed through self-reported data-that has been given priority.

Much can be said about reported beliefs held by family members in terms of relationships between autonomy and freedom of choice of individuals being cared for, and how caregivers may paternalistically intervene:

> in the making and executing of decisions for the welfare of that person.... The interventionist may also use force, deception, threat, misinformation, manipulation, or other strong means in the process of intervening in the decision ... [when] one is convinced that one knows what is best to maximize benefits and minimize harm to the individual. (Cicirelli, 1992, p. 27)

But the distinctively social features of these and related involvements-just how these activities get interactionally brought off throughout the initiation, management, and negotiation of decisions about health-related actions and their possible consequences---can only remotely be grasped through measurement scales assessing family members' beliefs toward "respect for autonomy," "paternalism," and "ethical situations" (Cicirelli, 1992, pp. 206-234).

And similar to the previously reviewed research on bulimia, researchers focusing on intergenerational relationships have noted inherent problems with generating overly global claims where "only with difficulty can the existing theoretical constructs be applied in an empirical context" (Homolova et al., 1984, pp. 8-9). Although attempts to interconnect global and ungrounded theory with empirical observation lies at the heart of the stated problem, related but unstated concerns rest with the following key questions: What limitations are imposed on the study of intergenerational relationships when self-reports are the predominant method of investigation? If

the "empirical context" is perceptually rooted in reports about relationships, what then can be said about the practical organization of intergenerational interactions? In short, what counts as "social context"?

This chapter concludes by proposing CA alternatives for understanding social contexts by investigating interactions and their constituent activities.

CA ALTERNATIVES

Participants in interaction routinely make available their orientations to, and thus understandings of, the moment-by-moment contingencies of unfolding actions-circumstances that cannot be fully intuited nor anticipated in ad

ven It illy byl to god co rst Ilve 3 t(sa h~)ns

vance, the details of which are impossible to capture by means of self-reported information. Basic questions underly concerns with excavating the constituent and organizing features of collaborative actions: How do specific kinds of actions get brought off as demonstrably relevant by and for participants? What is the distinctive, methodical, and achieved character of any given spate of interaction? On what behavioral (and scenic) resources do participants rely in contributing to and providing solutions for immediate interactional circumstances? These queries begin to address how participants delicately tailor their talk-in-interaction in ways influencing the recognizable evolution of practical courses of action. By attempting to describe and explain the precise ways participants' actions make a practical difference, impacting the continuous and negotiated character of everyday conversation, the empirical focus rests with providing evidence revealing (among other features) the inherent consequentiality of communication:

> For the target of its inquiries stands where talk amounts to action, where action projects consequences in a structure and texture of interaction which the talk is itself progressively embodying and realizing, and where the particulars of the talk inform what actions are being done and what sort of social scene is being constituted.... How does the fact that the talk is being conducted in some setting ... issue in any consequences for the shape, form, trajectory, content, or character of the interaction that the parties conduct?
>
> And *what is the mechanism by which the context-so-understood has determinate consequences for the talk?* (Schegloff, *1991, pp. 46, 53;* italics added)

The consequentiality of communicative actions becomes important, therefore, first for participants of interaction and second for analysts of conversational organization: not as some removed, telescopic conceptualization or component of social order, but as evident in how participants differentially and embeddedly reveal and document, each for the other, "what is going on" within a given spate of talk and in consideration of its attending relevancies (see W. Beach, 1990b, 1991a, 1995b; Jefferson, 1981; Sigman, 1995; Wootton, 1988). Stated somewhat differently, exactly what gets achieved is undeniably the upshot of how speakers fashion, shape, and make available to one another their understandings of the local environment of which they are an integral part.

Although the research assumptions undergirding these concerns are varied and complex (see, e.g., Atkinson & Heritage, 1984; Boden & Zimmerman, 1991; Drew & Heritage, 1992; C. Goodwin, 1981), the following three sets of issues briefly summarize and begin to map out relevant CA commitments and priorities.

First, CA employs research methods fashioned after the social phenomenon being examined: the independent and natural existence of social order. A basic tenet of CA is the recognition that social order, evident within the detailed and contingent activities of societal members, exists independently of social scientific inquiry. Irrespective of the possibility of being examined and in some way analytically dissected for purposes of research, interactants simply go about their daily business performing routine and often mundane tasks. Thus, CA gives priority to gaining access to social activities comprising a wide variety of natural settings. However, in order to examine such activities in "real-time" detail (i.e., on their own merits as interesting phenomena), there is a systematic reliance on carefully produced transcriptions of audio and videorecordings. Recordings and transcriptions allow for repeated hearings, viewings, and inspections of "actual and determinate" (Schegloff, 1986) interactional environments. Although neither recordings nor transcriptions are conversations in and of themselves (W. Beach, 1990b; Zimmerman, 1988), they nevertheless preserve and embody the integrity and

distinctiveness of many conversational activities. Moreover, as selected fragments of transcriptions are made available for readers' critical inspections, attention can be drawn to specific details and practical consequences of unfolding actions rather than glossed or presumed versions of what might/could have happened (i.e., idealized, intuited, and/or recollected data; see Atkinson & Heritage, 1984, pp. 2-5; Heritage, 1984, pp. 234-238). Direct examinations of recorded and transcribed interactions can begin to remedy the traditional gaps and problems between what people say and what they do (see Drew & Heritage, 1992), in part by analyzing those interactional processes through which persons make available their beliefs, perceptions, and the like to one another. Rather than focusing on personality attributes brought to social occasions, or individuals' beliefs about some reconstructed occasion, attention is given to the talk-in-interaction through which these attributes and beliefs were used and relied on to achieve practical actions and in these ways organize social occasions (see W. Beach, 1989, 1990c, 1995b; Sigman, 1995).

Second, analysis of conversational involvements reveals the omnipresence of patterned orientations to "context." It becomes increasingly evident throughout the G-S analysis that, as originally described by Sacks, Schegloff, and Jefferson (1974) and further elaborated by Schegloff (1987a, 1987c, 1992), "context" is not understood as external to or otherwise exorcized from interaction (see also W. Beach, 1990c; C. Goodwin & Duranti, 1992; Mandelbaum, 1991). On the contrary, context is continually and intrinsically reachieved as participants display their understandings of specific and locally occasioned moments of conversational involvement: Each emergent action is both *context-shaping* in the way it is tailored to prior and immediate circumstances, and *context-renewing* by means of its contribution to and thus impact on next-positioned actions. Consistent with Schegloff's (1991) reference to CA's concern with "structures of single actions and of series and sequences of them" (p. 47)-the necessity to work closely with single cases and aggregates

of recurring phenomena (Schegloff, 1996a, 1996b), and in general how unique interactional circumstances reflect instances of generalized action types (see Atkinson & Drew, 1979; Mandelbaum, 1993; Whalen, Zimmerman, & Whalen, 1988)-it becomes clear that even a minimal understanding of context begins with a compilation of the following: First, whenever participants design and place their utterances within a series of actions, a speaker's current turn projects the relevance of a next turn, such that the range of possible activities accomplished by the second speaker reflect not only an orientation to, but also an understanding of, the emergent character of interaction. Second, in and through the adjacent ordering (see Heritage, 1984, pp. 245-253; Sacks, Schegloff, & Jefferson, 1974; Schegloff, 1996b) of first and second actions, utterances are seen to be "sequentially implicative" (see Schegloff & Sacks, 1973) in the exact ways that speakers systematically organize the occasions in which they are involved. During a series of turns-in-interaction, therefore, speakers design their talk to the occasion of its use and with particular recipients in mind. Finally, just as speakers rely on recipients to display whatever impact(s) speaker's utterance might have in the course of their delivery, so do recipients overwhelmingly design their talk in "conditionally relevant" ways: not just any response will normally suffice because the prior speaker projected the relevance of some range of appropriate and next actions. Of course, as talk has been found to be "sensitive to recipients' design," just how some next turn-at-talk is tailored to some prior action or set of actions becomes the "grist" for analysts' "mills" as speakers contribute to an already unfolding interactional environment.

A third and final set of issues arise from a melding of the dual focus on interaction as structurally organized and contextually oriented: "these two properties inhere in the details of interaction so that no order of detail can be dismissed, a priori, as disorderly, accidental, or irrelevant" (Heritage, 1984, p. 241). However messy and disordered naturally occurring conversations might appear, at least initially, there exists considerable evidence supporting a central tenet of social interaction studies: that there is "order at all points," much of which awaits discovery by analysts, and all of which was produced in the first instance as meaningful and thus in meaningful ways by and for interactants.' And considerable effort has been invested toward evidencing the bedrock details underlying the very possibility of an interactionally produced social order (but see also Goffman, 1983). Further, in turning directly to interactional materials to discover how participants

'M. H. Goodwin (1990, pp. 1-17) traced a neglect of talk-in-interaction through the history of anthropological, sociological, linguistic, and communication research. By ignoring the embedded details of interactional conduct, the diverse range of social actions achieved through talk-in-interaction are systematically excluded. Such a position is, of course, a rejection of Chomsky's (1965, pp. 3-4) well-known but misdirected assessment that "talk" per se is altogether too messy, flawed, and degenerate for studies of phenomena such as "competence." meaningfully organize conversation, there is an unwillingness to rely on intuited or idealized data, and posit, a priori, that interaction is "driven" by individuals' motives, needs, or other mentalistic phenomena (as was the case, e.g., with Garfinkel's original critique and extension of Parson's treatments of "moral norms," "need dispositions," and "personality"; see Heritage,

1984). Findings emerging from data-driven analyses tend not to be synonymous with a priori theoretical propositions. On the contrary, empirical observations drawn from naturally occurring interactions repeatedly make clear how "theory construction," when operationalized via indirect measurements of social processes, is frequently and overwhelmingly premature. Due to its proclivity toward underspecification, claims and warrants about the detailed workings of interactional activities are routinely glossed by a priori theoretical propositions and, consequently, incapable of revealing recurrent practices and patterns of everyday talk. There is, therefore, a decided "off-stage" rather than "atheoretical" role of theory in CA that includes a set of long-standing debates and empirical studies (see, e.g., Alexander, Giesen, Munch, & Smelser, 1987; W. Beach, 1990c, 1991c; W. Beach & Lindstrom, 1992; Boden & Zimmerman, 1991; Drew & Heritage, 1992; Hopper, 1989; Mehan, 1991; Roger & Bull, 1989; Sacks, 1963, 1984a, 1984b; Schegloff, 1987b, 1991a, 1991b): for example, framing "culture and/or institution" as some externalized causal agents predetermining actions and their consequences, versus situating "culture and/or institution" as ongoing, methodically produced, locally occasioned, inherently accountable, altogether practical achievements. These traditional "macro-micro" debates (e.g., involving matters of power, status, role, gender, class, bureaucracy, or, as with the present analysis, the social context of bulimic illness and grandparent caregiving) will no doubt continue to receive considerable attention and are not limited to CA and traditionally quantitative studies (e.g., see Clayman & Maynard, 1994; Zimmerman & Boden, 1991). Consistent with concerns regarding premature theory construction, therefore, close inspection of the interaction between G and S has given rise to subsequent generalizations and broader theoretical discussions.

Toward the Identification of Institutionally Relevant "Constraint Systems" in Casual (Family) Talk

Having laid grounds for understanding the basic research assumptions of CA, attention can now be given to previewing centrally important and distinctive features of the G-S interaction: how medical and thus institutionally relevant concerns with "bulimia" emerge, and are interactionally managed, between two family members; the recognizable "constraint systems" at work in the G-S conversation, what might roughly be characterized as the "bureaucratization of casual relationships." On the one hand, there is nothing remarkable about interactions of these sort because it is altogether normal for family members

to talk about and work through medical problems. But on the other hand, these data are remarkable due to the very fact that so little is known about such interactions (i.e., the social organization of family interactions addressing "institutional" matters "informally").

Families represent the elemental and thus primordial societal institution: Family interactions routinely operate as a site for the exercise of "authority" and the pursuit of role-specific, agenda-relevant, task-related activities (see Maynard, 1988; Spear, 1973). Drew and Heritage (1992) clearly articulated how institutional interactions are not restricted to specific kinds of settings:

> Just as people in a workplace may talk together about matters unconnected with their work, so too places not usually considered "institutional," for example a private home, may become the settings for work-related interactions. Thus the institutionality of an interaction is not determined by its setting. Rather, interaction is institutional insofar as participants' institutional or professional identities are somehow made relevant to the work activities in which they are engaged. (pp. 3-4)

Framed in this manner, what is the relevance of G and S's "institutional or professional identities" to "the work activities in which they are engaged"and what counts as "work"?

It is from family interactions such as G and S that institutional-like conduct can be identified, first and fundamentally by contrast with other forms of casual (informal) conversations. The body of research on these topics has grown substantially since Sacks' pioneering work in the 1960s and 1970s (see Sacks, 1992), and is "brought to bear" throughout this single-case analysis. But with the G-S interaction, useful comparisons can also be made with more recent findings generated from studies within institutional (more formalized, work) occasions (see Drew & Heritage, 1992; Markova & Foppa, 1991): Interactions whose describable features reveal the social organization of marked and specifiable constraints when compared to casual conversations (e.g., see Greatbach, 1992; Heritage & Greatbach, 1991). Particular attention has been given to how "professional-lay" persons (e.g., lawyers-witnesses, judges-defendants, doctors-patients, therapists-clients, news interviewers-interviewees, health visitors-firsttime parents) are routinely caught up in task-related interactions wherein one or more participants is a formal representative of a given organization or bureaucracy. It is an overwhelming and thus distinctive feature of these interactions that professionals work to accomplish the occupational tasks and agendas germane to the institutions they represent. And the more formalized the interactions (e.g., in courts, classrooms, and news

interviews), the more restrictive the turn-taking regulations and, consequently, the more "constraints" imposed on lay person's conduct. These constraints reflect the often "asymmetric" and authoritative nature of institutional interactions: Professionals typically engage in such actions as asking more questions, displaying more specialized knowledge and vocabulary than lay persons, and conduct themselves as institutionally priviliged and empowered representatives whose job it is (in part) to "take control" of interaction. This description applies equally well to judges processing cases (see W. Beach, 1995a), doctors managing diagnostic interviews, and news interviewers soliciting information from interviewees. Thus, the interactional work involved in setting and regulating agendas, initiating and restricting elaboration of topics, and imposing "sanctions" (Drew & Heritage, 1992, p. 27) on lay persons' actions that depart from formalized institutional procedures are normalized responsibilities for professionals (and, as becomes evident, concerned family members).

Contrasted with courtroom interaction, for example, where it is typically the case that "modifications to or departures from conversational organization" (Atkinson & Drew, 1979, p. 228) are most clearly evident in recurrent and formalized speech exchange and enforced constraints (e.g., witnesses being instructed to respond directly to lawyers' questions, or being limited in the types of questions they can ask), with G and S what might be described as primordial constraint systems "at work" in the family are evident. Although it was earlier noted that G is also an RN, we can now raise questions (and offer a preview) of how that professional identity is reoccasioned in the family system, and relied on as a resource when laying grounds for the reasonableness of, and need for, S to admit her problem and seek professional (medical) advice and assistance. Just as G's actions can be shown not to be solicited by S but nevertheless (and persistently so) offered by G, so will it become evident that S does not directly request "help." The "interrogation-like" character and quality of portions of the G-S conversation can usefully reveal how G makes it her business to address and resolve S's abnormal family conduct, and how such actions are less formal and constrained than courtroom involvements, but also more formal and constrained than family or other casual interactions wherein agenda, role, and task-specific (e.g., medically relevant) concerns are less apparent. Moreover, when considering the nature of G's queries and S's responses to them, specifically in the ways S can be understood to be avoiding and otherwise discounting G's efforts (e.g., by claiming that Gramma is "so full of shit" and "weird"), it is shown that this family interaction is obviously less restrictive than most formal and even nonformal institutional involvements between professional and lay persons (e.g., see Atkinson & Drew, 1979; Byrne & Long, 1976; Drew & Heritage, 1992; Erickson & Schultz, 1982; Heath, 1986; Sudnow, 1972). And with G and S representing a grandparent-grandchild interaction, not only does no formalized agent-client relationship exist but it is clearly the case that S (allegedly the one "in trouble" due to bulimic tendencies) did not willingly seek out G as a professional whose expertise may aid in remedying or assisting whatever troubles exist. The G-S interaction thus stands in contrast with service encounters (see Jefferson & Lee, 1981), 911 emergency phone calls (see Whalen et al., 1988; Zimmerman, 1992), the possibly unwanted assistance of British Health Visitors visiting firsttime

mothers (see Heritage & Sefi, 1992), as well as patients' involuntary visits with psychiatrists during intake interviews (see Bergmann, 1992). Here and elsewhere, there may very well be consequences of unasked-for assistance, such as troubles with offering and receiving diagnosis and advice (see Bergmann, 1992; Heritage & Sefi, 1992; Perakyla, 1993).

Finally, Labov and Fanshel's (1977) analysis of a 15-minute psychotherapeutic interview, between a therapist and patient clinically diagnosed as anorexic nervosa, offers a germane backdrop for this present study but also a distinct methodological contrast. In an attempt to identify the kinds of speech acts performed by therapist and patient (e.g., admissions, evaluations, challenges, denials), attention was given to how speakers come to understand "surface forms" of the actions achieved through single utterances as well as linkages between utterances. This required the development of (largely unexplicated) "translation rules" to determine utterance functions, including considerable interpretive work involved in assessing speakers' intentions as uttered and as connected with subsequent and thus locally removed actions in the interview. However, a close reading of Labov and Fanshel's (1977) analysis of speech act functions (see also Searle, 1969, 1987) fails, in numerous cases, to provide support for the kinds of claims forwarded (see W. Beach, 1990b; Drew & Heritage, 1992; Levinson, 1980, 1981, 1983, 1992; Schegloff, 1988, 1992; Streeck, 1980): Not only do the constituent features of "challenges" or "counterchallenge" remain largely unexplicated (e.g., see pp. 202-207), but interactional relationships between utterances-in-sequence (as with "assertion-denial") focus on researchers' "translation rules" at the expense of understanding what and how speakers treat specific moments and contingencies as relevant or problematic.

SUMMARY AND IMPLICATIONS FOR STUDY

The evolution of this study represents a shift from specific and local concerns with how G and S interactionally occasioned matters of bulimia and caregiving, toward an understanding of the daily consequences and thus far reaching significance of these inherently social processes for family members as well as researchers, clinicians, and practitioners alike who deal routinely with family medical predicaments. Early on in my search for cumulative research findings it became clear that, aside from gaining a fundamental grasp of and appreciation for extant literature, the need to "find bulimia" by identifying features of social action was mandated. A special concern was with the omnipresence of conversations about illness in everyday life as family members talked through ongoing medical problems, informally, preferably in their home environments. However, an articulation of patterns (i.e., constituent practices) of the everyday interactional activities that bulimics, their families and friends, and caregivers in general (with an eye toward grandparents) get routinely caught up in was noticeably absent. Although specific sorts of puzzles had emerged from direct analysis of the G-S conversation-What specific interactional techniques for raising, avoiding, and being preoccupied with bulimia had been identified? Are other conversations regarding bulimia and caregiving organized in similar fashion? Just how representative and typical was the G-S conversation as an exemplar of how family members work through versions of and concerns about bulimia?-this post hoc search for previously identified features of social action was accutely naive. The upshot of asking these questions was, perhaps, quite predictable: Despite the rich texture of basic and applied research on eating disorders and family caregiving, prior studies had not relied on naturalistic, interactional methodologies for pursuing inherently conversational problems and the often delicate yet complex ways family members sought to remedy them. It is perhaps worth noting that across nearly 300 reviewed sources (only a sampling of which are included in the aforementioned review), not a single study was found that directly examined interactions between either family members expressing bulimic concerns or grandparent-grandchildren conversations on any set of health-care topics. Just as descriptions have thus far been provided of the predominant reliance on psychologically based self-report and field interview data as methods for understanding the social causes and consequences germane to bulimia and caregiving, so should the need for detailed explications of naturally occurring conversations about illness be self-evident.

The fundamental task thus remains to reveal what the study of interaction might offer to understandings of both bulimia and grandparent caregiving as social processes. Attention can now be given to an extended analysis of the G-S conversation, especially how activities characterized in most general terms-for example, initiation, confrontation, avoidance, denial, and preoccupation-are in practice detailed and organized achievements embedded within yet more complex interactional environments.