

**ANOREXIA NERVOSA, DEPRESSION AND
MEDICALISATION: A CORPUS-BASED STUDY OF
PATIENTS AND PROFESSIONALS**

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Abstract

This study reports on the analysis of the Mental Health Discourse Corpus. This dataset is comprised of four sub-corpora that contain patients' online discussions of anorexia nervosa, patients' online discussions of depression, general practitioners' discussions of anorexia, and general practitioners' discussions of depression, respectively. The methodology integrates quantitative corpus linguistic approaches with qualitative analysis drawing on Hallidayan functional grammar, discourse analysis and discursive psychology. By interrogating corpora of health communication across communicative modes and participants, the study offers novel insights into the verbal presentation of anorexia and depression by patients and professionals, and examines their respective uptake of medical explanations of mental illness.

Common patterns in the online patient interactions are linguistic choices which realise the externalisation and personification of anorexia and depression, the discursive construction of individual helplessness, and the representation of psychological distress in terms of medical pathology. The uptake and proliferation of biomedical explanatory models of anorexia and depression serves to reduce illness stigma for individuals and, notably, is also used to perform local interactional tasks.

In the practitioners' talk, participants draw on medical and social explanations of depression and anorexia. Doctors construct depression as a categorical medical diagnosis while also expressing doubt towards its medical treatment and advocating non-medical interventions. When discussing anorexia, clinicians emphasise the bureaucratic role which body mass index scores occupy in managing anorexia and repeatedly highlight the difficulty of overcoming patients' resistance. In both cases, participants highlight the bureaucratic and communicative challenges of working with anorexic and depressed patients and construct a range of unfavourable moral identities for the chronically ill.

The practical implications of the research for users of online support groups and general practitioners working with depressed and anorexic patients are identified. In particular, I emphasise the centrality of communication to primary mental health care and the utility of studying online support groups to illuminate the experiences and beliefs of patients. A critical evaluation of the study's methodology is offered, along with recommendations for future research.

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1 Introduction

1.1 Anorexia, Depression and Medicalisation

Anorexia nervosa is an eating disorder and mental health condition affecting 0.3% of young women and is a leading cause of admission to child and adolescent hospital services in the UK (Morris & Twaddle, 2007). Clinical depression affects 15% of the British population and represents the fourth highest contributor to the global burden of disease (WHO, 2001). Both conditions have profound and far-reaching consequences for the lives of sufferers and, despite the advances of contemporary healthcare, are notoriously difficult to treat. Chronic ill health affects the lives of sufferers who endure protracted distress and debilitation and the experiences of healthcare professionals who are duty-bound to alleviate these recalcitrant conditions.

The deleterious effects of anorexia and depression and the financial and emotional demands they make on healthcare resources have provoked an expanding body of research that aims to improve health service interventions for these conditions. In particular, qualitative healthcare studies have begun to examine sufferers' and professional' beliefs and experiences of anorexia and depression. The present study contributes to this growing research programme. While typically conducted outside of clinical settings, such research is clearly relevant to professional practice since, as Swartz observes, 'clinician and patient roles in the clinical encounter are to greater or lesser degrees determined by their different understandings of the disorder' (1987: 613).

However, these understandings of mental disorder are not simply the product of professional-patient interactions in the clinical encounter itself. Indeed, it has long been recognised that

much health communication takes place outside of the consultation during informal interactions between patients and their friends and families, and between practitioners and their colleagues (Beach, 2001). These are contexts in which beliefs about mental health and illness can be shaped and negotiated amongst peers but which are difficult to capture using quantitative methods or traditional qualitative interviews. More recently, the advent of the internet as a medium for consuming and producing health information has radically altered the landscape of contemporary health communication outside the clinic. Electronic support groups remain an enduringly popular facet of such online behaviour (Seale, 2005). These groups provide an accessible source of health information and interpersonal interactions which can mitigate the social exclusion and withdrawal which frequently characterise experiences of mental illness (Karp, 1996; Rich, 2006).

As archives of non-elicited interaction, electronic fora also provide a unique resource for illuminating how anorexia and depression are conceptualised by lay individuals and how they communicate experiences of these conditions with one another (Davison & Pennebaker, 1997). For individuals with long-term conditions, online fora may become a principal source of health information and significantly shape the meanings that individuals give to their illness and their relationships with healthcare professionals. This has led to calls for greater understanding of the effects of online support groups on the experiences and beliefs of their members. Latterly, there has been considerable interest in the role of support groups in fostering medicalisation, that is, the increasing definition of embodied behaviours as medical problems (Barker, 2008). While the expanding remit of medicine is not a new phenomenon, the internet has been pivotal in the proliferation of medical information by and for lay individuals (Conrad, 2005). However, many remain concerned that medicalisation encourages laymen and professionals alike to pathologise embodied experiences and concomitantly delimits responses to human suffering to those involving clinical interventions.

Depression in particular is repeatedly cited as an instance of the ‘medicalisation of misery’ (Pilgrim & Bentall, 1999), in which common and understandable unhappiness has been reframed as a biological pathology and non-medical responses to sadness have been delegitimised .

Widespread development in how lay individuals encounter health information and understand their illness impels research which seeks to understand such changes. As such, there is now a clear need for research that elucidates the effects of increasingly democratised medical knowledge and the impact of online support groups on the experiences of lay individuals (Rose, 2007). At the same time, group discussions about anorexia and depression amongst healthcare practitioners’ remain surprisingly under-studied. Given the potential of this context for elucidating professionals’ understandings of anorexia and depression and thereby informing practitioner training, there is also clear warrant to address this lacuna.

To this end, this study reports on the analysis of patients’ and professionals’ respective discussions of anorexia nervosa and depression, conducted using the tools of corpus linguistics and critical discourse analysis. Specifically, it considers discussions of depression and anorexia that take place in two separate online support communities and discussions of anorexia and depression which occur in separate groups of co-working general practitioners. In each of these four contexts, the analysis also examines the deployment of medical and non-medical representations of anorexia, depression and sufferers of mental illness.

1.2 Corpus linguistics and health communication

Corpus linguistics has emerged as a leading methodology for the analysis of texts and is ideally suited to the investigation of the large volumes of health communication compiled during the present study. Corpus linguistics offers systematic methods with which to pinpoint repeated and unique linguistic patterns in text and talk (Baker, 2006) and hence with which to

identify common and singular representations of anorexia and depression. Despite these advantages, to my knowledge there are few studies utilising corpus techniques to examine online discussions of mental health issues. Similarly, I believe this is the first study to employ corpus linguistics to interrogate practitioners' group discussions of anorexia and depression. In this respect, the study treads largely unexplored ground in studies of online health communication and corpus linguistics. In doing so, it demonstrates the utility of linguistic analysis for understanding the beliefs and experiences of healthcare professionals and mental health patients towards anorexia, depression and their clinical management. As a corollary, the study signals that sensitivity to the nuances of verbal communication may aid healthcare providers in understanding patients' (and their own) beliefs about mental health.

Whilst my analysis places strong emphasis on lexical and grammatical features of texts and talk, my interest in this thesis is not to provide a purely descriptive account of the language used by patients and doctors in different contexts. My reasons for this are two-fold: firstly, linguistic descriptions of computer-mediated communication, group interactions, and talk between medical professionals are not in short supply. Secondly, for the participants and, I believe, the social scientist, the primary significance of the interactions examined here does not lie in their status as language data. Rather, it lies in the rich, first-hand accounts of suffering and treating mental illness which they provide. To present a purely descriptive account of these texts would therefore disregard an opportunity to understand the subjective accounts of pernicious mental health conditions that the different participants offer.

This practical orientation places the study squarely in the tradition of applied linguistics. In Corder's (1973: 10) terms, this 'is not a theoretical study. It makes use of the findings of theoretical studies' and does so to illuminate issues in the 'real world'. By its very nature, this makes applied linguistics an interdisciplinary endeavour. Accordingly, this study combines

substantive aspects of linguistics, health sociology and medical humanities and orients as much to the two latter disciplines as to the former.

It is also a collaborative project which has sought to connect the research and the researched by directly involving healthcare professionals from the planning and design stages to the dissemination of its findings. The study thus provides an opportune response to contemporary social changes, research lacunas and the concerns of the professional group under scrutiny.

1.3 Research questions and outline

In examining patient and professional discussions of anorexia and depression, the study addresses three principal research questions:

- How are anorexia and depression representing during the course of online support group interactions and group discussions between general practitioners?
- Do sufferers' and professionals' discussions draw upon medical discourses to represent anorexia and depression as fundamentally biological phenomena?
- What are the implications of different representations of these conditions for patients' and practitioners' beliefs and expectations towards treatment?

It is my intention that, in pursuing these questions, the study increases understanding of the experiences of sufferers of anorexia and depression and the general practitioners who encounter them in their daily work. Given its sustained focus on the words of patients and practitioners, I believe the study offers a propitious and timely contribution to the study of experiences of mental health, online support groups and the semiotic dynamics of medicalisation.

The study is assembled into eight chapters. Chapter 2 further introduces anorexia, depression and the concept of medicalisation and discusses common themes emerging from existing

research in these areas. Chapter 3 then describes the corpus linguistic and critical discourse analysis methodologies which are combined in this study, the criticisms and debate each has engendered and the mutual benefits of their synthesis. Chapter 3 also outlines the composition of the corpus used in this study and the theoretical, practical and ethical nuances addressed in its compilation.

Chapters 4-7 present the analysis of the patient and professional discussions of anorexia and depression which make up the corpus. Guided by initial keyword analysis, chapter 4 examines online forum users' linguistic constructions of anorexia, dietary restriction and 'behaviours' and their discussion of food and eating. I also discuss the medicalising tendency of discussions of anorexia in the context. Chapter 5 analyses online patients' representations of depression, antidepressants and suicide. I also consider the reproduction of and resistance to medicalised explanations of emotional suffering in the online depression support group.

Chapters 6-7 offer findings from GPs' discussions of anorexia and depression respectively. In chapter 6, I examine GPs' accounts of anorexia and its diagnosis, the utility of the Body Mass Index and the various difficulties which the participants identify in the treatment of patients with anorexia. GPs' discussions of depression are examined in chapter 7. I focus on the participants' different constructions of depression, its diagnosis and the use of screening tools. The GPs' discussions of antidepressants and non-clinical 'therapy' are also considered, as well as their efforts to 'challenge' and responsabilise patients with whom they associate 'heart sink'.

Chapter 8 synthesises these findings and draws comparisons between the chapters. I describe the consistent externalisation and personification of anorexia and depression in the patient corpora and the uptake of medical discourses online. In contrast, I argue that the GPs appear resistant to wholly medicalised understandings of anorexic and depressed patients and their

treatment. The findings, I argue, undermine any attempt to distinguish ‘lay’ and ‘medical’ understandings of mental illness since both patients and practitioners draw on lay and professional knowledge to explain anorexia, depression, and patienthood. I consider the implications of the study’s findings for both online support group users and healthcare professionals before offering an evaluation of the study’s methodology and analytical framework. Finally, I outline a number of avenues for further research suggested by the study.

1.4 ‘Patients’, ‘clients’ and ‘service users’: a note on terminology

Scholars venturing into the field of health sociology are presented with a freighted nomenclature with which to name (and hence construct) individuals who experience mental health problems. ‘People with mental health problems’ thematises personhood over pathology yet the lengthy post-modification is textually cumbersome; ‘clients’ reiterates the uptake of commercial discourse into healthcare, a process towards which I believe there are strong grounds to be sceptical; ‘service users’ encodes an active role, though it is not clear that all the individuals whose talk is examined hereafter actually use healthcare services. Hence, in referring to the individuals using the online support groups under examination, I use the terms ‘forum members’, ‘users’, ‘sufferers’ and ‘patients’. I realise the latter of these may appear a conservative choice. However, the ensuing analysis suggests that, both grammatically and medically, patienthood is a salient aspect of how the users of the online support groups represent themselves.

Literature Review

2.1 Anorexia: Introduction

Anorexia nervosa is characteristically associated with severe and physically dangerous loss of weight and malnutrition due to lack of food intake and has the highest mortality rate of any psychiatric disorder (Hoek, 2006). The Diagnostic and statistical manual of mental disorders (*DSM-IV*) (APA, 1994) stipulates weight below 85% of an individual's expected body mass, amenorrhea in females and psychological characteristics as diagnostic criteria. According to the *DSM-IV*, patients with anorexia are distinguished by '[i]ntense fear of gaining weight or becoming fat, even though underweight' and 'disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight' (1994: 307.1). Apprehension over weight gain leads anorexics to strictly control their diets and perceive weight loss positively. Prolonged malnourishment and low weight places stress upon the body, which can lead to osteoporosis and increased vulnerability to infection. In acute cases, anorexia can lead to death through physical exhaustion, electrolyte imbalance, dehydration and infection (Herzog *et al.*, 1997). Patients with anorexia nervosa also show an increased risk of suicide (Hoek, 2006) and around a quarter of patients do not fully recover (Louw *et al.*, 2001). Contemporary medical descriptions suggest a multifactorial aetiology for anorexia, with risk factors including genetic disposition and personality traits – such as compulsiveness and obsessionality – that may have a hereditary basis; environmental, social and familial factors; and childhood adversity such as abuse or the death of close relatives (Schmidt, 2002; Strober & Johnson, 2012).

Despite ostensibly definitive diagnostic criteria and statistics denoting its prevalence and social distribution, anorexia is the subject of extensive research across the biological,

psychological and social sciences and cultural theory. These disciplines provide divergent accounts of anorexia that belie the simplicity of the foregoing diagnostic guidelines. The following sub-sections outline major themes in these perspectives, beginning with a brief history of anorexia nervosa and its contemporary treatment. I then detail contrasting critical and feminist analyses of anorexia and, finally, review recent studies examining patient and professional accounts of anorexia.

2.1.1 Original formulations and contemporary treatment

The original medical formulations of anorexia nervosa were made independently by Lasèque (1873) and Gull (1868, 1874) and based on examination of a small number of female patients. Gull emphasised that anorexia nervosa was a nervous disease with psychological causes, concluding that the cause of anorexia lay in ‘hysterical’ tendencies (1874: 25). Whilst this psychological assessment by a renowned medical professional may have appeared neutral and scientifically appropriate, the notion of hysteria was itself profoundly ideological. Attributing anorexia to hysteria served to frame the condition as an extension of the supposed irrationality of women while constituting anorexia as a ‘mental perversion’ of self-starvation established the view that it was a self-inflicted condition of ‘obnoxious’ women (Hepworth, 1999: 25).

Despite being well over a century old, residual notions of self-infliction and irrationality that characterised early classifications of anorexia are apparent in contemporary clinical descriptions. Beumont, for example, describes anorexia as a ‘condition of self-engendered weight loss’ by individuals who are ‘divorce[d] from the reality that most of us recognise’ (2002: 162). Self-infliction is also implied in the psychiatric descriptions of anorexia, most obviously the *DSM-IV*’s first diagnostic criteria for anorexia nervosa as a ‘*refusal* to maintain body weight’ (1994: 307.1, my italics). Similarly, Fleming and Szmukler’s (1992) study of

over 350 medical and nursing staff found that eating disorder patients were considered more responsible for developing their condition and less likeable than patients with schizophrenia. This mirrors more recent work by Stewart *et al.* (2006), who found that lay members of the public believe patients with anorexia are more to blame for the onset and maintenance of their condition than individuals with schizophrenia or asthma.

The conception of anorexia nervosa as a self-inflicted condition has important consequences for the way in which anorexia is treated therapeutically. Most obviously, if anorexia is conceptualised as developing from and maintained by the will of the individual patient, treatment will be focused on adjusting their personal psychology (Hepworth, 1999).

Contemporary treatment for anorexia largely reflects this model of anorexia as an individualised psychopathology (Malson *et al.*, 2004) with psychological interventions regarded as crucial to long-term recovery (NICE, 2004). Individual psychotherapy for anorexia often draws variously on cognitive and behavioural therapies, interpersonal psychotherapy and motivational enhancement therapy (Morris & Twaddle, 2007), though treatment may also include family therapy that actively involves the patient's family in treatment. These interventions are normally delivered in a secondary care setting on an outpatient basis, although more severe cases of anorexia – usually determined by patients' body weight – are treated on an inpatient basis. Patients with anorexia who are at a dangerously low weight and unwilling to accept treatment may be detained as inpatients under the Mental Health Act 1983. Inpatient treatment typically includes a re-feeding programme which aims to safely increase the patient's weight, and is carried out coercively through feeding tubes in extreme cases. While comparatively rare, compulsory re-feeding practices echo Gull's claims that anorexic patients display signs of insanity and that their treatment preferences can be disregarded during treatment (Gull, 1874: 24).

2.1.2 Cultural and feminist analyses of anorexia

Alongside medical, psychological and psychiatric research, there is a large body of non-clinical literature available on anorexia, its potential cultural aetiology and its social meaning. Such writing typically utilises qualitative methodologies and a social constructionist epistemology that regards concepts such as health, illness and disease not as simple, measurable facts but as products of cultural discourses, institutions and social norms. This has resulted in accounts of anorexia that stand in marked contrast to clinical studies which construe anorexia as an apolitical, individual psychopathology (Malson *et al.*, 2004). Socio-cultural research has, for instance, sought to countermand the notion that anorexia is a 'self-engendered' pathology on the grounds an individual's desire to be thinner results, at least in part, from external socio-cultural pressures in Western society.

Giddens (1991) interprets anorexia as a consequence of developed societies. In contemporary society, he claims, manifold lifestyle choices have supplanted the traditional social roles through which individuals previously established distinct social identities. For example, in its moderate form, the widespread practice of dieting exemplifies the general late modern trend of bodily management through which individuals produce their self-identity. Anorexia nervosa represents an extreme form of this reflexive identity project; a rejection of the dietary pluralism of modernity and adoption of a 'deliberate asceticism' that clearly differentiates the individual from others (Giddens, 1991:105). Giddens' analysis affords insight into the increased occurrence of eating disorders amongst females by citing the higher value placed on the physical appearance of women and hence their greater need for bodily regulation. Giddens also argues that weight loss and the pursuit of an anorexic identity offers women a more feasible mode of self-definition than social goals such as professional success, which remain relatively more difficult for women to achieve. This in turn accounts for the sense of

self-empowerment from restrictive dieting reported in patient-based studies (Eivors *et al.*, 2003).

Giddens' (1991) attempt to situate anorexia nervosa in relation to social structures, and particularly those affecting women, parallels feminist readings of anorexia. Feminist writers have offered trenchant criticism of medical explanations of anorexia. In opposition to bioscientific and psychiatric research, they implicate the gender inequalities that pervade industrialised Western societies as an aetiological factor in anorexia nervosa (Gimlin, 1994). Feminist literature departs strikingly from psychiatric research in its resistance and occasional outright rejection of the description of anorexia as an individual pathology that distinguishes healthy and unhealthy individuals. Rather, anorexia has been reinterpreted as an acute example of the culturally engendered psychological difficulties shared by all women (Orbach, 1986). Indeed, Bordo argues that although the aetiological causes of eating disorders are indeed 'multidimensional', gender inequalities in Western culture play a preeminent role amongst these (2003: 52). Despite this, she argues, medical models have consistently relegated cultural norms to a merely contributory role in the development of anorexia, on the grounds that only a minority of individuals within developed societies develop the condition. The search for additional, non-cultural factors then effaces the primary role played by aspects of Western culture in the proliferation of eating disorders.

Bordo argues that several fundamental aspects of contemporary culture support the propagation of anorexia. Chief amongst these is the cultural legacy of Cartesian dualism that dissociates the rational mind from a weak physical body whose needs require control. This mind-body dualism has subsequently developed into a male-female dualism whereby women acquire negative cultural associations of physicality, mental weakness and insatiability. These contrast with esteemed 'masculine' qualities of rationality and physical and mental restraint,

to which women are encouraged to aspire. This pervasive set of cultural values underscores symptomatic characteristics of anorexia nervosa including wilful suppression of appetite, a sense of security gained from bodily control and a fear of female sexual development (Bordo, 2003: 146-160). Bordo argues that the widespread over-valuing of physical restraint and the equation of the thin body with self-control means that anorexic individuals' obsession with thinness cannot be understood wholly in terms of individual pathology. Rather, the anorexic body needs to be seen within the context of cultural values which idealise physical self-control (Malson, 1998: 123).

Additionally, Bordo suggests that a misconception of body size and fear of weight gain, which feature in the *DSM's* diagnostic criteria, can be deconstructed as evidence of pervasive gender oppression. For example, women's over-estimation of their own body size reflects ubiquitous media depictions of a glamorized, thin female body and, more generally, mirrors a cultural norm of feminine beauty that values a diminutive, submissive appearance (Bordo, 2003: 55-57; Wolf, 1991). Similarly, women's enactment of control over the size of their bodies can be regarded as symptomatic of a culture in which their physical appearance is used as an index of their social and moral worth (Rothblum, 1994; Valentine, 1994).

Bordo's reanalysis of the concealed cultural logic of dualism and contextualisation of individualised psychological symptoms against cultural gender norms provides valuable insight into the shortcomings of a strictly medical understanding of anorexia. As such, her text has proved highly influential to recent sociocultural analyses of anorexia and studies examining the experiences of anorexic individuals. In her radical interpretation of anorexia, McCaughey (1999) is critical of the feminist view that anorexics strive to achieve unfeasible ideals of beauty and body weight and are simply acute examples of a culture-wide concern with weight control. McCaughey is sceptical of assuming a deterministic link between the

cultural values of female beauty propagated through, for example, the mass media, and the attitudes of individual women. To do so risks interpreting anorexics simply as victims of cultural values and implies a somewhat naïve model of media consumption (see Stice *et al.*, 2001 for an empirical study of this). Instead, McCaughey argues that anorexics seek to maintain a very low weight because visible emaciation makes them less conventionally attractive; that their sense of empowerment stems precisely from avoiding the predatory heterosexual male objectification to which other women are subjected.

Fox *et al.*'s (2005) study of the online pro-anorexia movement – a highly developed anti-recovery subculture directly opposed to the curative treatment of anorexia – also found that anorexia was considered a source of reactive control in the face of previous traumas or uncertainty. In contrast to McCaughey (1999), however, Fox and colleagues document pro-anorexics' claims to pursue slimness precisely because of its social connotations with attractiveness. Similarly, the study illustrates pro-anorexics' esteem of 'thinspirational' female celebrities, who are said to embody an ideal of restraint and heterosexual beauty norms (2005: 960-1). Thus, even when an anorexic identity is deliberately pursued – as it is by pro-anorexics – Fox *et al.*'s research does not suggest that this pursuit is part of a politicised struggle to disrupt men's subordination of women.

Nevertheless, it would be presumptuous to simply dismiss McCaughey's evidence as disingenuous or her contention as entirely unfeasible. Instead, her argument usefully demonstrates the multiple possible interpretations of anorexia as a social phenomenon and subjectively lived experience. For example, the socio-cultural analyses reviewed above involve a recurrent representation of anorexia as a means of self-control. However, each study specifies particular personal motivations for seeking self-control including – though not limited to – a crisis of self-identity (Giddens, 1991); an unattainable beauty ideal and

subordinate female subjectivity (Bordo, 1993); and the subjugating effects of heteronormativity (McCaughey, 1999). Taken as a whole, these diverse analyses underline the unavailability of a single, comprehensive explanation of anorexia. Instead, there are multiple explanatory models of anorexia that draw upon biomedical, psychological, sociological or feminist paradigms to configure anorexia and the anorexic patient in particular ways.

However, just as feminist writers have argued that professional psychotherapies individualise patients with little appreciation of broader cultural contexts, Bordo's treatment of eating disorders on the level of Western culture can lead to a generalising of individual experiences to a macro level. There is a danger that such theorising can lead to sophisticated interpretations of anorexia as a cultural phenomenon, but which bear diminishing resemblance to the accounts of individual sufferers. For example, although she states that culturally enshrined gender inequalities are 'productive of eating disorders' (2003: 50), Bordo fails to clearly assert that any such production occurs at the level of the individual, rather than an entire culture (Giordano, 2005). In contrast, by attending directly to the accounts of individuals with anorexia, Fox *et al.*'s (2005) study demonstrates how social discourses of feminine beauty, physical restraint and medical knowledge are negotiated interactively on an individual and group basis. Until recently, however, such research has been in surprisingly short supply (Malson *et al.*, 2004). As Rich avers in the introduction to her ethnographic study of an inpatient facility, there is 'a plethora of studies which explore the discourses around eating disorders. There is, however, relatively little research which addresses how young women actually manage these discourses; [...] how they make sense of the various social constructions of eating disorders at an everyday level' (2006: 285). Examination of literature suggests that there are even fewer studies investigating the experiences of healthcare professionals – particularly general practitioners – and the accounts that they

provide of anorexia. The following sub-sections address the available literature in these fields and examines its relation to the foregoing sociocultural studies.

2.1.3 Patient accounts of anorexia

Rich's (2006) ethnographic study found that anorexic individuals perceived a high degree of social stigma for their condition. Rich's participants reported that their families and peers failed to understand their profound internal conflict and instead regarded anorexia as pathological, self-inflicted and 'deviant'. This perceived stigma led these sufferers to seek support in alternative contexts such as online groups. These sufferers also discursively managed the social castigation of anorexia by constructing their illness in terms of the restraint and self-control attributed to esteemed social actors such as athletes. By constructing a narrative of self-empowerment, anorexic patients were able to create a positive anorexic identity that they were unwilling to relinquish, leading to conflict with their healthcare providers. Rich argues that anorexic patients have a complex and contradictory relationship with their condition; they resist others' attempts to index their health through physical measurements such as body mass yet remain profoundly concerned with their own weight and calorie counting. Similarly, they engage in non-compliance behaviours during treatment and regard anorexia as personally vindicating whilst simultaneously aware of the negative impact it has on their own and other people's lives.

This ambivalent experience of anorexia reflects findings in other studies (Giordano, 2005). Eivors *et al.*'s (2003) interviewed women who had withdrawn from professional anorexia treatments, who depicted anorexia as a means of exerting a sense of control after a stressful life event or transition. This sense of control led to conflict with close relations who attempted to pathologise behaviours that the anorexics experienced as functional. Increasing tensions with their immediate social relations had led the interviewees to reinterpret their

anorexia as potentially dysfunctional. Nevertheless, the study participants reported feeling opposed to a pathologising diagnosis of mental illness and experiencing a renewed sense of lost control during professional interventions that focused on managed diets. Unilateral withdrawal from professional therapies offered the interviewees a means of reasserting control over their lives and routines. However, early drop-out from treatment also left some participants with no alternative strategies for managing stressful experiences, increasing their reliance on disordered eating and leading some to adopt the identity of an 'incurable anorectic' (2008: 105).

Themes of control and resistance to treatment are also present in Malson *et al.*'s (2004) work with inpatients on specialist anorexia wards. Their interviewees frequently rejected professional claims that they were medically unwell, a resistance that served to undermine the legitimacy of their hospitalisation. Further, the patients strongly resisted being treated solely as a case of anorexia by their attending clinicians. Rather than seeing anorexia as defining their identity and behaviour (a view they largely attributed to professionals), the patients sought to present anorexia as separate from themselves (see also Malson, 1998: 145). This allowed them a position from which to challenge the professionals' treatment plans as harmful to their (non-anorexic) selves, rather than this resistance being regarded as symptomatic of anorexia itself. However, at times, some recovering participants also used this 'patients are 100 per cent anorexic' view to contrast their current distance from anorexia with their previously whole-hearted adoption of an anorexic identity. Malson and colleagues' work is valuable in demonstrating the fluidity of constructions of anorexia and patienthood. They illustrate that sufferers utilise different descriptions of anorexia as pathological or empowering, all-encompassing or a separate part of themselves and that they adopt these contrasting constructions strategically to achieve interpersonal objectives, such as legitimising resistance to treatment or demonstrating personal recovery.

Several studies of pro-anorexic web communities demonstrate the uptake of medical information among individuals with anorexia (this thesis examines a 'pro-recovery' web community and a more comprehensive review of 'pro-anorexic' research is therefore beyond its scope. I direct the reader to Fox *et al.*, 2005, Gavin *et al.*, 2008 and Giles, 2006 for constructive insights). Fox and colleagues (2005) illustrate the promulgation of scientific and medical information amongst communities who remain firmly opposed to the categorisation and treatment of anorexia as a medical pathology. Participants in Fox *et al.*'s study display a sophisticated knowledge of calorie content, body mass information, exercise regimes and weight loss pharmaceuticals. These 'pro-anas' demonstrate a clear willingness to deploy biomedical knowledge of anorexia and malnourishment while explicitly subverting clinical accounts of anorexia and the implication that they are mentally ill. Lay uptake of clinical knowledge of anorexia is also exemplified by sufferers who have previously accepted clinical intervention. Gremillion (2003) reports that patients learn the body weight which clinicians use to determine their need for hospital admission and internalise this as their maximum allowed weight, enabling them to maintain their condition while avoiding hospitalisation. In doing so, characteristically clinical criteria of weight, body size and calorie intake come to define the anorexic patient's identity (Malson, 2008).

A recent study by Easter (2012) further illustrates the tensions created when sufferers adopt biologically-based explanations of eating disorders. Easter argues that explanations which attribute anorexia to genetic factors could potentially alleviate stigma towards eating disorders by diffusing the widespread belief that anorexics could 'pull themselves together if they wanted to' (Stewart *et al.*, 2006: 322). Interviewing individuals with current or previous experience of anorexia and bulimia, the vast majority believed that genetic explanations could provide 'scientific' validation for the illnesses and specifically counteract the stigmatising notion that eating disorders are self-inflicted. Participants believed that this in

turn could challenge concomitant moral indictments of sufferers as “shallow,” “vain,” “conceited,” “selfish,” or “indulgent.” (Easter, 2012: 1412). However, one third of Easter’s interviewees were also sceptical of adopting a genetics-based explanatory model of eating disorders. Specifically, participants believed that genetics could undermine the causal explanations they had evolved through their own illness narratives, which often implicated environmental factors and past abuse. Further, they believed genetic explanations could lead to fatalism in which eating disorders are considered hard-wired into the individual, thereby trivialising their efforts to recover. Finally, participants were concerned that advocating genetic causes could lead others to believe they were seeking excuses to avoid recovery. As with the work of Fox, Malson, Eivors and their respective colleagues, Easter’s study demonstrates a characteristic ambivalence amongst sufferers towards biomedical information and explanations for eating disorders. While they may be welcome in dismantling accusations that eating disorders are a personal choice, these studies indicate that biological explanations also have potentially profound implications for the identity of the sufferer and the value of their struggle towards recovery.

2.1.4 Professional accounts of anorexia

While general practitioners are seldom involved in psychological interventions directly, primary care is the most likely venue for an official diagnosis of anorexia (Boulé & McSherry, 2002). GPs also play a key role in facilitating patients’ access to specialist services and coordinating multidisciplinary treatment teams for patients and may be involved in monitoring and managing patients’ physical health even when they are receiving psychological care through secondary services (Green *et al.*, 2008). Despite this, to my knowledge there is currently only one published qualitative study of general practitioners’ experiences of treating eating disordered patients, signalling a clear need for additional

research in this area. Reid *et al.* (2010a) found that GPs believe eating disorders are difficult to recognise and diagnose, leading to concerns about missed diagnoses. This difficulty was partly explained by the belief that patients sometimes deny or hide their symptoms, which also entails repudiation of diagnosis and referral plans. As such, eating disordered patients were perceived to be demanding and necessitating significant professional and emotional input in a context of sparse specialist services. The GPs reported having insufficient skills to manage the complexity of most eating disordered patients and regarded specialist referral of such cases as a necessity. These findings are supported by Currin *et al.*'s (2007, 2009) questionnaire studies, which identify generally low and variable knowledge of the symptoms and physical complications of eating disorders as well as inconsistent referral practices that do not reflect weight-based protocols. Similarly, Boulé and McSherry (2002) report GPs' anxieties over the management of patients with eating disorders, who were regarded as time-consuming and as having complicated care needs compounded by frequent comorbidities. Warren *et al.*'s (2009) questionnaire study investigated primary care professionals' experiences of treating eating disorders. They report that 83% of respondents claimed that they felt patients monitored or evaluated their appearance while 70% reported having felt self-conscious about their appearance during treatment with eating disordered patients. More positively, 70% reported that their view of food had altered since working with eating disordered patients, normally for the better, while 50% said their eating behaviours had changed in terms of eating more healthily or engaging in 'emotional eating' or over-eating.

While studies specifically examining GPs remain rare, several studies consider the views of other healthcare professionals. Reid *et al.* (2010b) examine a multidisciplinary eating disorders team and identify consistent concerns over insufficient prior training in treating managing eating disorders (see also Lester *et al.*, 2005). Reid and colleagues' participants provide multifactorial explanations of eating disorders, though their most frequently cited

causes – family issues, low self-esteem, stress, ‘control issues’ and past abuse – appear to exclude sociocultural models of anorexia. Non-compliant patients were viewed unfavourably, although one interviewee suggested that viewing patients as ‘manipulative and devious’ was unhelpful and a ‘cop out’ for professionals (2010b: 396). Negative evaluations of anorexic patients are also apparent in King and Turner’s (2001) study of nurses caring for adolescent anorexia in-patients. The nurses report that repudiation and deceitful behaviour by patients led them to be suspicious and untrusting, attitudes that they found hard to reconcile with the caring and non-judgemental principles of nursing. As a result, the nurses report disenchantment with their work and a need to distance themselves from individual patients and believe that their care did not determine whether or not patients recovered.

Finally, an overriding theme of control is also central to Jarman *et al.*’s (1997) study of a multidisciplinary eating disorder team. Their participants claim that the treatment of anorexia is inherently conflictual because they are attempting to stop practices which patients experience as at least partly beneficial. Some participants perceived patients with anorexia as entirely controlled by their anorexia or as deliberately using their illness to manipulate the responses of those around them. In order to manage the difficulties caused by non-compliant patients, practitioners claimed to adopt more assertive and less client-centred forms of management. This provided them with a greater sense of confidence and command over individual cases, though some were wary that more assertive management also involved paying less regard to the preferences of the patient during treatment.

These foregoing studies illustrate that the association of anorexia and control that is found in sociocultural analyses is also exemplified in patient- and professional-based research. For professionals, the claim that anorexia itself controls the patient appears to correlate with disregarding patients’ beliefs during therapy (Jarman *et al.*, 1997; Malson *et al.*, 2004). This

more assertive treatment may well engender a feeling of lost control that increases the likelihood of the patient seceding from professional treatment (Eivors *et al.*, 2003). This pathologising construction of anorexia thus appears to remove responsibility for recovery from the patient and justify more assertive professional interventions. Responsibility for anorexia is also highlighted by Easter (2012), who demonstrates the potential for accounts of anorexia as a biomedical pathology to neutralise volitional stigma towards anorexia, with the corollary of displacing sociological understandings of anorexia and promoting its biomedical management (Stoppard, 2000). Medical knowledge and descriptions of anorexia as a totalising or biomedical pathology therefore also have clear implications for the way in which the individual patient and their care are constructed. While we may expect professional responses to anorexia to be guided by medical and psychological understandings, several studies also highlight clinicians' discontent with typical service organisation (Reid *et al.*, 2010b) and the moral defamation of patients over their non-compliance and the emotional demands of their care (Jarman *et al.*, 1997; King & Turner, 2001; Rich, 2006).

This thesis extends upon these studies to illuminate the descriptions of anorexia provided by patients and healthcare providers in the comparatively under-studied contexts of a pro-recovery web community and GPs' group talk. Chapters 4 and 6 consider the way in which speakers draw upon the socially available explanations of anorexia detailed above and examine the effects of these choices on their identities as sufferers or healers respectively.

2.2 Depression: Introduction

Despite its status as the 'common cold' of psychopathology (Seligman, 1975), it is difficult to overestimate the potential severity of depression and the breadth of its effect upon the health of Western populations. Clinical depression affects 15% of the British populace and is the most common factor involved in suicide (Pilling *et al.*, 2009). Besides this tangible human

loss, a Sainsbury Centre for Mental Health report (2010) estimated the annual cost of depression at £105.2 billion in 2009/10. This includes expenses from healthcare services and indirect economic costs such as lost productivity due to sick leave, premature death and those leaving work to care for the ill.

As with anorexia nervosa, depression is more common in females than males, with women being twice as likely to become depressed (Stoppard, 2000). Unlike eating disorders, depression is more common amongst individuals with a lower socio-economic status, the unemployed and those living in poor quality housing. This demographic distribution is reflected in the current multifactorial clinical model of depression which implicates genetic and biological characteristics which interact with negative events during childhood to produce vulnerability in adults. Experiences in adulthood such as job loss, bereavement, poverty, or other health problems then lead to a debilitating level of unhappiness (Dowrick, 2004). Depression also frequently presents with a range of comorbidities, particularly lower back pain and heart problems, where physical and psychological problems mutually impede recovery (Dowrick, 2004).

Treatment for depression at least partially responds to these different factors. In cases of major or continued depression, both antidepressant medication and 'talking therapies' are used to respond to the belief that depression is a physiological disorder characterised by neurological chemical imbalance and a psychological problem caused by vulnerability factors (Kangas, 2001). Patients frequently express a preference for talking therapies, which are typically delivered as Cognitive Behavioural Therapy or counselling (NICE, 2009). In cases of major depression, research has shown similar levels of efficacy for both antidepressant drugs and generic counselling (Chilvers *et al.*, 2001), although concerns regarding the long

term effectiveness and suitability of drug therapies are well established (see Dowrick, 2004: 80-84 for a review).

While 80%-95% of individuals diagnosed with mild and moderate depression recover within two years, the trajectory of major depression is less optimistic, with severe cases marked by long-term difficulties. The results of a large cohort study by Judd (1997) and Judd *et al.* (1998) indicate that patients diagnosed with major depression report suffering from depressive symptoms 59% of the time over twelve years. Whilst these patients were three times more likely to report feeling minor symptoms, they recorded symptoms of major depression lasting for 15% of a twelve year period. For individuals admitted to psychiatric units, longitudinal studies report recovery for between 24% and 40% of patients (Piccinelli & Wilkinson, 1994; Surtees & Barkley, 1994). In a large, 25-year study, Brodaty *et al.* (2001) report a symptom recurrence rate of 84% and readmission of 58% of former in-patients, with 27% of patients' symptoms improving between fifteen and twenty five years, 55% remaining the same, and 18% deteriorating. These studies demonstrate that major depression remains a frequently intractable condition that dominates the lives of sufferers and resists sophisticated psychiatric and pharmacological interventions.

The *DSM-IV* criteria for diagnosis of a major depressive episode are:

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others.
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day as indicated by subjective account or observation.
- Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day.

- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day, observable by others.
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
- Diminished ability to think or concentrate, or indecisiveness, nearly every day, identified by subjective account or observed by others.
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

(APA, 1994: 296.20-296.30)

For a diagnosis of a major depressive episode to be made, individuals must present with five or more of these symptoms, including depressed mood and/or diminished interest in activities, in a period of two weeks or more.

These diagnostic criteria have often acted as a point of departure for trenchant criticisms of the concept of clinical depression. The following sections shall consider arguments against this established medical formulation and the problems it generates when operationalised for diagnosis and treatment. Sections 2.2.2 and 2.2.3 then detail recent qualitative studies of patient and professional accounts of depression that further problematise conventional diagnostic and treatment measures. Such research demonstrates the need for alternative frameworks with which to understand and treat depression and the value of eliciting patient and professional accounts in order to inform such developments.

2.2.1 Problematising the diagnosis of depression

As a scientifically validated label, the value of the diagnostic category of depression is its identification of an underlying psychopathology that transcends subjective accounts of unhappiness and requires professional training to understand (McPherson & Armstrong, 2009; Stoppard, 2000). As such, a diagnosis of clinical depression is intended to distinguish depressed individuals from those who feel a normal, non-pathological unhappiness and from individuals who suffer from other mental pathologies (Dowrick, 2004). However, the 70 different possible combinations of the *DSM* symptoms reproduced above mean that individuals who do not share a single symptom can be positively diagnosed as sharing the same underlying pathology (Pilgrim & Bentall, 1999; Stoppard, 2000). Similarly, an individual can experience a number of symptoms yet remain within the parameters of medical normalcy, and those with sub-clinical symptomatology may experience significant personal impairment (Dowrick, 2009a).

Pilgrim and Bentall (1999) highlight the continuing theoretical disagreement over the definitive criteria for clinical depression. Whereas the *DSM* affords primacy to depressed mood and anhedonia, Beck *et al.* (1979) state that depression's defining feature is a negative view of the self and the future while Willner (1985) claims there is no essential symptom for depression at all. Similarly, Dowrick (2004: 56-63) outlines several contemporary arguments over the concept of depression and its distinction from other mental disorders. Depressive symptoms overlap with several other conditions such as adjustment and anxiety disorders and debate continues on whether these conditions should remain separate or be regarded as different presentations of a shared underlying problem. Others aver that depression should be further sub-divided into several related subtypes. In light of these enduring arguments, Pilgrim and Bentall conclude that there is 'no consistent transcultural, transhistorical

agreement about minimal necessary and sufficient pathognomic criteria' for diagnosing depression (1999: 263) and further that there are no definitive divisions between various mental disorders and between mental disorder and normality. Therefore, despite the *DSM*'s position as the international standard of mental illness diagnosis, its concept of depression is as much a product of contentious professional and institutional trends as it is an objective description of a mental health condition (Bentall, 2003).

In the absence of a definitive biological test, the diagnosis of depression is often dependent on the communicative event of the clinical consultation. The ambiguity of linguistic interaction and the flexibility of diagnostic criteria increase the risk of inappropriate (non)diagnosis where a patient over or under states the extent of his or her unhappiness, or where the doctor fails to correctly interpret the patient's intended meaning (Parker, 2007). Tylee *et al.* (1995) suggest that up to 50% of cases of major depression may go unnoticed in primary care, leading to increased risk of suicide in untreated cases (Hickie, 2007). Their study found that practitioners' recognition of depression was heavily dependent on whether the patient had a marked physical illness, which was afforded primacy in the consultation. For patients without physical complaints, recognition was ten times more likely if they mentioned their psychological concerns early in the consultation. More notably, even though the participating practitioners were aware that the study was investigating recognition of depression, one sixth did not make a single diagnosis of depression over the course of twenty hours with patients, two-thirds of whom had previously scored highly on a depression screening questionnaire.

Kessler *et al.* (1999) investigated the correlation between the explanations of emotional suffering provided by lay individuals and the recognition of depression in primary care. They found that participants who frequently attributed symptoms to situational factors such as

'being over-worked' were significantly less likely to be diagnosed with depression by their general practitioners. By contrast, participants with a psychologising style of attribution – being 'emotionally exhausted' – were significantly more likely to be diagnosed with depression. Kessler *et al.* suggest that, where patients present their concerns using a medical-psychological discourse, doctors are encouraged to respond empathically with a psychological formulation of their problems (c.f. Heath, 1999 for criticism of the study's method and Kessler *et al.*, 2002 for a rejoinder). Kessler *et al.*'s study suggests that statistics on the prevalence of depression may appreciably underestimate the extent of depression amongst those who provide normalising explanations for their distress (Stoppard, 2000). The difficulty of discerning depression in individuals can be compounded by patients' reluctance to discuss psychological problems with healthcare professionals. Gask and colleagues (2003) aver that depression has the potential to disrupt communication with professionals if patients feel they do not deserve to take up the doctor's time or that an emotional disclosure would be misunderstood. Additionally, Pollock (2007) argues that distressed patients must simultaneously negotiate social expectations of stoicism and a desire to request professional help. Since few patients have an emotionally close relationship with health practitioners, they are obliged to conform to norms of emotional self-reliance and social composure expected in ordinary social interaction. A wish to avoid the stigma associated with displays of distress may therefore diminish the likelihood of patients articulating their concerns and receiving a diagnosis.

Parallel to the evidence that current statistics may understate the true extent of depression in the populace are widespread concerns that a diagnosis of depression may be reached too frequently. The lack of objective diagnostic criteria mean that for borderline cases 'no subjective checklist of a patient's history and complaints can infallibly separate clinical syndromes that qualify as disorders from human discomfort of a lesser intensity' (Chodoff,

2002: 628). However, the diagnosis of depression offers general practitioners an effective way to respond to patients' distress and reduce a large and heterogeneous set of symptoms and experiences into a single label with an available treatment protocol (Chew-Graham *et al.*, 2002; Dowrick, 2009b). The strategic use of a diagnosis of depression to simplify patients' complicated personal and social problems represents an example of the medicalisation of unhappiness that might otherwise be interpreted as a non-pathological reaction to adverse personal circumstances (Burroughs *et al.*, 2006; Parker, 2007; Pollock, 2007). On the one hand, such diagnosis may bring the patient relief through professional recognition of previously confounding unhappiness. At the same time, diagnosis may well catalyse an individual's entrance into treatments that can radically alter their lives and personal identity (Karp, 1996).

Having outlined major arguments around the nature of 'depression' and the interactional influences on its diagnosis, the following subsection outlines existing work into lay experiences and explanations of depression. Subsection 2.2.3 then addresses research into depression's management in primary care.

2.2.2 Patient experiences of depression

In response to the voluminous clinical literature on depression, a growing corpus of qualitative social science research investigating depressed patients' illness experiences has emerged. While these qualitative studies do not uniformly oppose the medical treatment of depression, they do emphasise that illness narratives 'provide meaning, context, and perspective for the patient's predicament' and can be used in shaping therapeutic interventions (Dowrick, 2004: 194). Indeed, these studies fundamentally endorse patients' accounts as a source of valid information on depression and accuse quantitative studies of

homogenising complex longitudinal experiences into quantifiable variables that are predetermined by researchers (Stoppard, 2000).

Karp's (1996) extensive interviews with depressed individuals and their families detail a range of beliefs and experiences of those whose lives are dominated by depression. The preeminent theme amongst Karp's interviews is the feeling of isolation engendered by depression (1996: 26). All fifty of Karp's interviewees and many of those interviewed by Kangas (2001) describe experiencing intractable feelings of social discomfort whilst simultaneously longing for a sense of interpersonal connection. In addition, many of Karp's respondents reported a fear of revealing their constant unhappiness to others and persistent difficulty in articulating their feelings, leading to a sense of frustration that increased their social withdrawal and subsequent depression. Karp's research is supported by Epstein *et al.*, (2010), whose participants describe the experience of depression as one of social isolation. Epstein *et al.*'s participants also describe symptomatic experiences of sleeplessness, anhedonia and lost appetite as well as feelings of constriction, enclosure and the experience of a mental 'fog' or 'haze' that impairs their ability to think clearly and feel in control (2010: 958). Depressed individuals' anxiety towards social contact suggests that the remote communication of online health fora may provide a less threatening form of social interaction that could help reduce patients' sense of isolation. That is, in addition to the support and advice available through electronic support groups, the very process of electronic communication may alleviate a prevailing negative aspect of the depression experience, an avenue which remains largely unexplored in medical literature.

In comparison with clinical explanations of depression's aetiology, lay accounts frequently foreground a relationship between depression and situational and social factors (Rogers & Pilgrim, 1997). In interviews with south Asian immigrants in America, Karasz (2005) found

that 85% of explanations of the cause of depression implicated situational factors, particularly on-going problems with a spouse or in-laws. These respondents also offered the markedly non-medical explanation that depression could be caused by 'thinking too much' (2005: 1630) and many did not see depression as a disease unless it led to physical illness. By contrast, when describing situational factors, Karasz's middle class Caucasian interviewees were more likely to cite specific life events such as bereavement, divorce or miscarriage that could precipitate a depressive reaction. The same conception of depression as a reactive condition was also identified in work with lay patients by Lewis (1995), Rogers and Pilgrim (1997) and Cornford *et al.*, (2007). Karasz's respondents also displayed a more granular understanding of depression by differentiating between a reactive depression identified as an indirect object – 'depressed about something' – and depression used substantively – 'it's depression' (2005: 1629). When discussing depression as a distinct phenomenon, respondents were more likely to provide a complex explanation that demonstrated the influence of medical knowledge. Three quarters of white American respondents mentioned possible biological causes of depression and utilised psychodynamic concepts of emotional triggers and childhood trauma, but also offered twice as many explanations that identified social problems. Similarly, elderly interviewees in Wittink *et al.*'s (2008) study saw life events and failed relationships as engendering unhappiness but were able to combine this folk model with the concept of depression as a clinical condition with particular medical symptoms.

This heterogeneity was also identified by Kangas (2001) and Chew-Graham *et al.* (2009), whose respondents favoured explanations involving harmful structural patterns of society and employment but who also drew on psychodynamic theories and biomedical notions of neurotransmitter disruption and genetic predisposition. Similarly, Rogers and Pilgrim found that '[l]ife events, family problems and economic hardship were mentioned frequently [by patients], with genetic and biological causes noted much less often' (1997: 28). Past research

therefore suggests that supposedly 'lay' accounts of depression in fact integrate folk and scientific discourses in complex and sometimes contradictory ways (Kangas, 2001: 89) and simultaneously attribute depression to factors internal and external to the individual. Whilst this variability partially reflects the multifactoral medical model, lay accounts in face-to-face interviews consistently prioritise socially-situated explanations of depression (Dowrick, 2004) and foreground the strain it places on their social roles and relationships.

Their variety notwithstanding, these non-professional accounts share a common theme of locating depression outside of the individual's control. That is, whether the cause of unhappiness is attributed to social or biological factors, childhood or relationship traumas, explanations of depression consistently displace culpability from the individual sufferer. As such, these accounts of depression also signal patients' need to 'patch up the moral rupture presented by illness' (Kangas, 2001: 77), and justify suffering to those who do not otherwise comprehend it. For Karp (1996), neutralising stigma and constructing depression as beyond individual control is a salient aspect of living with chronic depression, particularly when feelings of abject unhappiness persist in the absence of situational or social problems. For Karp's participants, a medical model of biological predisposition effectively accounted for the feeling that depression was beyond their control. Positive experiences with antidepressant medication validated this explanation and encouraged participants' long-term gravitation towards a medicalised understanding of depression.

Despite the overlap between lay and biomedical descriptions, existing research suggests that patients are ambivalent towards a disease model of depression. Whilst allowing individuals to avoid blame for depression (Schreiber & Hartrick, 2002), capitulating to a biochemical explanation also cues the adoption of a passive patient identity and acceptance of professional pharmacological interventions (Lewis, 1995). Similarly, Epstein and colleagues' participants

claimed that describing depression as a chemical imbalance reduced personal stigmas but also 'neglected the uniquely personal aspects of the depression experience and devalued behavioural or psychological treatment options' (2010: 960). Resistance to a passive, 'patient' identity is apparent in other studies: Rogers and Pilgrim (1997) and Cornford *et al.* (2007), for instance, found that patients advocated personal responsibility, stoicism and emotional stability rather than dependence on healthcare. These individual coping strategies enabled patients to maintain a sense of agency and empowerment even when uncontrollable factors lay at the heart of their aetiological models of depression.

The above research highlights a number of disparities between the model of clinical depression and the embodied experience of being depressed. Non-professional's culturally-specific explanation may diverge from ostensibly objective medical knowledge and typically emphasise the role of immediate situational and social factors in causing depression. Belief in the value of emotional self-reliance and fear of social encounters can also lead to anxiety towards admitting distress to healthcare professionals (Pollock, 2007). Non-professional explanations of depression often utilise some features of medical paradigms, particularly as a means of mediating perceived responsibility for illness. Nevertheless, completely accepting a biomedical model is believed to negatively affect a sufferer's self-identity and sense of agency and many patients resist the identity of a victim that a disease model entails.

The diversity of patients' beliefs identified above suggests the potential for conflict when patients and professionals hold divergent understandings of depression. As Rogers and Pilgrim argue, where there is such a discrepancy between patients' and clinicians' interpretations of emotional distress, 'there is also likely to be less satisfaction with service delivery and other aspects of professional-patient contact' (1997: 24). The following

subsection explores this issue further, reviewing qualitative studies that examine the beliefs and understandings of depression amongst frontline healthcare professionals.

2.2.3 Treatment implications

Despite the apparent acceptance of a multifactorial model of depression, there is much evidence that actual clinical practice often fails to address the social and environmental causes of depression. Instead, where patients offer personalised, subjective accounts of socially situated unhappiness, diagnosis reduces individuals' complex cases to a clinical synopsis and attendant treatment protocol that governs management (Rogers *et al.*, 2001). Additionally, standard treatments such as antidepressants or Cognitive Behavioural Therapy reflect a model of depression as an individualised biochemical or psychological malfunction and can do little to alleviate the social conditions that patients frequently implicate in their unhappiness (Karp, 1996). As such, contemporary treatment of depression has been described as a 'technical fix' of patients' symptoms with little regard for their personal experiences or the wider causes of their misery (Pilgrim & Bentall, 1999: 272; Leader, 2008).

This disparity between patients' experiences of depression and the availability of healthcare that attends to their needs has direct implications for patients' and professionals' attitudes towards primary care. For instance, Burroughs *et al.* (2006) and Gask *et al.*, (2003) both report that depressed patients have low expectations of primary care treatment. Additionally, participants in numerous recent studies mention reservations about disclosing emotional troubles to healthcare professionals, believing that their GPs are primarily concerned with treating physical conditions or that they would be prescribed antidepressants, which they felt were an unsuitable treatment for their problems (Burroughs *et al.*, 2006; Chew-Graham *et al.*, 2009; Gask *et al.*, 2003; Pollock, 2007; Rogers *et al.*, 2001).

However, reservations towards the treatment of depression in primary care are not the sole preserve of patients. In a series of interview studies led by Carolyn Chew-Graham and colleagues, GPs repeatedly frame depression as an unrewarding burden on their workload (2000). GPs portray consultations with depressed patients as a personally demanding aspect of practice and describe feelings of powerlessness at their inability to alleviate social and environmental sources of patients' unhappiness (2002; 2004). As well as any medical interventions, patients with depression are perceived to require bureaucratic management on the part of the GP. This includes organising longer consultations and scheduled appointments to allow time to develop rapport with patients while accommodating such extra demands into the GPs' overall workload (2000; 2002; Thomas-Maclean *et al.*, 2005). Chew-Graham *et al.* (2002) also report doctors using the prescription of antidepressants with set fortnightly review meetings as a means of spacing out time-consuming consultations. Chew-Graham's studies have been instrumental in demonstrating that GPs seldom construe depression as a wholly biological condition. Rather, their accounts weave moral and personal concerns and give precedence to the idea that depression is a workload burden rather than a discrete diagnostic category (May, 2005).

Chew-Graham *et al.* (2000; 2004; 2009) also illustrate that working practitioners are conscious of sociological and psychosocial accounts of depression and offer aetiologically diverse explanations of patients' distress. Similarly, the GPs interviewed by Rogers *et al.* (2001) and Thomas-MacLean and Stoppard (2004) demonstrate a similar negotiation of medical and non-medical explanations of depression to that found in lay accounts. These practitioners regarded depression as simultaneously an individual biochemical pathology and a 'normal' reaction to childcare obligations, financial hardship and gender inequality. Likewise, GPs interviewed by Maxwell (2005) claim to diagnose depression using knowledge of individual patients and their socio-cultural contexts, rather than just by

reasoning about their medical symptoms. Thomas-MacLean *et al.* (2005) contains similar findings, with some GPs reporting resistance to the use of diagnostic checklists developed in psychiatry, and a preference for 'spending time' and 'listening' to a patient in order to arrive at a diagnosis. Practitioners in Dew *et al.* (2005) claimed to use diagnosis strategically and would avoid an explicit diagnosis of depression if it was expected to be resisted or unhelpful for particular patients. Other research suggests non-diagnosis is used strategically for the GP's benefit; Burroughs *et al.* (2006) and Chew-Graham *et al.* (2009) quote doctors who claim to be reluctant to diagnose or even inquire after their patients' feelings if they believe there are few appropriate treatment options available.

Even when a diagnosis of depression is provided, GPs may not continue to regard patients as medically unwell. McPherson and Armstrong (2009), in particular, found a clear tendency for GPs to demedicalise patients' depression if they were unresponsive to antidepressants. In the face of ineffective biomedical treatment, GPs reconstructed patients' unhappiness in terms of their flawed personalities and explained their prolonged misery as a form of social deviance, thereby detaching the label 'depression' from any underlying physiological pathology. As in Chew-Graham and colleagues' studies, McPherson and Armstrong's GPs also recounted feelings of hopelessness and frustration towards patients who were unaffected by antidepressants and yet remained expectant of effective medical care.

Strategic non-diagnosis, eschewal of diagnostic instruments and social and moral reasoning about patients all suggest that the treatment of 'depression' reveals the limits of the medical paradigm in which GPs have a mandate to operate (Roberts, 2004). As Thomas-MacLean and Stoppard (2004) emphasise, neither medical training nor the structure of the healthcare system are designed to facilitate the treatment of depression as a socially-determined problem, no matter how much patient and practitioner experience may highlight its necessity.

When practitioners do attempt to move beyond the limits of conventional medical care this can be in the form of suggesting patient ‘homework’ such as lifestyle changes or joining social groups, helping with social welfare applications or taking up patients’ problems with their family members (McPherson & Armstrong, 2009; Thomas-MacLean & Stoppard, 2004). Although such pragmatic interventions are viewed favourably by patients, they require GPs to step beyond the conventions of evidence-based working and patient confidentiality that govern normal practice and take an authoritative role in matters where they have little or no professional jurisdiction. Alongside these examples of practitioners working beyond their professional mandate, there are equally frequent reports of doctors’ frustration with patients and the paucity of services to which they can be referred. The absence of straightforward medical treatment for structural causes of depression also leads GPs to describe an undesirable reliance on antidepressant treatments as a means of offering patients some relief (Chew-Graham *et al.*, 2002; Maxwell, 2005; Russell & Potter, 2002).

The tension between medical and non-medical approaches to depression manifest in the professional narratives discussed above clearly signals that the frontline diagnosis and treatment of depression are more complex than a purely medical conception implies (Maxwell, 2005). Any model which solely emphasises biological or social causation appears unlikely to sufficiently explain and treat the range of human suffering labelled and experienced as depression (Lewis, 1995). This foregoing research suggests that GPs require a ‘therapeutic flexibility’ (Pilgrim & Bentall, 1999: 272; Byng, 2012) to respond sensitively to the distress of individuals in different circumstances, explore the sources of their unhappiness and use such investigation as a guide to their treatment.

2.2.4 The linguistic study of depression

Despite the recurrent theme of difficult or mis-communication in depressed patients' lives, there is a scarcity of research engaging in detailed linguistic analysis of patients' and professionals' talk about depression (though see Stoppard, 2000 and Galasiński, 2008 discussed below). For example, while Kessler *et al.* (1999) investigate the sources to which patients attribute depressive symptoms and its effects on diagnosis, they do so only in the form of questionnaires rather than scrutinising the interaction occurring inside the GP's office. Similarly, although Thomas-MacLean and Stoppard (2004) discuss the metaphors used by doctors to explain depression, their analysis remains superficial, occasionally inaccurate and is at most peripheral to their study.

Nevertheless, there is good evidence to suppose that accounts of both depression and anorexia will be amenable to study through informed linguistic analysis. Chronic illness has profound effects upon the identities of sufferers and it seems reasonable to assume that the negotiation of personal identity and the meanings that individuals ascribe to their conditions will be encoded in their verbal interaction (Stoppard, 2000). Galasiński (2008), for instance, demonstrates that male patients utilise grammatical structures to present depression as a distinct discourse participant that is separate from themselves. This separation, he argues, allows men to verbally distance their own identity – and particularly their sense of masculinity – from the stigma of mental illness (see chapter 5). Similarly, the language used by healthcare professionals will be pivotal to how diseases and patients are constituted during real consultations and, as in the present thesis, during group interactions. Accordingly, the detailed analysis of mental health communication provided in the present study is intended to illuminate aspects of patients' and professionals' experiences that may be overlooked in less granular analyses of content. A focus on the linguistic features in speakers' accounts also

allows insight into the social and cultural discourses that are used by speakers to ascribe meaning to depression and anorexia and to construct patient and professional identities in specific contexts (Stoppard, 2000).

2.3 Medicalisation: Introduction

As the foregoing examinations of anorexia nervosa and depression have demonstrated, research in the medical humanities and social sciences has repeatedly challenged the authority of scientist, biomedical explanations of health and illness. Explicitly or otherwise, this research is largely oriented in opposition to medicalisation, that is, to the expansion and cultural dominance of medical understandings of the human body and embodied experiences. The following sub-sections expand upon the concept of medicalisation, the historical context of its emergence and influence on contemporary society, and its relevance to the present study. This section will adopt a social constructionist approach to medicalisation, with the belief that understanding the social processes involved in the generation of medical knowledge can help us evaluate its therapeutic use, potential shortcomings and practical implications (Conrad, 1992).

2.3.1 Defining medicalisation

The twentieth and twenty first centuries have seen undoubted progression in medical science and its faculties to prevent, control or even wholly eradicate disease. As a result, developed healthcare services now utilise increasingly sophisticated means to sustain life far beyond humanity's previous capacities. My intention is not to undermine the value of these advances but rather to present research in support of three related propositions. First, that the development of medical science has occurred alongside the expansion of the scientific medical paradigm into previously non-medical areas of life; a process of medicalisation. Second, that developments in healthcare sciences and their use are not confined to the

medical clinic and its technologies. Rather, and thirdly, the process of medicalisation impels lay individuals to understand themselves in ways shaped by medical science.

Recent research on medicalisation has been extensive, such that the term itself has come to refer to a number of processes occurring in different contexts. The range of activities through which medicalisation can be realised is captured by Conrad's classification as 'defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to "treat" it' (1992: 211). More recently, Rose discusses the effects that medical developments have on lay individuals, regarding medicalisation as a process by which people come to 'describe themselves in the language of health and illness, question themselves against medical criteria of normality and pathology, take themselves and their mortal existence as circumscribing their values' (2007: 700). Inherent in both of these descriptions is the contention that medicalisation involves a reconceptualisation of phenomena from a non-scientific folk paradigm into the practices and epistemology of medical science.

Medicalisation is driven by and reflected in activities at various levels of social organisation, from the macro level of government public health policy and the structures of the healthcare system; the institutional level of functioning hospitals and medical education; the micro level of self-identity and interpersonal communication; and finally a conceptual level defining which behaviours can be properly considered as relevant to medical practice (Brown, 1995). The different strata at which medicalisation occurs are necessarily interrelated such that broad alterations to the political and cultural landscape refract into the micro levels of patient and professional communication that are the focus of the present study. Thus, while macro processes such as the market dominance of self-interested pharmaceutical companies are both

worrying and eminently worthy of study, the interest of this review is to show how these changes impact upon the practices of individuals inside and outside of clinical settings.

2.3.2 Conceptual and institutional medicalisation

The growing number of diagnosable medical pathologies established during the twentieth century offers prima facie evidence of a medicalisation process. For example, the *DSM-II* (1968) contained 182 mental pathologies compared with 265 in the *DSM-III* (1980) and 297 in the *DSM-IV* (1994). Whilst such increases reflect advances in diagnostic technologies and refinements in nosology, they have also been characterised by an expansion in the parameters of medical pathology to include formerly non-clinical aspects of life. Conditions such as restless legs and snoring and life events such as hair loss and menopause are now categorised as medical problems with recommended medical treatments. This extension of the medical gaze provides the conditions for individuals to reconceptualise previously normal facets of their embodied lives in terms of pathological biological characteristics requiring medical explanation and treatment (Blech, 2006; Moynihan *et al.*, 2002).

At the institutional and conceptual levels, Mizrachi's (2002) research reveals how professional and organisational pressures have influenced the criteria for 'acceptable' scientific knowledge on anorexia nervosa. Mizrachi's meta-analysis of articles in a leading peer-reviewed journal over a forty year period demonstrates that studies which reconfigured psychological aspects of anorexia into quantifiable variables and which made use of statistical analyses were increasingly prioritised for publication over non-statistical submissions. This entailed the under-representation of research that located anorexia in a qualitative, socio-psychological context and a preference for publishing 'standardised knowledge and verifiable results [that was] essential for the success of *Psychosomatic Medicine* as a legitimate medical journal' (2002: 485). This bias towards certain types of

research concomitantly narrowed the range of relevant scientific knowledge about anorexia, emphasising biological and psychological factors and excluding socio-cultural factors from the clinical model of anorexia. Mizrachi argues that by censoring qualitative studies, the editors of the journal were able to safeguard the scientific concept of anorexia from competing explanations offered by contemporary socio-cultural theories and thereby protect their own professional authority (2002; Porter, 1995).

As a practising therapist, Guilfoyle (2001) claims that a comparable professional defence occurs during the psychotherapeutic treatment of bulimia. Where patients challenge the psychotherapist by emphasising social or cultural explanations of their eating, therapists must attempt to reconstruct this resistance as an aspect of the patient's pathological psychology. By shifting the patient's perspective so that they reinterpret their political resistance as an aspect of their eating disorder, the patient becomes amenable to the professional-led therapeutic process. Psychological theory is thus employed to disarm patients' socio-political explanation of bulimia that could otherwise undermine the professional therapist. Guilfoyle also argues that this psychologising process is not confined to the clinic. Instead, psychological concepts are increasingly pervasive in lay understandings of the person, such that we see ourselves as 'psychological beings' (2001: 157).

Mizrachi and Guilfoyle's work highlights two features of the medicalisation process. Firstly, both medical research and therapeutic practices do not reflect the rational and impartial development and use of scientific medical knowledge. Rather, medical knowledge is inexorably tied to the politicised contexts in which it is generated and deployed and which undermine claims of rational neutrality in healthcare provision. Secondly, medical science and contemporary healthcare privilege certain conceptualisations of disease over others. As suggested in sections 2.1 and 2.2, historically these conceptualisations have underrepresented

social-cultural aspects of patients' lives or attempted to resituate them within personal psychology, a process that has led to long-standing accusations of explanatory reductionism (Engel, 1977). As the scope of medical knowledge encompasses ever-more aspects of our embodied existence, the range of physical and mental changes falling under this clinical spotlight similarly expands. As Guilfoyle's work indicates, lay patients may also adopt this medical perspective and view themselves and their health and illness through a medical or psychological lens.

2.3.3 Medicalisation at the macro-social level

At the macro level of health policy, Armstrong (1983) provides evidence that the expansion and reorganisation of public health care has driven forward a pervasive medicalisation of British society. Armstrong cites the establishment of community health dispensaries in the eighteenth century as a point at which medicine moved out of the hospital and into the general public. Rather than treating the physical symptoms of individuals in hospitals, the new community-based public health conceived of disease as the result of social interactions and shifted the gaze of medicine outside of the hospital and onto sexual relations, pathological childhood personalities and their relation to supposedly 'feckless mothers' (1983: 18). Armstrong also highlights the shift in early twentieth century medical psychiatry from treating the mentally ill to examining potentially pathological aspects of human life in order to maintain the health of the 'precariously sane' (1983: 26). As a consequence, children are now evaluated throughout their education and examined by educational psychologists, and GPs offer advice on correct parenting in an effort to prevent mental disorder late in life. The establishment of comprehensive healthcare in Britain in 1948 subsequently linked together previously disconnected aspects of public health from GPs, school clinics and

hospitals, extending the medical gaze throughout a person's life and recording them through individual medical records extending from before birth until after death.

Austin (1999) argues that the subsequent development of quantified measurements for the content of food and the establishment of normative body size criteria have scientifically validated the categorisation of individuals as pathological in terms of weight and diet. The saturation of public health literature and government health policy with concepts such as BMI, recommended calorie intakes, 'Five-a-Day' stipulations and messages of personal responsibility (see DoH, 2004) have propagated a biomedical model of normative eating amongst the populace and habituated concern with food and weight. In doing so, public health messages have warranted existing cultural concern with dieting and body shape and the 'popular moralistic notion that overweight is the result of laziness' (1999: 245-262). This conflation of health and morality is evident in lay descriptions of illness as a matter of personal blame (Hughner & Schultz Kleine, 2004) and of self-indulgence and lack of personal discipline as reasons for becoming ill (Lupton, 2003). In much the same way as Bordo (2003) contextualises the prevalence of anorexia against a cultural climate of bodily obsession, Austin's (1999) research situates eating disorders in light of cultural medicalisation. The result is to regard eating disorders not just as discrete, individualised pathologies but as deeply connected with public health messages of the value of self-regulation and dangers of dietary fat (Malson, 2008). Thus rather than being an unmitigated success in the promotion of a healthier society, Austin's research suggests public health policy plays a contributory role in the prevalence of disordered eating through its dissemination of scientific advances that reinforce norms of dietary and body management.

2.3.4 Lay medicalisation: Acceptance and resistance

The foregoing review has presented medicalisation is a largely top-down process driven by professional and institutional interests. However, it is important to recognise the complex roles that 'lay' individuals and so-called 'expert patients' play in promoting a medicalised understanding of health and illness (Shaw & Baker, 2004). Increased education, decades of public health information and the availability of medical information online have democratised knowledge such that healthcare professionals no longer have a monopoly on medical expertise (Barker, 2008). Increasing internet access and the proliferation of health information websites has enabled lay individuals to adopt the roles of informed patients and health consumers who can seek out and publicise medical knowledge themselves (Metzl & Herzig, 2007).

Along with exposure to medical concepts information and diagnostic criteria through the internet, media and public health literature, Rose (2006) claims that the recent increase in psychiatric diagnoses and rates of psychotropic drug prescription has radically altered lay people's self-perceptions. Rose argues that the expansion of psychiatry into conditions at the borders of normality and the ostensibly growing prevalence of psychological disorder have made doctors and laymen more likely to interpret behaviour using concepts of psychological pathology. Democratising medical and psychiatric knowledge, he argues

serves to lower the threshold at which individuals are defined, and define themselves, as suitable cases for treatment. It increases the numbers of those who enter upon a 'moral career' as a person suffering from a treatable condition, and reduces the age at which many enter upon this career.

(Rose, 2006: 481)

However, Fox *et al.*'s (2005) pro-anorexia research demonstrates that individuals who define their identities through medical diagnoses can assimilate medical knowledge into existing value systems and utilise characteristically biomedical information whilst simultaneously

rejecting its typical therapeutic use (Rose, 2007; Stoppard, 2000). Fox *et al.* (2005) and Fox and Ward's (2006) studies highlight that the medicalisation of everyday life is by no means complete; although medical concepts have undoubtedly become pervasive in lay understandings of health and illness, this does not entail a blanket acceptance of a biomedical model of disease, a patient identity, or the dictums of public health messages. Instead, lay beliefs come from a range of courses and

do not directly correspond to those of professionals, nor are they watered-down versions of what is taught in medical schools. Lay people form their own perspectives, drawing upon a wide variety of sources not limited to scientific or proven-in-practice dimensions.

(Hughner & Schultz Kleine, 2004: 416)

Medical knowledge is therefore only one of many different discursive resources that lay individuals can draw upon to understand their health and illness. As illustrated in sections 2.1.3 and 2.2.2, patients typically retain a concern for non-biological features of their illness experiences, such as anxiety about the effects of illness on their social, financial and emotional wellbeing (McKague & Verhoef, 2003; Stoppard, 2000). This foregoing work suggests that the lay (and professional) health communication examined in this thesis will be replete with different discourses of health and illness. The growing body of literature into lay medicalisation signals the value of examining whether patient and professional discourse exhibits linguistic signatures signifying an emphasis on the individualised, medical understandings of illness. In light of Austin's (1999) work, the subsequent analysis will also examine whether notions of morality and responsibility attend medical explanations of psychological distress. This in turn encourages a broader analytical concern with the relationships between the use of medical knowledge in talk, the negotiation of responsibility for illness, and patient and professional identities in relation to anorexia and depression.

2.3.5 Implications of medicalisation

Although the discussion above has highlighted some of the effects of medicalisation on public consciousness, it does not clearly establish whether medicalisation can be evaluated positively or negatively. As Conrad (1992) rightly asserts, demonstrating that the diagnosis of a behaviour as a medical pathology is itself the result of complex social and political processes does not mean that the diagnosis is wrong, or, more importantly, any better or worse than alternative explanatory models of human suffering. Indeed, given the astounding capacity of contemporary medicine to alleviate disease we may in fact have good reason to desire medicalisation (Ebrahim, 2002). As such, showing that established medical knowledge is not the product of purely rational scientific research does not undermine the medical perspective since any competing explanations of health, such as those of social and cultural theorists, may be equally socially constructed and partial. Concordantly, a doctor's privileging of biological symptoms over a patient's personal or social concerns does not invalidate the doctor's medicalising perspective. The difference in perspectives shows only that there is a need to understand how medical and non-medical conceptions of health are negotiated in patients' and professionals' interactions and what their implications may be for healthcare practice. As Rose claims, in addition to identifying medicalisation, we must also 'assess the costs and benefits of our thoroughly medical form of life – and of those that offer themselves as alternatives' (Rose, 2007: 702).

The discussion of anorexia and depression in the previous sections suggests that medicalisation may have diverse implications on the experiences of patients and the healthcare professionals with whom they interact. Easter's (2012) patient study indicates that biomedical explanatory models may nullify the volitional stigma of anorexia yet also undermine individuals' own explanations of their condition and invalidate their attempts at

recovery. As noted above, Fox *et al.*'s (2005) findings show that medical expertise is a prominent characteristic of pro-anorexic communities who nevertheless remain opposed to a pathological view of anorexia. For Karp's (1996) interviewees, medicalising their depression as a biologically predetermined condition accounted for their experience of uncontrollable, chronic unhappiness and enabled them to mitigate blame for their illness. However, as in Easter's (2012) work, a biological explanation of mental illness involved accepting the attendant subject position of a passive patient, and devalued non-medical treatments and explanations of misery (Pilgrim & Bentall, 1999; Stoppard, 2000). Karp and Easter's studies both suggest that adopting a medical understanding of mental illness allows patients to construe their condition as beyond their control, distinct from their volitional behaviours, and amenable to medical interventions (see also Epstein *et al.*, 2010).

In practitioner research, Chew-Graham *et al.* (2002) highlight the disconnection between practitioners' beliefs about the non-biological causes of misery and the biomedical treatment of depression through antidepressants. As McPherson and Armstrong (2009) demonstrate, one implication of models of mental illness that emphasise biological causes over social factors is that they restrict the mandate of healthcare professionals to propose socially-oriented interventions, even where these may benefit patients. Standardised medical models of mental illness may therefore 'imperil illness negotiation on the one hand, and curtail local healing opportunities on the other' by precluding non-medical approaches to treating illness (Lee, 1995: 31; Guilfoyle, 2001). These concerns over the medicalisation of anorexia and depression are summarised by Conrad (1992), who is particularly critical of the damaging implications of the 'dark side' of medicalisation and medical culture:

Assumption of medical moral neutrality, domination by experts, individualisation of social problems, depoliticisation of behaviour, dislocation of responsibility, using powerful medical technologies... the medical model decontextualises social problems, and collaterally puts them

under medical control. This process individualises what might be otherwise seen as collective social problems.

(Conrad, 1992: 223-224)

Having reviewed the tensions around medicalisation and medicalised accounts of anorexia and depression, the present study responds to Rose's (2007) call for an investigation of the effects of medicalisation. To this end, the study examines communication in two contexts where medicalisation and its effects could be expected to be manifest. Firstly, I investigate interactions between individuals with anorexia and depression in their respective online support groups, a venue described as a possible 'engine of medicalisation' in contemporary society (Barker, 2008; Conrad, 2005). Secondly, I examine accounts of real and fictitious patients in focus groups of general practitioners. Communication between medical professionals may be anticipated to be replete with medical explanations of illness. However, King and Turner (2001), Chew-Graham *et al.* (2002) and McPherson and Armstrong (2009) suggest that professional talk may balance medical and non-medical descriptions of mental health patients and their psychological difficulties. These discussions therefore offer an apt venue for examining if, and how, professionals negotiate the (de)medicalisation of patients with anorexia and depression. The following chapter addresses the compilation, composition and linguistic interrogation of these datasets in detail.

3 Methodology

3.1 Introduction

The present study adopts a necessarily diverse, multi-modal methodology to examine patient and professional discourses of anorexia, depression and the concept of medicalisation.

Capturing computer mediated communication between patients and face-to-face interaction between clinicians requires gathering written and spoken language from virtual and physical environments, each of which entails specific methodological considerations. These range from the logistics of conducting a study with British National Health Service employees and creating comparable patient and professional datasets to the ethics of online research.

Analytically, the present study combines corpus linguistics, an approach suited to describing large language datasets, with discourse analysis, a heterogeneous qualitative methodology used to foreground the verbal negotiation of ‘anorexia’ and ‘depression’ in the data.

In order to explicate these different methodological facets, the following sections present an overview of linguistic approaches to the study of healthcare and the recent uptake of corpora in this field. The details of corpus linguistics are then outlined, as well as the debate over its disciplinary status. In order to situate the present study’s second analytical position, I then propose the methodology of critical discourse analysis as a theoretical framework for connecting linguistic evidence to wider aspects of social structure such as medicalisation.

This is followed by the examination of several pressing criticisms levelled at critical discourse analysis. The subsequent discussion of corpus-based critical discourse analysis offers a rejoinder to these criticisms, and illustrates how this methodological synergy is applied in the subsequent chapters. Section 3.6 provides details of the Mental Health Discourse Corpus (MHDC) on which this study is based, and the practical issues involved in its collation and analysis. In the final section of this chapter, I outline salient issues in the

contested ethics of studying online communication, before offering my own position in this debate.

3.2 Linguistic approaches to healthcare

As part of the wider fields of health humanities and medical sociology, the study of health communication has generated a large body of work which describes the language through which healthcare practice is mediated and achieved. Initial studies in this area focus particularly on the doctor-patient dyad as the paradigmatic clinical encounter, often considering the linguistic means through which physicians enact authority over patients (Mishler, 1984; Ribeiro, 1996; ten Have, 1989). Latterly, the remit of health communication studies has widened to include a range of contexts and genres, including medical case reports and clinical meetings (Francis & Kramer-Dahl, 2004; Poirier & Brauner, 1988), oral examinations for GPs (Roberts & Sarangi, 1996), and pharmaceutical advertising (Scott *et al.*, 2004). Furthermore, the range of healthcare professionals studied in such research has diversified to encompass interactions involving nurses (Crawford *et al.*, 1998), hospital chaplains (Harvey *et al.*, 2008a), telemedicine advisors (Adolphs *et al.*, 2004) and medical students (Da Silva & Dennick, 2010).

Early health communication studies frequently utilised frameworks from conversation analysis to consider the co-construction of the spoken medical encounter on a turn-by-turn basis, often augmenting this microanalysis with critical arguments on medical authority (for example, Fairclough, 1992: 138-149). Whilst analytically rigorous, these purely qualitative studies were limited by their focus on relatively small datasets or single cases that ‘can only suggest possibilities’ of wider trends in health communication (Drew, 2001: 267).

With the pervasive shift towards a culture of quantitative research and evidence based practice in contemporary healthcare, the currency of small scale qualitative studies has

diminished. In response, Skelton and Hobbs (1999a) propose concordance-based analysis as a means of integrating quantitative and qualitative methods of language study. Subsequently, computational corpus methods have been increasingly used in the study of large, diverse collections of health communication data. These studies characteristically combine quantitative descriptions of linguistic features with qualitative assessment of their function and significance in the context of the medical encounter (Harvey *et al.*, 2008). For example, Skelton and Hobbs (1999a; 1999b; Skelton *et al.*, 2002a; 2002b) use a corpus compact of 373 GP consultations to investigate key lexical features of professional and patient discourse. The researchers integrate frequency counts, concordance analysis and collocation scores to demonstrate, *inter alia*, doctors' use of plural personal pronouns to establish collaboration with patients, GPs' metaphorical expressions, and the use of hedges and tag questions to mediate the force of patient directives.

Skelton and colleagues' studies are significant in their investigation of salient issues in contemporary healthcare – such as fostering patient compliance – through the examination of extensive textual evidence. Their use of corpus tools is pivotal to facilitating the identification of linguistic features dispersed throughout datasets that could not feasibly be tackled by manual reading alone. This in turn enables both quantitative and more traditional qualitative analysis of these disparate linguistic features. The present study adopts a similar methodology, utilising corpus tools to investigate professional and patient discussions of anorexia and depression in a corpus of over 366,000 words. Whilst the close linguistic analysis I shall conduct is comparable to that found in existing discourse analytic research, the complementary use of corpus methodologies is intended to support my interpretive claims using greater evidence than is possible in traditional qualitative studies.

3.3 Corpora and Corpus Linguistics

Despite some disagreement within the discipline, a relatively uncontroversial definition of a corpus is offered by McEnery *et al.* (2006: 4-5), who state that a corpus should be:

- **Machine-readable:** Modern corpora are rendered in a digital format that allows them to be read and analysed by computer.
- **Made from authentic texts:** Corpora should be compiled from real spoken or written language, rather than intuited sentences.
- **Sampled:** Texts should be deliberately compiled according to some principled criteria.
- **Representative:** A corpus should be in some way representative of a language or language variety.

Taking these specifications in reverse order; the final criteria, representativeness, results in the characteristically large size of corpora. For example, if we wished to create a corpus of spoken English we could start by recording and transcribing our own talk. Yet this would only result in a corpus of the particular, idiosyncratic English we each speak. To collate a corpus that represents spoken English more broadly we would need to record and transcribe English by people of different genders and geographical locations, and record language from different spoken genres and contexts – radio broadcasts, telesales transactions, political speeches, slurred chat-up lines – resulting in billions of words of data. Given the practical difficulties of such a task, large corpora are created using sampling in order to capture a generally representative collection of data from different registers. The use of sampling (the third criteria) means that larger corpora with diverse sampling frames such as the 100-million word British National Corpus and 650-million word Bank of English can claim to be generally representative of British English.

The use of attested, empirical language data is a core feature of corpus study (McEnery & Gabrielatos, 2006), and one that places corpus linguistics at the antipodes of the rationalist linguistics characterised by the Chomskyan tradition. In stipulating that only those discursive practices which can be intuited by the researcher are analytically relevant, the Chomskyan (1957) disregard for attested data represents a dead-end for empirical health communication research. In contrast, an overriding focus on naturally occurring language rather than native speakers' verbal intuitions grounds corpus linguistics in the social sciences (Stubbs, 1996) and the discipline of applied linguistics, where linguists' work has a fundamental engagement with real-world concerns (Teubert, 2010a; 2010b). The attested data used in corpus research exists prior to and regardless of its investigation by a researcher, permitting repeat analysis and the discovery of linguistic patterns not readily available to intuitions (Carter, 2004). This deliberate engagement with language use in contexts that are unfamiliar to the researcher is of clear relevance to the present study, where descriptions of experiencing and treating mental illness are unavailable to the researcher.

Finally, rendering language data in a format that can be manipulated by computer software provides myriad analytical advantages when using large datasets (Biber *et al.* 1994). Corpus software such as *WordSmith Tools* (Scott, 2007) can quickly, impartially and accurately quantify large volumes of language, identify recurrent collocations and isolate significant differences in lexical frequencies between corpora. Such calculations are carried out automatically, removing the need for laborious manual reading and the risk of a researcher falling into miscalculations when confronted with an overwhelming amount of data (Baker, 2010). Using concordance software, relevant words or strings spread throughout single or multiple texts can be presented together and reordered in numerous ways to facilitate qualitative comparison, with recourse to the wider co-text only a mouse click away. By collating multiple instances of a word or linguistic feature into a concordance, it is possible to

identify lexical, grammatical and semantic patterns that would not be apparent on manual reading or intuition. As a result, concordance-based studies have furnished extensive insights into the linguistic composition of texts (Sinclair, 2003, 2004; Stubbs, 1996).

In light of these analytical benefits, research in corpus linguistics has expanded rapidly in the past twenty years and particularly since the turn of the century. Running parallel to this expansion has been productive criticism and debate over corpus methodologies and the status of corpus linguistics as a field of research. For instance, there remains continued debate over whether corpus linguistics should be principally considered a methodology or a distinct and largely self-sufficient theory (see Worlock Pope, 2010). The debate draws largely on the division between corpus-based and corpus-driven linguistics. As set out by Tognini-Bonelli, corpus-based linguistics uses corpora to ‘expound, test, or exemplify theories and descriptions that were formulated before large corpora became available to inform language study’ (2001: 65). By Tognini-Bonelli’s formulation, the corpus-based tradition regards corpus investigation as a method, or range of methods, for conducting linguistic research into pre- or extra-corpus concerns. For example, Semino and Short (2004) use a specialised corpus of fiction, news reporting and autobiographies to expand descriptions of speech and thought representation originally derived from stylistics. Similarly, Stubbs (2005) and Hunt and Carter (2012) conduct corpus-based stylistic analyses to investigate traditional readings of literary texts.

By contrast, the corpus-driven tradition takes the corpus and the linguistic regularities and idiosyncrasies it contains as the object of study. As a result, corpus-driven research makes sparing use of pre-corpus theories of language. Sinclair (2004: 191), for example, eschews the use of automated part-of-speech tagging programmes to annotate corpora, preferring to interrogate corpus data that is ‘uncontaminated’ by tags whose grammatical foundations lie in

pre-corpus grammatical theory. As a result, observations and theories of language are arrived at inductively from the study of large volumes of corpus data (for example, Hoey, 2005). The corpus-driven approach has pushed forward numerous developments in linguistic theory, particularly in the areas of lexicography and grammar (Biber *et al.*, 1994; 1999; Hunston & Francis, 2000) while demonstrating the role of collocation in semantics has constituted a key advance arising from this tradition (Hardie & McEnery, 2010; Stubbs, 2011).

However, in its strongest form, the corpus-driven tradition seems unnecessarily exclusive, claiming that ‘there is no role in corpus linguistics for theories of language, or explanations of linguistic phenomena, that do not emerge from the study of corpus data’ (Hardie & McEnery, 2010: 286). I would contend that such attempts at methodological purity are flawed for several reasons. Firstly, although corpora are unique with regards to the volume of verbal evidence they offer to support theory, it seems unnecessarily stringent to forego all observations from non-corpus linguistics, particularly from rigorous and expressly empirical frameworks such as conversation analysis. More importantly, without recourse to extra-corpus information, there is a limit to the range of research questions that can be successfully investigated using corpora. Whilst theories of lexicography and grammar can be derived using corpora alone, these theories do not demarcate the limits of the questions we may wish to pursue regarding language use as a social phenomenon. For example, sections 4.7 and 5.5 of this thesis examine linguistic features which, I argue, realise a medical discourse of disease. Doing so requires some theory to mediate between evidence of lexical and grammatical patterns, their significance for establishing a medical discourse, and the relevance of this discourse for the texts’ authors. Were I adhering only to findings derived from corpus study, this connection between textual patterns and their wider relevance would be at best highly speculative, if not outside of the research aims altogether. As a result, the scope and potential impact of the study would be appreciably diminished.

There is thus a risk that, by delimiting the subject and methods of research to corpora alone, corpus-driven studies also circumscribe their utility in the mediation between language and non-linguistic social problems that characterises applied linguistics more widely (Widdowson, 2000). Thankfully, the relationship between corpus-based and -driven research is more of a cline than a pair of mutually exclusive poles and few studies sit at each extremity (Baker, 2010). Instead, corpus studies typically harness developments originating in both of these camps, such as the use of Louw's (1993) concept of semantic prosody – derived from broadly corpus-driven research – in corpus-based discourse analysis (Hardie & McEnery, 2010; see 3.6 below). However, it should be clear from the preceding discussion that the present study adopts a corpus-based approach. Specifically, corpus-based text analysis is used here as part of a broader critical analysis of patient and clinician interactions that is motivated by social issues rather than the nature of language itself. I discuss the basis of this critical discourse analysis below.

3.4 Discourse Analysis

The identification and analysis of 'discourse' has become a significant activity across the contemporary humanities and social sciences (Fairclough, 2002, 2003). As a result of the numerous disciplines examining spoken and written interaction within their own specific paradigms, few terms are now so freighted with meaning as the term 'discourse' itself. For the purpose of the present study, I wish to foreground two distinct interpretations of 'discourse' and its analysis that are taken up in the following chapters. The first construes discourse as any text – spoken or written – above the level of the sentence. As discussed in 3.5 below, corpus linguistic tools facilitate analysis of language at a discourse level by providing frequency information for lexical and grammatical features across whole or multiple texts. In the subsequent chapters, discourse in this sense is also analysed through the

qualitative study of language features across sequences of support group messages, and across different speakers' turns in GP focus groups.

The second, more theoretical understanding of discourse I wish to consider originates with Foucault, who conceives of discourse as not just

groups of signs (signifying elements referring to contents or representations) but as practices that systematically form the objects of which they speak. Of course, discourses are composed of signs; but what they do is more than use these signs to designate things. It is this *more* that renders them irreducible to the language (*langue*) and to speech.

(Foucault, 1969/2002: 54)

The concept of discourse presented here is notably more abstract than that of 'language above the level of the sentence' noted above. In Foucault's view, a discourse transcends the language that is deployed on a particular occasion; it is the active construction of reality through language in a particular context. Discourse is seen as a process of interaction that offers multiple ways of representing the world depending on the configurations of semiotic resources – such as language – that are utilised. Different perspectives on the world are realised through different discursive articulations, allowing for multiple possible constructions of reality through language (Fairclough, 2003: 124). Similarly, the same discourse can also be realised by consistent utterances across different times, locations and authors. A single text may also contribute to multiple discourses that are themselves interrelated. For example, a psychiatric research article may construct mental illness through particular verbal descriptions of the mind and mental states. In doing so, it also contributes to a wider discourse of clinical medicine that normalises particular representations of health and illness, and which itself instantiates wider discourses such as rationalism and empiricism. In this regard, texts are seen to contain and reiterate traces of wider social practices and organisation. When a particular verbal representation is reiterated in a relatively stable, consistent manner, a discourse can become an established and accepted way of viewing the

world. In this respect, Foucault's notion of discourse functions in a similar way to the historical materialist notion of ideology (Mills, 2005: 27). A discourse can therefore be not just a way of representing the world during linguistic interaction, but also become an epistemic resource that influences people's understanding of reality and themselves long after a specific communicative event (Willig, 2000).

3.4.1 Critical Discourse Analysis and Systemic Functional Linguistics

As in the social sciences more generally, Foucault's work has been highly influential in developing research into linguistic interaction and its effects on the construction of social reality. Within linguistics, Foucault's influence is particularly evident in the discipline and practice of critical discourse analysis. Where discourse analysis has been integral to illuminating the characteristics of spoken and written communication, critical discourse analysis (CDA) augments its non-critical counterpart by emphasising the influence of large-scale social organisation on texts (Fairclough, 1992; 2010). In practice, this has meant integrating close textual analysis with an understanding of the social and political contexts in which texts are produced, consumed and enmeshed. Historically, CDA has also scrutinised the language of powerful social actors and institutions and underlined the potential for discourse to normalise negative representations of particular social groups and thereby entrench forms of social inequality (Fairclough, 2001).

Viewed through the lens of Foucauldian CDA, alternative ways of describing the world through verbal choices are believed to reflect different worldviews. As a result, language is seen to be inseparable from ideology. Similarly, language use reiterates and strengthens particular representations of reality as speakers generate, reproduce and solidify normative ways of understanding the world (Blommaert, 2005). By adopting the view that verbal activity exemplifies ideological aspects of meaning-making, CDA reconfigures texts as both

locally important communicative acts and 'sensitive barometers of social processes and change' (Lupton, 2003: 20). Situating verbal interaction in a dialectical relationship with social organisation also leads to CDA's principal contention that 'linguistic analysis ought to be a powerful tool for the study of ideological processes which mediate relationships of power and control' (Fowler & Kress, 1979: 186). This in turn allows CDA to

focus on the level of the concrete, empirically observable, deployment of semiotic means, while at the same time seeing such micro-processes and semiotic features as immediately connected to a wider sociocultural, political and historical space.

(Blommaert, 2005: 74)

By relating local linguistic practices to social organisation, recent work in CDA has sought to examine the ideological influences on language in terms of 'interdiscursivity' (Chouliaraki & Fairclough, 1999), that is, the reiteration of powerful social discourses across different contexts. For example, Fairclough (2010) identifies the language of consumerism in university advertising and contextualises this in terms of the pervasive uptake of market-oriented practices from the private sector to higher education. In demonstrating the appropriation of institutional discourses into new contexts, critical discourses analyses have sought to show that 'such discourses may operate as points of identification, to be taken up, ascribed to, or inculcated by social actors' (Benwell & Stokoe, 2006: 43). In light of the discussion of medicalisation in the previous chapter, this understanding of discourse is clearly germane to the present study. Medical science may constitute just such an interdiscursive discourse, offering socially available ways of representing embodied experiences in terms of medical pathology and organising social roles such as doctor and patient accordingly. Hardin (2003), for example, examines the different discourses available for describing anorexia. Hardin argues that representing anorexia using the lexis of psychopathology serves to place anorexia within the remit of medical professionals, and cues identities of patienthood for those with anorexia. Discourses realised through talk therefore offer ways of constructing

reality and the identities of social actors, and can be used strategically by speakers to, for instance, place responsibility for recovery onto medical professionals (Hardin, 2003).

Working within the field of discursive psychology, Wooffitt (1992) offers a similar conception of personal and social identity as an interactional product. Rather than inhering in static properties such as sex or ethnicity, Wooffitt argues that aspects of personal identity ‘are “achieved” and made salient in day-to-day activities’ (1992: 45; Stokoe, 2003). Wooffitt’s own study examines narrators’ verbal construction of personal reliability whilst recounting questionable events such as ghost sightings. His analysis astutely demonstrates that identity construction is a purposeful social practice used to ‘provide for a certain set of inferable properties about the person and the events so described’ (Wooffitt, 1992: 41-42; Balocco, 2005).

While the analytical practice of CDA often integrates macro-sociological concepts such as ‘marketisation’ or ‘medicalisation’, these concepts are employed in conjunction with detailed linguistic analysis. Analytically, CDA has drawn extensively on Systemic Functional Linguistics (Halliday, 1994). As the name implies, Systemic Functional Linguistics emphasises the simultaneous functions of language as a means to ‘represent aspects of the world[...]; enact social relations between participants in social events and the attitudes, desires and values of participants; and coherently and cohesively connect parts of texts together’ (Fairclough, 2003: 26-27; Halliday, 1994). These three functions – representing the world, enacting social relations and attitudes and organising texts – are classified as the *ideational*, *interpersonal*, and *textual* metafunctions and are realised linguistically through particular lexico-grammatical features (Halliday, 1994).

The ideational metafunction is typically realised by features of the transitivity system, which specifies what is represented in a clause or, as Bloor and Bloor claim, ‘who does what, to

whom, for whom, when, how and why, etc.’ (2007: 183). For example, material processes represent a clause participant as acting in the physical world, often upon a grammatical object. By contrast, verbal processes represent an actor as speaking, often to another (the ‘beneficiary’), and mental processes present an actor as experiencing a mental event such as a thought, belief or feeling. Halliday (1994) also specifies relational processes that indicate attributes and identities of clause participants, such as ‘Kevin is tall’ or ‘John has depression’ (attributive relational processes) and ‘the diagnosis is depression’ (identifying relational process). As Benwell and Stokoe (2006) observe, transitivity choices can be used to represent relationships of power through grammar. For instance, in contrast to mental processes, transitive material processes represent actors as affecting the physical world and encode agency and passivity between the actor and goal of the clause. For example, ‘the doctor (actor) diagnosed (material process) the patient (goal)’ represents the doctor as actively diagnosing the patient, who passively receives the process. Conversely, intransitive processes, which do not have a grammatical object, do not specify a goal that is acted upon. As a result, clause actors in intransitive processes are represented as having less of an effect on the material world. The transitivity system thus offers speakers a range of options for grammatically encoding agency, responsibility, and the relationships between phenomena.

The interpersonal metafunction indicates relationships between speakers and signals the attitude of the speaker to what they are saying. In the present study, examination of the interpersonal metafunction focuses particularly on its realisation through speakers’ use of modality and specifically modal verbs to signal, *inter alia*, certainty, doubt, vagueness, factuality, and obligation towards their propositions. As Fairclough (2003: 166) suggests, modality ‘is important in the texturing of identity [...] in the sense that what you commit yourself to is a significant part of what you are’. The study of modality, therefore, can

demonstrate both how speakers represent themselves as, for example, tentative or certain, as well as their commitment to their ideational representations of anorexia and depression.

Finally, the textual metafunction embodies how the text is organised to create a coherent whole and whether any aspects of information are fore- or backgrounded. The importance of the textual metafunction is demonstrated in Trew's (1979) classic analysis of the use of a passive structure in the headline 'RIOTING BLACKS SHOT DEAD BY POLICE AS LEADERS MEET'. The use of the passive voice in this headline places the agent of the killing, the police, in a less prominent textual position than in an active clause structure, and hence backgrounds their responsibility (see van Leeuwen, 2008). As with the use of transitivity and modality, Trew's analysis demonstrates the imbrication of traditionally grammatical features such as syntax with aspects of semantics and meaning making. The result is to regard every aspect of a text and its textual organisation as contributing to its meaning.

Within CDA, Systemic Functional Linguistics has been used to emphasise that communication involves choices between mutually exclusive linguistic options – between using a transitive or intransitive material process, hedging or categorical modality, an active or passive clause – which carry implications for what meanings are conveyed (Fowler & Kress, 1979). According to van Leeuwen (2008), these linguistic choices are the basis for the analysis of textual discourse. In order to understand the discursive representation of reality, we can investigate 'which options are chosen in which institutional and social contexts, and why these choices should have been made, what interests are served by them, and what purposes achieved' (2008: 33). In parallel with Hardin's (2003) analysis of different verbal descriptions of anorexia, van Leeuwen's assessment highlights that discourse is used to achieve particular ends such as justifying a decision, establishing a social identity or making

others adopt the view of reality we represent. Similarly, Blommaert argues that features of verbal communication

are not only linguistic diacritics, but also *social* ones. They reflect speakers' identities, expectations as to what speakers intend to accomplish in a particular act of communication, elements of wider social structure in which speakers are caught, and so on.

(Blommaert, 2005: 11, italics in original)

Blommaert's description situates language use in a reciprocal relationship with wider aspects of society and culture; language both reflects and discursively produces society and its values. By interpreting discourse in this way, Blommaert emphasises the potential for critical discourse analysis to connect local textual evidence with larger social and political issues that are prioritised in sociological research. The following chapters adopt this theory of discourse to examine the different lexical choices made by speakers when describing anorexia and depression, the implications of these choices for how each condition is represented, and their alignment with interdiscursive discourses such as medicalisation.

3.4.2 Criticisms of CDA

Critical discourse analysis has been the subject of heated criticism, notably from Widdowson (2002a; 2002b) and those working in the field of conversation analysis (Schegloff, 1997; Wooffitt, 2005 and c.f. Wetherell, 1998). These criticisms divide broadly into two themes. Firstly, scepticism over the nature of data chosen for analysis and, secondly, doubts over the validity of critical discourses analysts' interpretations of linguistic features.

Exemplifying the former, Toolan (2002) argues that critical analysts' overt opposition to social inequalities leads them to investigate only those texts believed to encode self-evidently discriminatory values such as sexism, racism or classism. These oppressive discourses are often tied to particular social institutions such as sexism and racism in the media (Fowler, 1991) and consumerism and higher education institutions (Chouliaraki & Fairclough, 1999).

However, discourses do not always align so neatly or so identifiably with organisations such as academic institutions and media outlets. A more interesting form of critical analysis, Toolan avers, would address social practices 'where the politics are complex, and the marginalizations and forms of domination are multiple, sometimes overlapping and sometimes conflicting' (2002: 237). In this respect, the examination of the discourse of medicalisation broaches new ground in critical discourse analysis. By examining the discourse of medicalisation in patients' and professionals' respective group talk, I investigate data rarely used in CDA. Further, I seek to illustrate the implications of a discourse which is neither simply the preserve of social elites nor self-evidently deleterious in terms of naturalizing forms of social inequality.

As an example of the second criticism, Widdowson (2000; 2002a) argues that CDA's explicit commitment to left-wing political aims undermines the interpretative claims made under its aegis. This existing political stance, he argues, encourages the pre-analytical conclusion that traces of powerful, subjugating discourses are linguistically encoded within texts. This results in a preference for interpretations of textual features that suggest such discourses are present, and the attendant suppression of contrasting evidence. Critical analyses, Widdowson maintains,

are shaped and coloured in advance by the discourse processes and wider social processes that they are designed to discover. The analyst preconceives the [textual] data as evidence.

(Widdowson, 2002b: 162)

Widdowson's argument is premised on the notion that the meaning of a text is highly context-dependent and cannot simply be read off from its linguistic features. The lexicogrammatical features of a text, he contends, always indicate a number of possible interpretations from which interlocutors choose in the process of text comprehension (2002a: 141). The meaning of a particular stretch of text is thus underdetermined by its linguistic

features and only fixed contextually by language users during comprehension. Widdowson argues that critical analysts exploit this semantic indeterminacy by privileging those readings which support their political leanings and eschewing other interpretations. This problem of analytical bias is developed further by Verschueren (2001) and Stubbs (2002) who argue that critical analysts' methods of data collection and text selection are seldom explicit, and that analysis is frequently only of isolated or short textual fragments which do not demonstrate discursive structures over large or multiple texts. Altogether, CDA is accused of making partial choices of texts or text fragments and using analysis to demonstrate pre-analytical assumptions about textually encoded political bias. This results in a critical analysis which, whilst surveying broad social power relations, 'is built upon the frailest of text-linguistic foundations' (Toolan, 2002: 230).

A further criticism concerns CDA's interpretation of linguistic evidence in terms of sociological notions of discourse, and specifically how analysts identify particular discourses from textual data. For example, does the text in a magazine advertisement for women's cosmetics contribute to broad discourses of gender or consumerism, and/or narrower discourses of heteronormativity or post-feminism, and on what principled linguistic basis can we decide between these? In short, research within CDA offers little clarification of how to determine whether a textual extract realises one possible discourse rather than another. This argument is made particularly lucid by Wooffitt, who highlights CDA's ambiguity over what constitutes sufficient linguistic evidence for indexing a particular representation of the world. He concludes that

[t]here is a clear lack of consistency [in CDA] as to what counts as evidence for the presence of discourse: it could be a single world [sic], or a short stretch of talk, or a slightly longer account or narrative. This lack of consistency is problematic.

(Wooffitt, 2005: 183)

Thus, despite its claims to relate micro-linguistic structures to larger social practices, traditional CDA has no systematic methodology for identifying the linguistic features that mediate such a relation. The inconsistency with which CDA research connects linguistic events to the discursive ideologies it seeks to criticise raises questions regarding the utility of CDA as a critical endeavour and its mandate for intervening in social practices. Taken together, the criticisms of Widdowson, Verschueren, Stubbs and Wooffitt outlined above indicate clear limitations on CDA and the validity of its claims. The following section returns to the methodologies afforded by corpus linguistics as a means of conducting CDA in the light of these criticisms.

3.5 Corpus-based Critical Discourse Analysis

The present study can be considered a corpus-based critical discourse analysis; a critical analysis conducted on corpus data and which uses corpus analysis processes as a substantive methodological component. In practice, this means mixing the quantitative descriptions of frequency, keyword and collocation calculations provided by corpus software with a granular, qualitative analysis of language characteristic of traditional CDA. This section outlines the characteristics of corpus-based discourse analysis and the keyword, concordance and collocation utilities that are used in the following chapters. In doing so, it also discusses the solutions which these corpus tools offer to a number of the criticisms laid at CDA's door.

Stubbs (2002) contends that critical analyses typically infer characteristics of wider social structures from the analysis of only small amounts of data. In contrast, by investigating large volumes of text, corpus-based CDA is able to marshal large amounts of data to support its interpretations. The present research, for instance, draws upon data from across extended and multiple texts rather than isolated excerpts, and frequently provides numerous instances of linguistic patterns to substantiate readings of the texts and their relation to broader social

practices. Thus rather than analysing only single, short or fragmented texts, corpus-based CDA can uncover verbal traces of ideologies across numerous complete texts and evade the criticism of biased text selection.

Corpus-based discourse analysis characteristically involves a progression from quantitative corpus calculations to qualitative analysis of concordances, their surrounding co-text and situation in interactive contexts (Baker *et al.*, 2008). As a mainstay of such analysis, a keyword calculation offers an initial map of a corpus's salient lexical items based on their relative frequencies when compared with a large reference corpus of general English. The resulting keywords typically represent the lexical and semantic spine of the corpus; those central areas of meaning around which the corpus's texts gravitate and which distinguish them from the language of the reference corpus. The identification of negative keywords – those lexical items which occur with significantly lower relative frequency in a corpus compared with a reference corpus – can also indicate notable absences in a text or corpus; those lexical items which we would expect to find in relative abundance but which appear only sparingly. The absence of particular lexical items and the meanings they encode can signify partial representations that are characteristic of wider discourses. By using automated frequency calculations, keyword analysis provides a method of selecting lexical items for closer scrutiny that is determined solely by what is manifest in the corpus rather than the interests of the analyst. This in turn provides some riposte to Widdowson's (2002) claim that critical analyses selectively examine only those linguistic features which the analyst preconceives to be relevant.

After their identification, keywords can be investigated in their verbal contexts using concordancing tools to enable qualitative, systemic functional analysis of texts in a manner characteristic of non-corpus CDA. As a means of scrutinising multiple instances of a

keyword, concordancing software represents an effective tool for elucidating features of the ideational metafunction such as nominalisations, metaphor and transitivity choices in which keywords participate but which are not readily apparent from frequency information. The concordance programme can also be employed to search out and collate all instances of interesting lexical choices identified during manual reading. This search function offers the researcher an invaluable means of following up analytical intuitions which arise from close analysis.

Corpus-enabled analysis of lexical collocation can also provide a valuable perspective on the discursive structures in a text. Stubbs argues that the consistent co-articulation of particular lexical items around node words indicates 'the associations and connotations they have, and therefore the assumptions which they embody' (1996: 172). In short, the meaning of a node's collocates influences the meaning of the node itself. Louw (1993; 2000) refers to this dispersion of meaning as 'semantic prosody'; semantic associations established through the co-occurrence of collocates. Louw (1993) notes that the primary function of semantic prosody is to express the attitude of the writer or speaker, with prosodies coalescing into positive or negative inflections of a node's meaning. Similarly, Morley and Partington observe that analysis of semantic prosody offers the analyst 'insight into the opinions and beliefs of the text producer' (2009: 140). Drawing on Sinclair (2003; 2004), Hunston (2007) expands upon Louw's claims by arguing that prosodies established through consistent collocation can convey more granular semantic information than just positive or negative attitudes. Prosody, Hunston argues, indicates not only the broad attitude of speakers towards a node word, but also the semantic and conceptual associations it carries. Baker (2006) also highlights the ideological nature of collocation, claiming that collocation indicates 'two concepts have been linked in the minds of people and have been used again and again' (2006: 114; Hoey, 2005). In light of this analytic potential, collocation analysis has come to play a

central role in the identification of discourses in texts (Baker, 2006) and the development of linguistic theory more generally (Sinclair, 2004; Stubbs, 2011).

Concordant with Baker (2006; Baker *et al.*, 2008), I argue that recurrent collocations constitute textual traces of discourses because they establish particular, partial representations of phenomena that are normalised through their constant articulation. Likewise, consideration of colligation – the repeated co-occurrence of a word with a particular grammatical class of words such as determiners or modal verbs – can afford insights into how a discourse object is represented by speakers. As aspects of textual representation, collocation and colligation can also be the site of ideological contest in which differences ‘between socially, ideologically, or historically distinct discourses often crystallize in different semantic prosodies of key lexical items’ (Koller & Mautner, 2004: 223; Orpin, 2005). Discursive struggles over meaning and resistance to dominant discourses can thus be traced systematically to alternative collocation and colligation patterns in texts.

The use of collocation analysis also provides a rejoinder to Wooffitt’s (2005) accusation that CDA presents only inexplicit means of identifying discourses. Echoing Foucault’s assertion that discourses systematically form the objects of speech, Mills suggests that discourses can be ‘detected because of the systematicity of the ideas, opinions, concepts, ways of thinking and behaving which are formed within a particular context’ (2005: 15). As with Foucault, systematicity is central to Mills’ definition: discourses can be identified in language as consistent, systematic choices in the verbal representation of particular phenomena. By identifying frequently co-occurring words, collocation analysis objectively highlights just such systematic verbal representations – that is, discourses – in texts (Baker, 2006). The provision of corpus frequency information also allows discourses to be quantified in order to adduce dominant and minority discourses in terms of their respective collocation frequencies

across a corpus (Baker *et al.*, 2008). In this respect, corpus-based discourse analysis offers a systematic and transparent method for the identification and classification of discourses instantiated across corpora in the form of collocations and semantic prosodies (Baker *et al.*, 2008; Mautner, 2009a). As a result, collocation analysis is utilised extensively in the following chapters to identify frequent and less frequent patterns in the representations of anorexia and depression.

A final advantage of corpus-based CDA is the simplicity of conducting comparisons between corpora (Flowerdew, 2004). For example, collocations of a salient node in one corpus can be compared with their equivalents in other corpora to identify differences and similarities in how the node word is represented in each corpus. By comparing the language used by members of different discourse communities (such as lay patients and healthcare professionals) in their respective discussion of the same verbal signifiers (such as ‘anorexia’ or ‘depression’), different lexical choices and the discursive positions they designate can be foregrounded (Koteyko, 2006; van Leeuwen, 2008). Such comparisons between relatively large datasets would be unfeasible using non-corpus methods. The availability of large reference corpora also allow for interpretations of particular words or phrases in target corpus to be checked against other examples in other contexts, creating possibilities for triangulating interpretations of corpus data (O’Halloran & Coffin, 2004).

The foregoing discussion indicates that the methodological benefits of using corpora in the analysis of discourse are both manifold and reciprocal. Where CDA is accused of using vague methods of data collection and extrapolating social critiques from short, cherry-picked textual data (Toolan, 2002), corpus linguistics provides explicit procedures with which to organise copious linguistic evidence to buttress interpretations. Keyword and collocation analyses provide previously inaccessible avenues for identifying discourses through

consistent verbal choices, and inter-corpora comparisons offer a means of comparing linguistic interpretations against alternative reference corpora. Equally, where arbitrarily ordered concordance lines remove language from its original co-text, CDA underscores the need to approach texts with a nuanced appreciation of their situated contexts. Finally, combining corpus linguistics with CDA expands the horizons of both disciplines and promotes the methodological innovation and flexibility needed to conduct research into complex social issues (Mautner, 2009a; 2009b).

Nevertheless, it is unclear whether the uptake of corpus methodologies in critical discourse studies nullifies Widdowson's (2000; 2002a; 2002b) contention that CDA offers biased interpretations of favourably selected linguistic features. For instance, although corpus linguistics provides explicit procedures for conducting replicable linguistic inquiry, it does not preclude politically-motivated interpretation and its findings remain vulnerable to accusations of analytical bias. Further, the initial use of frequency and keyword analysis entails that only some lexical items are isolated for investigation even though 'every word in a corpus contributes to the discourse' (Teubert, 2005: 3). As a result, a vast number of other discourse features are neglected and corpus-based critical analyses are inexorably rendered as partial as traditional CDA studies.

While Widdowson's argument is robust, it is surely also defeatist in its outlook. It is, for instance, difficult to imagine any form of linguistic inquiry that would satisfy Widdowson's criteria of impartiality since even analysis of short texts will be non-exhaustive and necessarily prioritise some linguistic features over others. The ensuing examination of patients' and professionals' interactions is no exception to this and investigation of linguistic features not addressed in the subsequent chapters may augment my own findings.

Nevertheless, in interrogating the patient and professional sub-corpora, I adopt corpus methods which make my analysis replicable by further researchers.

With regard to analytical bias, all researchers will approach texts with at least some preconceptions and it follows that no linguistic analysis can claim to be wholly objective, regardless of its formality. Discounting *all* analyses on Widdowson's grounds of partiality neglects the fact that much can be learned even from partial analyses. Instead, rather than objective, dispassionate analysis, corpus-based discourse analysis offers transparent, replicable analytical procedures, automated processes for identifying salient textual features and quantitative information with which to triangulate qualitative interpretations across large datasets. While ultimately dependent on human interpretation, these methodological processes allow corpus linguistics to interrogate amounts of data and 'arrive at general conclusions in an adequate and convincing way without having to understand them as objective' (Blommaert *et al.*, 2001: 6). This quality constitutes an advantage for any qualitative social science research and makes corpus linguistics a strong methodological foundation for the present study.

3.6 The Mental Health Discourse Corpus

The following four chapters examine patients' separate discussions of anorexia and depression, and GPs' separate discussions of anorexia and depression. The data from each of these contexts constitutes of a sub-corpus of the Mental Health Discourse Corpus (MHDC), represented in figure 3.1 below. The sub-corpora divide into two corpora containing online discussions of anorexia and depression by patients and two corpora of group discussions of anorexia and depression between GPs. Details of the compilation of these corpora are outlined in the following pages.

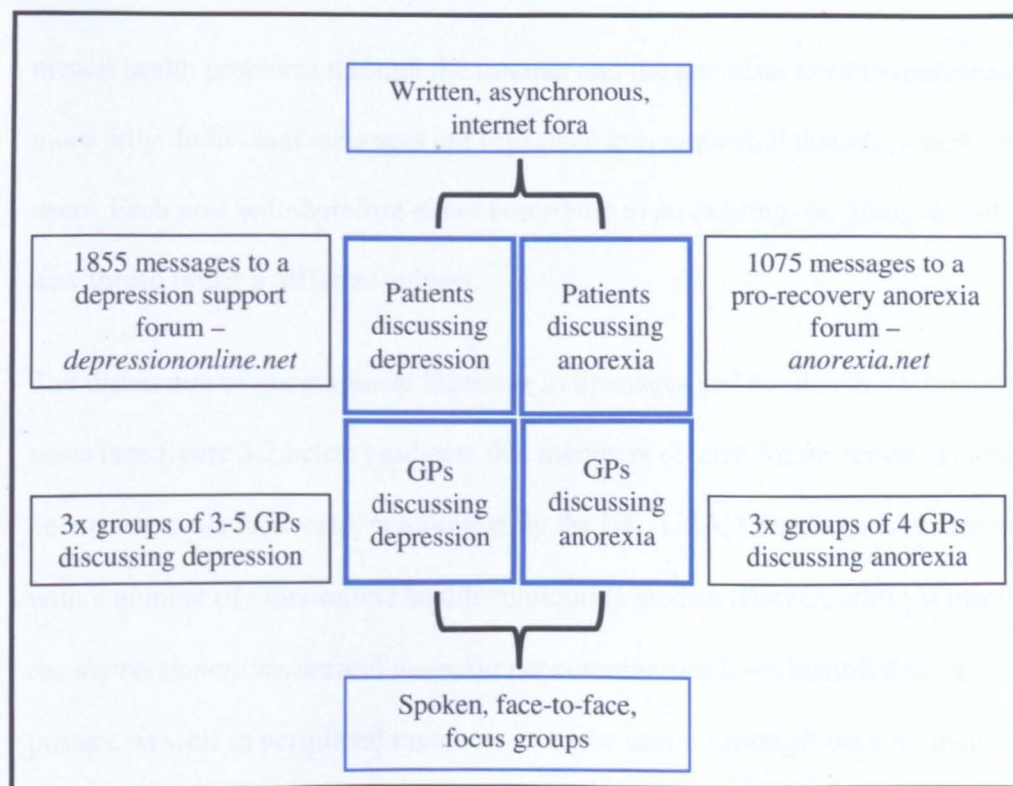


Figure 3.1 – The Mental Health Discourse Corpus

3.6.1 Online patient discussions

The two patient sub-corpora were compiled from message board interactions on two separate websites which offer information and supportive communities for individuals experiencing anorexia and depression respectively. Neither website is allied to a medical or commercial organisation, nor contains prominent content authored by medical professionals. For the purpose of anonymity (see section 3.8.2 below), I shall refer to these websites using the fictitious monikers *anorexia.net* and *depressiononline.net*. Each website hosts asynchronous bulletin boards which users can read and contribute to, and which cover a range of topics relating to anorexia, depression and other mental health conditions. Both websites' message boards are large and have highly active memberships: *depressiononline.net* contains over 40,000 individual messages authored by nearly 900 registered members. *Anorexia.net* has several thousand registered members and supports a repository of over a million messages. This significant volume of data is a clear testimony to the popularity of seeking support for

mental health problems through the internet and the attendant need to understand this context more fully. Individual messages are organised into sequential threads, which are started by users. Each post will therefore either contribute to an existing, on-going thread, or begin a new thread under a different subject.

The discussion of geographical locations in messages and the details accompanying users' posts (see figure 3.2 below) indicate that members of each forum reside in numerous countries across the world, predominantly the UK, USA, Canada and Australia. In keeping with a number of other online health community studies (Barker, 2008; Winzelberg, 1997), the *depressiononline.net* and *anorexia.net* communities have identifiable cores of frequent posters, as well as peripheral members and new users. Amongst the core membership, much discussion serves the function of providing on-going support for emotional troubles, advice on relationship, job and family issues and seeking advice regarding experiences with healthcare providers.

Both websites' fora support several modules – divisions of the forum in which topic-specific messages can be posted. For example, *anorexia.net* contains separate modules for posting messages on anorexia, bulimia and compulsive over-eating as well as modules for discussing sexuality, literature and films. Whilst many if not all of these modules are likely to contain some messages relevant to understanding patient experiences of depression or anorexia, messages were only taken from those modules explicitly labelled 'Depression' on *depressiononline.net* and 'Anorexia' on *anorexia.net*. This was to ensure the respective corpus content was consistently focused around discussion of these conditions. These two modules were both amongst the most active pages on their respective websites in terms of the number of message threads and individual posts within these threads.

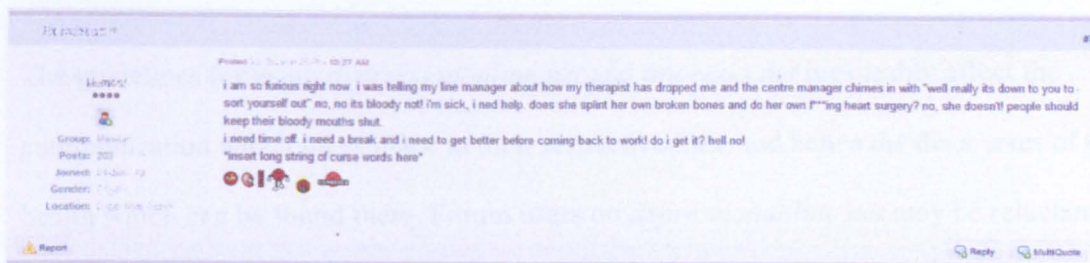


Figure 3.2 – Example message post to depressiononline.net. Details of the author and the date and time of posting have been blurred. The layout of messages on anorexia.net is comparable.

As with many internet communities, posting members are obliged to adhere to explicit forum rules, reached through a link displayed prominently in the forum interface itself. These include generic ‘netiquette’ principles, such as not posting deliberately provocative or inflammatory remarks and not disclosing your address or phone number. The guideline pages of both websites expressly state that their fora are designed to facilitate discussion and are not intended as a substitute for professional medical care. In addition, *depressiononline.net*’s rules proscribe posts that detail methods of suicide on the grounds that forum users are likely to find these upsetting. Similarly, *anorexia.net* prohibits discussion of suicidal ideation as well as a number of eating disorder-specific rules. These prohibit the use of numbers in posts relating to body mass index, weight, calorific intake and frequencies of self-induced vomiting, on the basis that other users find specific discussion of such issues intensifies their own anorexic compulsions. *Anorexia.net* also explicitly proscribes posts that present anorexia positively or encourages others to restrict their own diet. From reviewing other web fora, it is apparent that such guidelines are common to a number of other depression and anorexia websites. In the case of *anorexia.net*, its rules also clearly establish it as a ‘pro-recovery’ site that promotes recovery and support for anorexia as an illness. The site authors thus explicitly situate *anorexia.net* in opposition to the ‘pro-anorexia’ or ‘pro-ana’ websites studied by Fox *et al.* (2005) and Gavin *et al.* (2008). On each website, these rules are enforced by forum moderators who edit users’ messages – for example, by replacing numbers with asterisks – or occasionally delete entire posts.

The guidelines for using *depressiononline.net* and *anorexia.net* inexorably affect the communication which takes place in their respective fora, and hence the discourses of mental health which can be found there. Forum users on *depressiononline.net* may be reluctant to seek help for their own suicidal ideation and use a different website for this. Similarly, those wishing to discuss anorexia as a life-style choice rather than a serious illness will be prevented from doing so on *anorexia.net*. The decision to use a pro-recovery anorexia forum was made in order to enable comparisons between the patient and professional discussions of eating disorders. That is, since both healthcare professionals and pro-recovery website users seek to alleviate eating disorders, identifying points of similarity and divergence in their conceptions of anorexia is intended to offer clear basis for improving healthcare practices.

In order to protect the anonymity of the forum participants, I opted to compile the corpora from online fora which utilise 'bot' programmes to prevent messages posts from appearing in internet search engine results (see section 3.8.1-2). As a corollary, the bot programmes also inhibit the automated extraction of forum messages. Consequently, the corpora needed to be compiled manually through a process of copying and pasting messages into a text file. Whilst this appreciably increased the time taken to compile each corpus, the copying process did offer an initial opportunity to familiarise myself with the forum data and generate initial ideas for analysis.

To compile the corpora, messages posted to *anorexia.net* during a four-month period were copied to text files, organised by message thread. This provided a total of 1074 posts and over 155,000 words. Due to the website's smaller membership, the same sampling method applied to *depressiononline.net*'s forum resulted in a much smaller corpus. As a result, it was necessary to sample messages from *depressiononline.net* from an eighteen month period to compile a similarly sized corpus (see table 3.1 below).

Table 3.1 – Summary of the patient sub-corpora

	<i>Anorexia.net</i>	<i>Depressiononline.net</i>
Total threads sampled	71	150
Total posts	1074	1855
Mean posts/thread	15.13	12.37
Total words	155600	169791
Mean words/post	144.88	91.53

As is apparent in figure 3.2 above, each message post is accompanied by a substantial amount of textual data that provides details about its author and the time and date of its posting. This peripheral data is ancillary to the discussion of anorexia or depression in each corpus and would appreciably affect frequency and keyword calculations for each corpus. Consequently, only the substantive content of each message was used to compile the two patient corpora, though the peripheral data could be recovered by viewing the original web pages when necessary.

3.6.1.1 Spelling standardisation, emoticons and representing online discourse

Corpora derived from online communication present a number of challenges for automated corpus analysis (Claridge, 2007; King, 2009; Mautner, 2005). The different national varieties of English spoken by internet users and abiding potential for typographical errors in written communication result in a number of spelling inconsistencies throughout each corpus. Compounding this is the profusion of easily misspelled medical jargon and the simulation of spoken language forms through non-standard spelling in online communication (Baron, 1998). The result is a potentially ‘dirty corpus’ which, whilst containing much usable data, is also replete with orthographic variations (Kilgarrieff & Grefenstette, 2003: 342). Leaving these alternative spellings unaddressed has the potential to skew the frequency and keyword calculations which constitute points of analytical departure in chapters 4-7. For example, the

depressiononline.net corpus contains sixteen instances of *counsellor*, but also four instances of *counselor*, two instances of *councillor* as well as *counciller*, *counciler*, *counciller*, *councillor* (one instance each), and three uses of *counsellors*. An analyst considering the frequency of only the most common spelling, *counsellor*, would therefore overlook 38% of the total references to this professional role. This contingency necessitated the manual survey of frequency lists for each corpus to identify spelling variations which could be lemmatised and treated as the same word in subsequent calculations. Manual lemmatisation was conducted as thoroughly as possible in order to derive more accurate frequency data, particularly for orthographically complex words such as *counsellor* and *dietician* and predictable misspellings such as missed apostrophes on contractions such as *dont* or *cant*. This manual correction undoubtedly increased the precision of the subsequent quantitative analyses performed on the corpora.

As figure 3.2 indicates, forum posts also involve use of pictorial or animated emoticons. These rebuses are an attested feature of online communication designed to emulate prosodic and physical indices of emotional states and interpersonal relations in spoken discourse (Werry, 1997; Wright & Bell, 2003). Emoticons are not currently amenable to corpus analysis and, as such, they are not considered in the following analysis chapters. The restriction of corpus analysis to purely textual features demonstrates a limitation on text-based corpus software and its potential for investigating discourse in multi-modal contexts (Koller & Mautner, 2004; Mautner, 2009a). However, I would argue that the emoticons have a largely subsidiary function to the exchange of information in the fora, often repeating visually what is explicit in the adjacent text rather than conveying new information (Claridge, 2007). Further, the present investigation is primarily concerned with discursive constructions of anorexia and depression rather than the negotiation of interpersonal relationships online, for which an analysis of emoticon use would be more germane. Whilst presenting a

potentially rich resource for the study of computer-mediated pragmatics, these features thus fall outside of this present study's health communication remit.

Both *depressiononline.net* and *anorexia.net* utilise comparably simple interfaces relative to many Web 2.0 websites. The overwhelmingly text-based format of the fora's interactions makes them well-suited to compilation as text corpora. For example, with the exception of the aforementioned emoticons, neither website permits images, adverts, sound or video to appear in messages and *anorexia.net* prohibits users from posting hyperlinks to external webpages. Whilst links are permitted on *depressiononline.net*, forum members use them sparingly and they appear only 4 times in the sampled threads. These links lead to the website of the seasonal affective disorder association (www.sada.org.uk/), an online shop for nightlights (www.lumie.com), a *Wikipedia* page on psychoanalysis (en.wikipedia.org/wiki/Defence_mechanisms) and a webpage on keeping guinea pigs. Mautner (2005) suggests that the presence of hyperlinks disrupts the linearity of the texts which web users encounter, since readers can pursue any number of hyperlinks before returning to the original webpage. This poses the question of whether the storage of hyperlink-rich webpages in linear text files accurately reflects how online texts are encountered by their original users. By contrast, the minimal presence of external hyperlinks on *depressiononline.net* and *anorexia.net* encourages users to read message threads in a linear fashion. Whilst it may be that forum users are simultaneously browsing multiple message threads or websites through different windows, evidence of these browsing behaviours cannot be obtained from the forum interfaces. Instead, the composition of the patient corpora directly reproduces the manner in which each website organises users' contributions into threads of sequential messages. The linear nature of the patient sub-corpora therefore accurately reflects the way in which forum users' produce interactions and a probable (albeit not the only) way in which they consume them.

3.6.2 Verbal GP discussions

The professional communication sub-corpora are composed of spoken conversations between practising GPs. The design of the spoken sub-corpora is the result of sustained collaboration with experts in the fields of mental health and primary care practice. The decision to focus on primary care clinicians was made in conjunction with Dr Navjot Bedi, consultant psychiatrist for Nottinghamshire NHS Trust's Eating Disorder Service, and Dr Dick Churchill, a practising GP with a special interest in mental health and clinical associate professor at the University of Nottingham Medical School. Whilst I had initially intended to investigate the interaction between counsellors and psychiatrists who manage cases of anorexia and depression, Dr Bedi indicated that far less was known about general practitioners' attitudes towards eating disorders. This was confirmed by Dr Churchill, who claimed that eating disorders remain an area of practice where general practitioners feel uncertain (see Ford *et al.*, 1997; Reid *et al.*, 2010b; Russell & Potter, 2002). Dr Churchill also indicated that primary care would also be an apposite context for investigating professional discourses of depression because the majority of patients diagnosed with depression are treated in this context. In light of the apprehension felt by GPs towards the management of patients with eating disorders, Dr Churchill questioned the likelihood of securing clinicians to participate in one-to-one interviews about managing anorexia (Asch *et al.*, 2000). Instead, he proposed group meetings between collegiate doctors as an alternative venue of data collection. As well as increasing the chances of participant recruitment, the use of group conversations also provides greater parity between the professional and patient sub-corpora, each involving the negotiation of meanings between established peer groups.

Dr Churchill also suggested the use of hypothetical patient cases to stimulate discussion and to keep the subsequent conversations focused on depression or anorexia (see also Dew *et al.*,

2005). The hypothetical patient scenarios (see sections 4.1 and 5.1) were co-authored by Dr Churchill and myself and were designed to encourage discussion of issues emerging in existing literature and from preliminary analysis of the patient corpora, as well as issues suggested by Drs Bedi and Churchill. Specifically, each discussion stimulus describes two patients, the first with a borderline diagnosis of either depression or anorexia and a second with chronic depression or anorexia.

Research access to NHS sites – and hence to GPs – is dependent upon prior approval from local NHS Research Ethics and Research and Development committees. Applications for approval by these committees were undertaken and ethics approval was granted by the Nottingham Research Committee 1 in December 2010. Research and Development approval was granted by Nottingham City PCT R&D department in February 2011. The process of application to NHS ethics and R&D boards is a significant one, requiring negotiation of a system primarily intended for studies involving clinical trials with patients, rather than small-scale, low-risk qualitative projects. As the scope of this research falls outside of current National Institute for Health Research priorities, I was also unable to utilise the local primary care research network to assist in the recruitment and conduct of the study. Whilst I am conscious of the need to maintain the highest ethical and professional standards in healthcare research, there is a risk that the current application process may be prohibitively complex for small, non-clinical research teams with limited experience of NHS systems. Conversely however, the complexity of the application process may inadvertently encourage collaboration between academics and medical professionals who are familiar with NHS processes. As a corollary, healthcare professionals will be involved in research planning from an early stage, which increases the likelihood of research that responds to the needs and expertise of the participants themselves.

Following ethical and R&D approval, written participation invitations were sent to primary care practices in the Nottingham City primary care trust. Recruitment to primary care research is notoriously challenging (Bower *et al.*, 2007; Goodyear-Smith *et al.*, 2009; Ward *et al.*, 1999) but is greatly increased if initial contact is made by a fellow physician rather than a non-clinical researcher (Asch *et al.*, 2000). Accordingly, Dr Churchill and I drafted the initial invitation letters in his name. Potential participants were identified from a list of all practices within the Nottingham City Primary Care Trust. A minimum of three participants is needed for focus group interactions and practices with fewer than three GPs were not sent invitations.

Participants were incentivised by highlighting that the group conversations in which data collection would take place would contribute to their bi-annual professional development review requirements (Hoddinott *et al.*, 2007). Following data collection, participants were also invited to take part in seminars in which I fed back the results of the project as a whole. As well as a further professional development incentive for participants, these seminars presented a valuable opportunity for generating feedback with end users, increasing research impact and highlighting further avenues for investigation (see chapter 8.6).

From the original invitees, GPs from three practices agreed to take part in the anorexia discussions and GPs from three other practices agreed to participate in discussions of depression. Data collection took place in the groups' respective practices in order to minimise disruption to their schedules. Following informed consent procedures, participants were each provided with the hypothetical patient information. An audio recorder was then switched on and I left the room. Recordings concluded at the participants' discretion. Audio recordings were transcribed using corpus transcription conventions adopted from McCarthy (1998) to create the two professional communication sub-corpora summarised in table 3.2 below.

Table 3.2 – Summary of the professional sub-corpora

Discussion Group	Participants	Recording Duration	Number of words
Anorexia discussion 1	4	49:35	8952
Anorexia discussion 2	4	24:55	4835
Anorexia discussion 3	4	32:14	6492
Anorexia sub-corpus total:			20279
Depression discussion 1	5	29:30	5619
Depression discussion 2	4	35:42	6647
Depression discussion 3	3	45:59	8334
Depression sub-corpus total:			20600

3.6.2.1 GP discussions as focus groups

As an instance of semi-structured interaction between multiple participants, the clinician discussions are a form of focus group-based data collection. Although still less widely used than interviews, focus groups have become a popular research methodology in studies of primary care and, increasingly, linguistics (Kitzinger & Barbour, 1999; Macnaghten & Myers, 2004).

Besides the anticipated difficulty of recruiting GPs for interviews mentioned above, focus groups carry a number of advantages for discourse analytic research. In a review of focus group studies used in primary care research, Wilkinson (1998) argues that group interaction is particularly apt for exploring difficult, complicated or taboo subjects because participants are more willing to express socially undesirable opinions in a group compared with one-to-one interviews. For example, primary care clinicians participating in Russell and Potter’s (2002) focus groups admitted having difficulty in the diagnosis of depression and an undesirable reliance on medical treatments over inaccessible specialist treatments such as CBT. Similarly, Lester *et al.* (2005) conducted focus groups with primary care professionals, finding that GPs

believed they lacked sufficient specialised skills for dealing with serious mental illness and were concerned more with stabilising patients than leading them to recovery.

Wilkinson also suggests that focus groups provide researchers access to the idioms, vocabulary and 'ethno-concepts' (1998: 334) that are used internally by groups of participants but which would be hard to access in dyadic interviewer-interviewee talk. The use of focus groups rather than interviews also ensured that the participants did not orient to the researcher as a discourse participant and prevented the turn-by-turn construction of the research data by an interviewer (Mann, 2010). By minimising verbal contributions from the researcher and maximising participants' input, focus groups can allow participants to develop their own topics of discussion, reveal normative understandings held by individuals and groups (McNaghten & Myers, 2004; Wilkinson, 2004) and stimulate discussion of the implicit assumptions behind them (Bloor *et al.*, 2001). In this respect, they constitute a valuable resource for discourse analytic research, particularly that intending to explore conceptualisations of specific issues. As Wilkinson avers,

[f]ocus group interactions reveal not only shared ways of talking but also shared experiences, and shared ways of making sense of these experiences. The researcher is offered an insight into the commonly held assumptions, concepts, and meanings which constitute and inform participants' talk about their experiences.

(Wilkinson, 1998: 335)

Bloor *et al.* (2001) suggest an optimum focus group size of six to eight participants, though report studies involving between three and eight members. In this respect, 3-5 GPs per discussion represents comparatively small groups sizes. The group sizes in the present research were largely determined by the practical difficulty of securing simultaneous participation from large numbers of GPs working at the same practice. However, Bloor *et al.* (2001) also argue that small groups can be preferable where participants are knowledgeable about the discussion topic, as is the case in the present study. Further, Morgan (1992) claims

that using small groups in primary care research can precipitate intense, detailed discussions in which each individual's views are explored more fully than is feasible in larger groups.

The present research utilises existing social groups of co-working GPs and contrasts in this regard with studies which bring together strangers for focus group discussions. My decision to use existing peer groups of GPs was made in response to expectations about the interactions and the inevitable practical parameters of the research. Besides the logistical difficulties of communing GPs from disparate practices, I was concerned that using clinicians unfamiliar with one another would prompt participants to simply voice best practice guidelines for managing the hypothetical patients rather than explore personal experiences and nuances of patient care. Co-working GPs are also likely to have previously discussed problematic cases. Patient-based group discussions therefore offer a clearer parity with their existing interactional routines and thus reduce the artificiality of the data collection scenario. Using groups made up of peers with existing relationships was also anticipated to encourage mutual questioning and criticism of other participants' views where necessary. This is confirmed by Macnaghten and Myers (2004; Myers & Macnaghten, 1999) who draw parallels between focus groups and everyday conversation and argue that focus groups function better with participants who already have 'well-developed routines for talking to each other' (2004: 69). Similarly, Bloor *et al.* (2001) suggest that while strangers may avoid explicit disagreement, participants with established relationships may be more willing to challenge one another and highlight discrepancies between others' expressed attitudes and their previous behaviour. As such, discussions using existing groups may encourage more rigorous topic dissection and the expression of group norms that are the subject of this research.

The use of small, pre-existing groups of participants also affects the degree of direct involvement required by the researcher. Whereas focus group discussions are ordinarily guided by a facilitator responsible for managing turn-taking and topic change, this study's focus groups used only the patient vignettes to prompt initial discussion. The subsequent interactions were determined by the participants themselves. As such, they represent a 'hands-off' approach to group management, a strategy which carries the risk of discussion shifting far from the research concerns (Macnaghten & Myers, 2004). However, Morgan (1992: 183-188) recommends 'self-managed' groups in cases where groups are small and pre-existing, participants have an interest and experience of the discussion topics and only a small number of specific issues are covered, as is the case here. Crucially, using smaller, unmoderated groups also dramatically reduces my own direct co-construction of the MHDC discourse, allowing the content of the corpora and the representations of anorexia and depression therein to be largely determined by the orientations of the participants themselves. As the two online corpora are similarly free from my own verbal input, the choice not to facilitate the focus groups represents a trade-off between the risk of off-topic or brief conversations between the professionals and a desired symmetry between the MHDC sub-corpora.

3.6.3 Corpus size and representativeness

The corpus of mental health discourse used in this research constitutes a specialised corpus which is in turn compact of four separate specialised sub-corpora totalling 366,270 words. Even by the standards of specialised corpora, this is a relatively small corpus, which raises the question of whether the MHDC is sufficiently representative of electronic patient and face-to-face professional discussions of depression and anorexia nervosa to adequately meet this study's research questions.

Representative corpus design is typically achieved by sampling data based on non-linguistic criteria – spoken and written modes and multiple genres, geographical regions, speaker genders and speech communities – to achieve adequate coverage of all relevant language varieties. However, attempts to compile representative corpora from anonymous online communication are hampered by the absence of speakers' demographic details and because the full extent of language available on the internet is impossible to ascertain (Mautner, 2005). In the absence of such contextual information, I adopted a measure of lexical representativeness based on corpus-internal linguistic criteria. Lexical representativeness of the *anorexia.net* corpus was assessed by adding a fortnight's worth of forum messages to the corpus at a time and generating a keyword list. When the incremental keyword lists stabilised – that is, where adding another fortnight's worth of messages made negligible difference to the resulting keyword results – the corpus was judged to be lexically representative of the forum communication. I then collated a comparably sized corpus of *depressiononline.net* messages, which was also lexically representative in this fashion.

Rather than collate longer posts or those mentioning specific aspects of anorexia or depression, messages were extracted from *anorexia.net* and *depressiononline.net* based only on the date at which I began to copy each forum's threads. This time-based sampling method is the favoured choice amongst electronic discourse researchers (Herring, 2004), allowing the content of the online sub-corpora to be determined by the interests and preferences of the respective forum users during those time frames. This sampling method represents a further attempt to place patients' own voices and concerns at the heart of the research. Given the vast number of available electronic support communities, the MHDC is unlikely to be generally representative of all the verbal constructions of anorexia and depression available online. However, a principled method for ascertaining when the range of discussions of anorexia and depression available online has been adequately sampled is not immediately apparent. At the

very least, it would require the compilation of a far larger corpus than my own resources permitted. Instead, I opted to compile representative samples from two online communities that were both suited to my research questions and fulfilled my ethical obligation to maintain user anonymity (see section 3.8).

The GP conversations that make up the professional sub-corpora were stimulated using hypothetical patient scenarios. They therefore represent a special genre of professional discourse that is comparable with GPs' discussions of real cases during practice meetings. Compiling a spoken corpus that better represents interactions between GPs from across the country and from a range of different career stages would require a sizeable, geographically dispersed research team with the resources to fulfil multiple NHS R&D applications, and recruit and transcribe the conversations of dozens of professionals. This is, alas, a practical impossibility for a single researcher. The MHDC is thus testimony to the claim that a corpus's size and makeup depend significantly on practical and contextual considerations (Adolphs, 2006; Baker, 2010). For the focus group sub-corpora, the principle constraint on data collection was the number of practices in the authorised research which had three or more GPs that agreed to participate. Participant recruitment thus acted as a limit on the number of focus groups that could be conducted and hence the volume of language data that could be subsequently analysed. Nevertheless, I submit that even the relatively small MHDC can provide insights into patient and professional attitudes towards anorexia and depression. Whilst Sinclair (1991; 2004) avers that the larger the corpus the better, having a corpus that can supply thousands of concordance lines for every query does not guarantee that all these concordances will be investigated. In such cases, the volume of data would defy the time (and patience) needed by a sole researcher to exhaustively investigate the corpus (McEnery *et al.*, 2006). In contrast, Flowerdew (2004) and McEnery (2006) demonstrate that smaller corpora

enable a level of detailed qualitative analysis that would be impractical on a larger corpus. Such a qualitative focus coheres with the tradition of CDA in which I situate my analysis.

Despite its limited word count, therefore, I contend that the MHDC is an appropriate dataset with which to increase understanding of the discourses surrounding depression and anorexia. While discussions involving other health professionals or online communities may illuminate additional constructions of depression and anorexia, the following chapters nevertheless derive novel, empirically-grounded insights into these conditions from the patient and professional sub-corpora.

3.7 Statistical processes

There are a number of available statistical calculations that can be employed when conducting quantitative analyses of corpora and which necessarily affect the subsequent findings. For the present research, keyword comparisons were calculated with *WordSmith Tools 5* (Scott, 2007) using a log-likelihood comparison between the target corpus and the 10-million word spoken section of the BNC. The BNC's spoken sub-corpus was chosen as a reference corpus to offer a counterpoint to the spoken discussions which comprise the GP sub-corpora. Informal computer-mediated communication represents a relatively demotic register and contains a high occurrence of personal pronouns when compared with non-electronic written language (Hewings & Coffin, 2004; Morrow, 2006; Werry, 1996). As such, a spoken corpus is also a suitable reference dataset for the online patient sub-corpora. The highly interpersonal and often emotive nature of illness support group interactions also suggests that the more formal registers in the BNC's written section would constitute a less appropriate reference corpus.

The use of a spoken reference corpus means that examples of medical or technical lexis which pervade all partitions of the MHDC receive higher keyword log-likelihood scores than

if a written or multi-modal reference corpus had been used. For example, the word *treatment* in the *anorexia.net* corpus has a *log-likelihood* of 504.0 when compared with the BNC's spoken section but 242.72 calculated against the entire BNC. However, both of these scores are still highly significant and, given the domain-specific nature of the content of the MHDC, examples of medical or technical lexis would appear in the keyword list when using any non-technical reference corpus (see Scott, 2009).

Collocation analysis was also carried out using a -5 to +5 horizon and with a frequency threshold of $f \geq 5$. That is, collocating words were counted within a ten-word span of the node word and each collocate needed to co-occur with the node five or more times to be identified by *WordSmith*. Due to the non-standard use of punctuation and the high frequency of acronyms in the online data, automated collocation analysis of the patient support group sub-corpora continued over sentence boundaries marked by full stops, and stopped at paragraph breaks. For analysis of the spoken focus group sub-corpora, automated collocation analysis stopped at sentence breaks.

Collocational association is calculated throughout subsequent chapters using a log-likelihood formula. Log-likelihood offers a robust and statistically sophisticated calculation of collocational strength with a readily interpretable result (Manning & Schütze, 1999) and is widely used in computational and corpus linguistics (Evert, 2004). Unlike the z-score calculation available in *Wordsmith*, log-likelihood does not assume a normalised distribution of lexical items over the data (which is unlikely to be the case for most words in a corpus of this size) (Dunning, 1993, cited in McEnery *et al.*, 2006: 216-7). Log-likelihood is also useful for deriving lists of high and low frequency collocates. This offers an advantage over calculating collocational strength using a mutual information statistic, in which the statistical formula privileges low frequency collocates, often proper nouns, over lexical bundles which

appear frequently (Evert, 2004; 2008; Manning & Schütze, 1999). As collocation is used in the following chapters to identify discourses that are instantiated as frequently repeated lexical patterns, it would therefore be inappropriate to adopt mutual information as a default measure of collocation. Indeed, the analysis in sections 4.4 and 5.2 below suggests high frequency grammatical collocations foregrounded using log-likelihood are instrumental in the particular presentations of anorexia and depression in the online corpora, despite their marginal MI scores. This choice of association measure, therefore, is appropriate for the aim of the study (Evert, 2008). Having examined the compilation and make-up of the MHDC, I turn finally to the ethical issues posed by the research design.

3.8 Online research ethics (or a lack thereof)

In collating the MHDC outlined above it was necessary to respond to ethical questions posed by the sensitive nature of its contents and the collection of data from general practitioners and anonymous internet-using patients. Approval for recording consenting GPs was granted by the local NHS Research Ethics Committee in accordance with rigorous, established standards for research involving human participants. The ethics of online research, however, remains contentious. The lack of clear ethical guidelines is particularly surprising given the research potential of online communication and the number of studies that have already begun to use the internet as a source of naturally occurring data. For example, at the time of writing (September 2012), the British Association of Applied Linguistics' (BAAL) current good practice recommendations supply broadly deontological principles for conducting research across the field of applied linguistics. Nevertheless, the current guidelines remain ambivalent on online research, noting that

[o]nline discourse provides certain challenges to the conduct of research, particularly with respect to informed consent and confidentiality... In the case of an open-access site, where contributions

are publically archived, and informants might reasonably be expected to regard their contributions as public, individual consent may not be required. In other cases it normally would.

(BAAL, 2006: 7)

Although BAAL's guidelines are rendered frustratingly noncommittal through the use of hedging modality ('might reasonably', 'may not', 'normally would'), its recommendations do highlight the private or public nature of online discourse as a determining factor of online research practice. This public-private dichotomy has structured much of the debate on the ethics of online research, and particularly that concerning the need for obtaining consent from research participants.

3.8.1 The internet as a public or private domain?

The internet now has millions of individual users who regularly access and contribute to publically available web pages. Congruent with the increase in internet users is the growing number of websites whose content is predominantly user-generated rather than site-authored. These characteristics of contemporary internet use suggest the World Wide Web can be considered a public medium *par excellence*, with its content equivalent to a collaboratively written electronic book (Frankel & Siang, 1999).

Although there is a precedent of published studies adopting this stance (Morrow, 2006; Seale, 2006), its attendant risks are equally apparent. Finn and Lavitt (1994) published the name of an online group for victims of sexual abuse and incest while Finn (1999) uses data from an online disability support group that explicitly discouraged researchers from joining. Members of the self-help group in Finn and Lavitt's study could easily identify themselves and, quite understandably, felt the privacy of their highly sensitive community had been violated. While ethically deplorable, Finn and Lavitt's research lucidly demonstrates the potential disconnection between the technical accessibility of online communication and the perceptions of actual participants. In this vein, Frankel and Siang's (1999) influential report

argues that an online community's *perceived* privacy should dictate the scale of responsibility exercised by researchers.

Several features of websites can be used to assess their perceived privacy level. Firstly, Eysenbach and Till (2001) highlight that the majority of message boards now have user guidelines and Frequently Asked Questions pages that offer an explicit site policy on research. Secondly, Eysenbach and Till also aver that the number of participants in a web forum offers a guide to its perceived privacy, with users seeing fora with high memberships as more public and indicating that a large range of people may read their posts (see also Eysenbach & Wyatt, 2002). Thirdly, they suggest that a website that requires users to register, request a password or receive approval for entry is more likely to be considered private (Herring, 1996). These technical features provide clear indicators of whether a website is likely to be considered private or public by its users, with password-secure webpages equivalent to rooms with locked doors to which researchers do not have a key.

In keeping with these suggestions, I have purposefully sampled web fora which have hundreds or thousands of members and which do not explicitly discourage researchers from viewing their content. However, the discussion of eating disorders and depression are clearly personal and sensitive subjects which open sufferers to social stigma. This vulnerability clearly dictates that the research should be undertaken with a due sense of responsibility to the forum users (Ess *et al.*, 2002; Frankel & Siang, 1999).

3.8.2 Anonymity, informed consent and teleological considerations

Chief among these responsibilities are obligations to maintain the anonymity of research participants and to seek their informed consent (Eysenbach & Till, 2001; Rodden, 2012; Sharf, 1999; Wærn, 2001). In response to the first obligation, I am withholding the names of the fora under investigation and have anonymised all instances of user pseudonyms

reproduced in the following analysis, since even pseudonyms do not guarantee user anonymity (Frankel & Siang, 1999). More importantly, I have taken data from fora whose digital architecture prevents their content being indexed by web search engines. In short, the fora's content cannot be Googled, nor feasibly located from the extracts reproduced in the subsequent chapters. In combination, these measures ensure an extremely high degree of anonymity for the forum users whose discourse is studied here.

The second obligation, that of informed consent, is more problematic. Eysenbach and Till (2001) and Seale *et al.* (2006) maintain that participant consent should be sought particularly when studies involve direct quotations that could be traced using a search engine (though c.f. Seale 2005, 2006, which both involve lengthy quotations with no mention of consent). A similar position is adopted by Sharf (1997) who sought *post hoc* consent from members of a breast cancer mailing list whom she had quoted. However, when applied to my own study, Sharf's recommendation rapidly becomes unworkable. It is unlikely that a large proportion of forum users would respond to such consent seeking, thereby reducing the coherence of the corpus data. This would effectively reduce this investigation to a handful of case studies that would fail to actualise my own research aims or the potential of the research medium (Herring, 1996; Lamerichs, 2003). A third option for obtaining consent would be to ask forum moderators for permission to use data from the board for which they are responsible. However, doing so would privilege the perspective of a single, powerful individual who cannot be assumed to speak for the heterogeneous views of thousands of forum participants (Eysenbach & Till, 2001).

More importantly, it seems necessary to consider the consequences of seeking informed consent. In particular, I am mindful that the bulletin boards I am analysing and the interactions that occur therein constitute a vital means of social and emotional support for

their users. To impose upon these groups with requests for consent would risk disrupting the fora and undermining their primary dynamic as supportive, recovery-oriented communities (Barker, 2008; Winzelberg, 1997) and could affect the research participants in a negative way (Nosek *et al.*, 2002). Indeed Ess *et al.* state that a researcher's 'primary ethical obligation is to *do no harm*' (2002: 8) and to consider the risks of a study's procedure. Ess *et al.*'s maxim suggests that, in my own case, not seeking participant consent is ethically viable. In support of this position, Marx (1998) argues that traditional deontological guidelines should be adapted to contemporary forms of data acquisition, claiming that consent should be considered an ideal rather than an absolute necessity:

[T]he absence of informed consent is not automatically a sign of unethical behaviour (although situations where it could be offered, and is, are clearly morally preferable to those where it is not).

(Marx, 1998: 178)

Marx further suggests that the ethical evaluation of an internet-based study should balance the means of data collection with ethically appropriate goals. Specifically, whether the methods of data collection reflect the use to which data will be put, or whether the data will be used for other, unrelated purposes or as a means of personal profit. Again, in this case, I believe my own study is justified: firstly, the risk of harm occurring to internet users or their online communities as a result of my investigation is minimal (see Herring, 1996: 159-160). Secondly, the extraction and analysis of online interactions is intended to offer novel insights into ruinous health conditions and contribute to improving standards of care for sufferers of anorexia and depression.

3.8.3 Some ethical conclusions

The preceding sections have outlined the ethical responsibilities owed to the internet users whose interactions are reproduced in the following two chapters. These obligations are grounded in a model of online privacy as it is conceived by internet forum users, rather than

the technical matter of the forum's public accessibility. Responsibility for the research participants has been realised through using non-traceable web fora and by eliminating personally identifiable information from the quoted data. In this instance, the obligation to obtain informed consent has been waived on the basis that seeking consent could jeopardise the integrity of the online communities and their vulnerable members. Given the precautions taken to ensure anonymity during data selection and processing, the study poses minimal risk to participants. In this instance, the anticipated benefits of the research are believed to off-set the imperative for consent – which is not a feasible option in this case – and make the study ethically viable.

Having set out the study's data and the theoretical foundation for its interrogation, the following chapters commence analysis of the MHDC, beginning with chapters examining the *anorexia.net* and *depressiononline.net* corpora. I turn thereafter to analysis of the anorexia and depression GP focus groups in chapters 6 and 7 respectively.

4 Online discourses of anorexia

4.1 Introduction

This chapter considers the linguistic signatures emerging from the *anorexia.net* corpus. Rather than a formal description of the forum discourse, the following analysis concentrates on the discursive construction of anorexia and forum participants' attendant negotiation of self-identity. In line with this study's overall concerns, particular attention is given to textual evidence of medicalisation, which is discussed toward the end of the chapter. The analysis suggests that the forum users' linguistic choices construct a conception of anorexia that demonstrates the influence of psychological and medical discourses. Additionally, linguistic choices ranging from determiner selection and clause transitivity patterns to discourse features extending over multiple messages illustrate the forum participants' attempts to negotiate an acceptable personal identity in relation to a debilitating condition.

4.2 Establishing categories for analysis

The keyword lists in this and subsequent chapters provide myriad avenues for possible investigation. A straightforward approach would be to use the disaggregated list as the point of analytical departure, beginning with the highest rated keyword on the basis of its statistical salience in the whole corpus, and then proceeding step-wise down the list of 686 keywords. However, doing sufficient analytical justice to even a small portion of the total keywords would require more word space than this chapter – and indeed thesis – would permit.

Alternatively, the keywords could be arranged into lexical groups to examine, for example, the relative frequency of vague language – *thing, things, something*; intensifiers – *really, so, so much, soooo*; or negated verb forms – *dont, don't, not, cant, can't, didn't*. However, I am concerned that such an approach may offer a comprehensive illustration of the textual

characteristics of the discourse at the expense of duly relating these features to the lives of individuals suffering from anorexia. The intention is that the findings of this and subsequent chapters offer novel insights into experiences of anorexia and depression, rather than primarily describing the linguistic particularities of the online and focus group interactions in which such experiences are disclosed. As such, from the outset of analysis it is necessary to consider the keywords in the *anorexia.net* corpus as linguistic traces of real individuals reflecting on the lived experiences of anorexia and responding to others' accounts of their own experiences.

With this in mind, the lexical keywords constituting the keyword list have been organised into semantic categories specific to the experience of anorexia. These emergent discursive domains can be considered key areas of meaning in the sampled forum interaction and the ensuing analysis shall use these categories as a primary avenue into the data (Seale *et al.*, 2006). A categorised list of the top 200 keywords (Table 4.1) thus provides a way of managing the vast investigative possibilities offered by the whole keyword list whilst also prioritising topics that the forum participants themselves are discussing (Baker, 2006; Baker *et al.*, 2008). A full keyword list for each sub-corpus is provided on the accompanying data CD.

Pursuing the data via these categories should not be seen to preclude analysis that attends to the lexical and grammatical features mentioned above however. Rather, these lexico-grammatical features are considered in reference to the emergent semantic domains in the communication of the forum members.

Table 4.1 – Key lexical and semantic categories and associated keywords of the anorexia.net corpus

Lexical / semantic category	Associated keywords
Anorexia and disordered behaviour	<i>ED, weight, behaviours, disorder, healthy, anorexia, body, treatment, restricting, illness, life, control, voice, scale, EDs, disorders, anorexic, sick, weigh, ED's, restrict, exercise, disordered, mental, issues, normal, triggering, coping, gaining, unhealthy, behaviour, rules, purge, scales, weighed, underweight, trigger, obsession, voices, binge, exercising, starving, pain, habits, addiction, urge</i>
Eating	<i>eating, eat, food, restricting, foods, mealplan, calories, restrict, ate, meals, fat, fluids, junk, nutrition, gaining, intake, [feeding] tube, plan, diet, starve, binge, hunger, starving, cookbooks</i>
Social relations	<i>mom, friend, family, friends, hubby, guys, husband, boyfriend</i>
Emotions	<i>hard, alone, scared, fear, anger, emotions, scary, hope, hugs, anxiety, angry, glad, hate, honest, proud, ashamed, awesome, freaking, overwhelming, denial, wow, esteem, guilt, afraid, scares, strong, anxious, freaked, safe, terrified, love, fears, messed, guilty, discomfort, frustrated, emotionally, depression, overwhelmed, struggle</i>
Medical and healthcare lexis	<i>anorexia, treatment, OCD, IP, therapy, mealplan, relapse, appt, calories, meds, anxiety, anorexic, fluids, nutrition, relapsing, medical, hospital, brain, physical, physically, appointment, symptoms, inpatient, PTSD, tx, diagnosed, calorie, BMI, depression, addiction, electrolyte, mental</i>
Healthcare professionals	<i>therapist, t, dietician, nutritionist, doctor, pdoc, counsellor, team, GP, doc, cardiologist, psychiatrist, psych, dieticians, n</i>
Abbreviations	<i>ED [eating disorder], IP [in patient], t [therapist], meds, pdoc [general practitioner], appt [appointment], GP, doc, PTSD [post-traumatic stress disorder], OCD [obsessive compulsive disorder], tx [therapy], psych, n [nutritionist], ppl, lol [laugh out loud]</i>
Recovery	<i>recovery, help, support, treatment, healthy, progress, accomplishment, helpful, supportive, stronger, recovering, yoga, challenges, recover, recovered, better, healthier</i>
Forum-related lexis	<i>thread, post, posting, posts, email, posted, forum, website, lol, threads</i>

Several of the keywords in the above table appear in more than one semantic category. Most obviously, a number of key lexical items relating to food and eating such as *restricting* and *starving* also refer to practices typical of anorexia. Similarly, the keyword *anorexia* features in the keyword table as both an example of lexis from a medical domain and a means of lexicalising a specific type of disordered eating behaviour, and so also appears in the top category. The most frequently overlapping domains in the above table are the medical lexis, healthcare professionals, and abbreviations categories because medical diagnostic labels and titles of professional healthcare roles also appear as abbreviations. Alphabetised forms of diagnostic and medical terminology such as *PTSD*, *OCD* and *IP* signify that the forum users also recurrently deploy a form of professional jargon represented by these shortened forms. Single letter abbreviations such as *n* and *t* for referring to specific healthcare professionals suggest that these are used with sufficient frequency as to necessitate abbreviation and that their meaning can be resolved from a single letter rather than requiring the fully lexicalised form.

4.3 Lexicalising anorexia

Of the lexical choices used by the forum members to signify anorexia, by far the most frequently used form was *ED* (623 occurrences), followed by *eating disorder* (79 occurrences), *anorexia* (77 occurrences) and *disorder* unmodified by *eating* (17 occurrences). Two other abbreviations, *AN* and *ana*, occurred four times and once respectively. The forum users' clear preference for the shortened form, *ED*, could simply be regarded as typical of the abbreviation of common lexis that characterises electronic communication (Baron, 1998; Morrow, 2006). However, this interpretation would overlook the fact that the forum users also adopt a form denoting the superordinate term 'eating disorder' despite posting messages in a forum module intended specifically for the discussion of anorexia and not

bulimia, compulsive over-eating or eating disorders in a less specific sense. Consequently, although the available labels for referring to anorexia have some denotational equivalence, it would be ill-considered to presume each label therefore communicates the same meaning (Fleischman, 1999 and see Giles, 2006 for a similar distinction in a pro-anorexia community). For example, the forum participants' use of a hypernym in place of the more specific *AN* or *ana* orients to anorexia as part of a general category even though clinical literature indicates clear differences between the various eating disorders (Garfinkel, 2002; WHO, 1992). The absence of clarification when the abbreviation *ED* is used also implies that forum participants are able to resolve its meaning without difficulty. That is, users appear to have sufficient communal understanding of the meaning of *ED* that they do not need to write *eating disorder* in full.

The preferential use of a noun form, *ED*, to nominalise anorexia also renders incongruous certain articulations of the relationship between the individual writers and their anorexia. For example, statements which posit an attributive relationship between speaker and condition such as 'I'm *ED*' or 'I'm *ED*'d' become harder to understand compared with 'I'm anorexic', and remain entirely absent from the corpus. As shall be elaborated below, the avoidance of constructions that directly equate forum users with anorexia is typical in the *anorexia.net* corpus, and is sustained through various consistent linguistic choices.

4.4 A collocation profile of *ED*

Collocation analysis indicates that *ED* occurs most frequently with *the*. While this may seem unsurprising given that *the* is the fourth most frequent lexical item in the corpus, *the* is also the strongest collocate of *ED* ($n = 292$, $\log\text{-likelihood} = 1347.15$) and overwhelmingly appears in an L1 position to form *the ED* ($n = 200$). This bigram accounts for 32% of instances of *ED*. The next strongest collocate of *ED*, *an* ($\log\text{-likelihood} = 595.23$) forms the

bigram *an ED* on 84 occasions whilst *my ED* appears 71 times in the corpus. These frequencies indicate a statistically significant preference for referring to anorexia as *the ED* or *an ED*, using determiners that do not encode grammatical possession and which construe anorexia as a singular, countable entity. As the most frequent *determiner+ED* construction, *the ED* is the generic form used by the forum participants to refer to their condition. Examples of this collocation are presented below. Corpus extracts are reproduced with their original spellings and relevant keywords and collocates are highlighted in bold in these corpus extracts, and in extracts provided hereafter.

1. I know I need it [a nutritionist appointment] because **the ED** always convinces me that I am having plenty...even though clearly that isn't the case.
2. I feel that most people are really scared of high fat food and it's just another way of **the ED** telling me that I don't have a problem since I eat chocolate (my biggest weakness)....
3. but it went against everything **the ED** tells me. I felt like I was gross and lazy. I didn't think I could stand it and **the ED** was telling me how much I would have to compensate today by not eating much and by walking a lot.
4. I have been doing much better the past few days and **the ED** is getting scared. I reached out for support from my parents when I needed it before and after meals and made it through.
5. But I know that I have to trust my team and those around me rather than **the ED**.
6. But then I get guilt later that I'm a failure even at **the ED**, or when the scale is off by ****_**** pounds!

These examples provide an initial snapshot of the diverse concerns of the forum contributors communicated in the online forum. These include a need for appointments with and trust in healthcare professionals (extracts 1 and 5), discussion of particular foods (ex. 2), engaging in exercise perceived to compensate for eating (ex. 3), entreating parents for help with eating (ex. 4) and the relationship between weight and self-esteem (ex. 6). Throughout these examples, the authors' use of the definite article when discussing their anorexia aptly reflects their knowledge of a condition with which they have a long-standing familiarity.

Nevertheless, in each of the above extracts, it would be possible to substitute *my ED* for *the ED* without changing their overall propositional meaning or syntactic structure. Each excerpt

refers to a singular condition associated with the writer, yet each author refrains from grammatically encoding possession of her eating disorder. Where use of a possessive determiner at least indicates a relationship of ownership between anorexia and the writer, the definite article elides this relationship, leaving it as neither one of identity nor possession. In addition to indicating the authors' familiarity with their anorexia, therefore, recurrent use of a definite article in place of a possessive determiner serves to dissociate these anorexics from their condition and objectifies their own anorexia as a discrete entity (Malson *et al.*, 2004). Indeed, as I argue below, the use of the objectifying definite article when lexicalising anorexia is the most frequent amongst a number of linguistic strategies through which the forum users extricate themselves from the phenomena denoted by *ED*.

Cassell argues that the language patients use when discussing sickness reflects 'the prevailing philosophy of disease that underlies modern medicine [which] sees diseases as objects' (1976: 143). For example, patients suffering from physical illness frequently refer to their disease or affected body parts as distinct objects that can be referred to using 'it' or 'the'. In grammatically objectifying medical conditions, Cassell claims, patients construct a separation from them, indicating that their sense of self cannot be equated with their disease. Examples such as extracts 1-5, in which the forum users refer to *the ED* rather than *my ED*, provide evidence that this linguistic disconnection features prominently in the forum discourse. However, Cassell claims that less physically discrete conditions such as diabetes are seldom objectified and that patients' concept of mental illness are not objectifying at all; 'it would be odd,' he argues, 'to hear someone speak of "*the depression*" when speaking about his own depression' (1976:145). Consequently, the generic use of *the ED* on *anorexia.net* demonstrates that participants in the anorexia forum habitually diverge from expectations for discussing mental health conditions and reify anorexia through their choice of determiner.

This objectification is particularly lucid when members use the same bigram to refer to other individuals' conditions and to anorexia in general:

7. Remember that that pain is the reality of **the ed** and not about recovery. Turning pain into self harm in whatever form is no answer.
8. WHY do we feel this way about ourselves, other than that **the ED** is making us feel this way?
9. this thread is fro myself and anyone else who would like to join to finaly let go off **the ed** by realisin the things we get from it are not woth it and that we have so many other qualities to us that we need to celebrate and remember.
10. I realize now that that was **the ED** talking and ED LIES!!!

These extracts suggest that the forum participants not only refer to their own condition as an object but also construct the multiple personal conditions of every forum user as the same single entity (see Fleischman, 1999 on a similarly homogenising discourse of another illness).

For example, the plural pronouns 'we', 'ourselves' and 'us' in extract 8 clearly signify reference to the forum members as a group, yet the author also refers to a singular 'the ED' that is 'making [them] feel this way'. Similarly, extract 9 contains three references to plural 'we' but also uses a 'the ed' and an anaphoric 'it' to represent anorexia as a singular condition that affects numerous individuals. Such verbal choices naturalise anorexia by presenting it as a pre-constructed phenomena that exists separately from the group members (Fleischman, 1999; Nijhof, 1998), even while they refer to its subjective effects upon them. Repeatedly choosing *the ED* thus serves to represent anorexia as universal and external to the individual. At the same time, presenting anorexia as an independent entity also dissociates the forum users from the continuation of their anorexia and obscures the fact that it is reproduced through their emotions and behaviours, including their verbal behaviours when discussing anorexia (Giddens, 1984; Giordano, 2005 and see Wenger, 1998: 58). According to Nijhof (1998) and Wenger (1998), such naturalisation also serves a social function by solidifying important aspects of social reality and discursively assigning them the status of natural, objective phenomena. It does not seem surprising, then, that this naturalised concept of

anorexia as a single independent object is the foundation upon which the online community is based and is presented as something the community's members share in common.

In contrast to *the ED*, instances of *my ED* ($n = 71$) are far less frequent in the *anorexia.net* corpus, accounting for only 11% of L1 collocates of *ED*. Examples of *my ED* in the corpus indicate that it is used in a different verbal context to *the ED*:

11. I have been recovering from **my ed** for about a year now. When I did have **my ed**, I used to be the SAME exact way! I used to make sure everyone around me ate, but I never did.
12. Since I sought help for **my ED** in November last year (and feel free to search my posts- I kicked and screamed as much as you did initially) I have had to visit numerous professionals-
13. During the many years I had **my ED** I ate very little, but what I did eat was alot of candy, sweets, etc.
14. I really don't want **my ED** back but am torn because I always think I was happier when I was thinner.
15. I have been honest with my caregivers (I was already receiving services for trauma) about **my ED** from the beginning, and it has brought nothing but good. I encourage you to give T all the information and honesty you can,
16. My friend doesnt know about **my ED**, and im having a hard time telling her. Hopefully Ill be able to attend the party still, Ill have to get my Ts opinion.

The most appreciable difference between instances of *the ED* and those of *my ED* presented above is the preference for *my ED* amongst forum members who report either being recovered or in the latter stages of professional treatment and recovery. This is indicated by use of spatial deixis – ‘I really don't want my ED back’ (ex. 14) – and use of past tense verbs forms – ‘When I did have my ed’, ‘During the many years I had my ED’ (ex. 11 and 13) – to signal past experience of anorexia. Similarly the use of the present perfect tense in ‘I have been honest with my caregivers... about my ED from the beginning’ (ex. 15) implies the author's previous and on-going experience of treatment is of current relevance to their advice-giving in the present (Crystal, 1995). As in extract 15, reference to recovery or foregoing experience of treatment frequently prefaces the provision of advice to another forum member. Detailing previous experience of, or recovery from, anorexia is therefore

used in this context to display competence and construct the author as an authoritative advice-giver (Morrow, 2006; Potter, 1996).

The comparatively infrequent use of *my ED* supports Cassell's (1976) and Davison and Pennebaker's (1997) claims that constructions such as '*my*+medical condition' reduce the distance expressed between the speaker and their illness and represent atypical language use. This contention is clearly exemplified in the *anorexia.net* corpus, in which members' use of *my ED* to encode possession of anorexia occur during expressions of temporal and psychological distance from anorexia. There appears, therefore, to be a trade-off between temporal distance from anorexia and the degree of grammatical possession in the forum users' discourse; forum members using *the ED* describe immediate and on-going struggles with an eating disorder that is distanced from them grammatically. Conversely, forum users who represent anorexia as a past-tense matter are also willing to construct it as something they previously possessed – *my ED*. In accordance with this, existential clauses such as 'I'm anorexic', which collapse the relationship between speaker and condition to one of identity, appear only twice in the entire corpus (Fleischman, 1999). Instances of *my ED* such as extract 16 that encode possession of anorexia by those currently suffering from it constitute 43% of instances of *my ED* and represent a minority discourse on the forum (Baker, 2006).

Returning to patterns of collocation around *ED*, table 4.2 details the fifteen strongest lexical collocates of *ED*.

Table 4.2 – Top 15 lexical collocates of ED

Collocate	Frequency	Collocational Relationship (log-likelihood)
<i>voice*</i>	42	316.212
<i>OCD</i>	24	189.684
<i>back</i>	24	103.583
<i>tells*</i>	10	84.356
<i>talking*</i>	12	74.409
<i>telling*</i>	13	70.387
<i>life</i>	17	63.961
<i>voices*</i>	8	60.624
<i>thoughts</i>	13	57.34
<i>really</i>	22	56.272
<i>makes</i>	12	54.563
<i>part</i>	12	53.246
<i>group</i>	8	53.21
<i>things</i>	18	53
<i>friend</i>	17	49.832

Along with the weaker collocates *saying* (10 collocations) and *says* (5 collocations), five of the strongest fifteen collocates of *ED* refer to speech acts or voices (marked with * on table 4.2). These collocations signal that verbal processes are a consistent feature of how anorexia is represented on *anorexia.net*. Concordances of these collocates and their related lemmas reveal distinctive, surprising usage, in which verbal and material processes associated with human agents are attributed to the disorder itself (see also ex. 1-3 and 10 above):

17. We all have a ME and an ED. Sometimes the ED **voice talks** and sometimes the REAL **voice talks**. Your you **voice is telling** the ED that you can have bread and eat normally and it's okay to eat and gain some needed weight.
18. Now the goal is to not let my emotions dictate my eating this weekend because, as I have written before, Saturdays are often the hardest day for me and therefore the day when the ED **voice screams** "RESTRICT" and "EXERCISE" the most.
19. There was one line in my friend's email reply that sounded just like what the ED **voices yell** at me - "Please don't do this to the ministry."

20. I now have to combat the ED voices telling me "I had a good week, so I am all done now."
Obviously that isn't the case but it is very convincing.

21. the ed voice tells me to do so many things that are against my core values as a person.

22. Ed makes me think horrible things about myself; it takes away my self-esteem.

As the above corpus excerpts clearly demonstrate, the lexical collocates of *ED* are frequently verbs whose agency is attributed to anorexia or a personification of anorexia as the *ED voice* or *ED voices*. Where *ED* or *the ED voice* is the subject of a transitive process, the forum users present themselves as the direct object who is either spoken to (ex. 19-21) or made to 'think horrible things' (ex. 22) by their condition. Extract 20 describes the 'ED voices' as 'convincing' while the authors of extracts 18 and 19 use the reporting verbs 'screams' and 'yell' and capitalised reported speech to convey the intensity of the 'ED voice'. The replication of direct speech in these extracts also suggests that the 'ED voice' is experienced by these forum users as communicating specific content about their diets, exercise and personal lives rather than a more impressionistic urge towards eating disordered behaviour.

These excerpts go beyond euphemisms such as 'losing my mind' that are typically used to articulate a perceived loss of mental control (Allan & Burrige, 2006) and explicitly attribute responsibility for chaotic thoughts to an external speaking agent. As with *the ED*, through the notions of a distinct 'ED voice' or 'ED thoughts' the forum participants situate theirs and others' anorexia as external to their sense of self; as the author of extract 17 states, 'We all have a ME and an ED'. By ascribing agency to 'the ED' the forum members represent anorexia as beyond their control and, when they are the grammatical objects of its actions, as directly affecting them. They report feeling that their anorexia persuades them to engage in characteristically anorexic behaviour and undermines their capacity to act of their own volition. In ascribing agency to their anorexia, examples such as these also perform identity and accountability work on behalf of the forum users. That is, by recurrently presenting anorexia as an active agent that 'lies', 'convinces' and which makes them 'feel' certain ways,

the forum users displace responsibility for their actions and thoughts onto an external entity. Congruently, by presenting themselves as grammatically and semantically patient, the forum users convey a limited capacity to resolve their situation or accurately perceive its gravity. In short, anorexia is presented as an entity that happens to them, rather than a condition they have any control or responsibility over. Using these repeated transitivity patterns, the forum users construct a discourse of powerlessness and lost control (Eivors *et al.*, 2003; Hardin, 2003) in which their own personal agency is compromised and anorexia has a will of its own. This discourse is also reinforced lexically through collocations between *ED* and *control* ($n = 12$), instances of which represent anorexia as a state of being controlled and recovery as an effort to 'stop the control that the ED has over your life'.

In light of the agency that forum members readily ascribe to their anorexia, we are in a better position to re-evaluate the 'odd' discursive separation they enact between themselves and their eating disorder (Cassell, 1976: 145). Morse and Mitcham argue that an individual's perception of physical impairment 'gives rise to the internal distinction between the self and the part of the body felt to be the site or the origin of the constraint' (1998: 677). Even though anorexia does not inhere in a specific body part, users of the anorexia forum clearly construct their eating disorders as acting of its own volition and, as per Morse and Mitcham's claim, as separate from themselves. The tendency for forum users to present themselves as the object of anorexia's actions also sheds light upon their choice of grammatical determiner for *ED*. In the face of a condition that is described as deceptive, manipulative and beyond their control, it is unsurprising that the forum users avoid encoding grammatical ownership of anorexia.

In contrast to Malson (1998) and Bordo's (2003) studies, the forum participants analysed here do not ostensibly separate their identity from their physical bodies nor present anorexia as a mastery of their appetitive bodies. Rather, they overwhelmingly present anorexia as a state in

which agency and self-determination is lost to their eating disorder; as one user claims, ‘I can’t “just choose” to eat normally. So, being ill with an eating disorder is to my mind the OPPOSITE of being in control of yourself’. Such claims also problematise descriptions of anorexia as ‘self-engendered weight loss’ (Beumont, 2002: 162) since, for the forum’s anorexics, the ‘ED’ that is responsible for their starvation is not some entity that they would identify as their ‘self’. This in turn indicates a disparity between sufferers’ and professionals’ accounts over whether the anorexic patient is equated with their anorexia (Jarman *et al.*, 1997; Malson *et al.*, 2004).

In externalising *the ED* and *the ED voice*, the forum members construct threats to their agency as originating from outside the self. In doing so, forum users can simultaneously safeguard their self-esteem by representing risks to their self-integrity as external and beyond their control (Hardin, 2003). As well as conveying psychological turmoil, therefore, the dualism established by representing anorexia as an external *ED voice* can also be seen as a discursive resource for negotiating an acceptable identity whilst living with a socially stigmatised condition.

4.5 Anorexic behaviours, restricting and control

The following section continues these issues of control and agency in examining members’ accounts of dietary control and anorexic ‘behaviours’. The analysis considers the collocational patterns of *behaviours* before pursuing discussion of the relationship between *behaviours*, control and professional treatment identified during manual reading of the concordances.

The keywords *behaviours*, *restricting*, *restrict*, *exercise* and *purge* in table 4.1 all refer to practices associated with anorexia. Of these, the most frequent and salient keyword is *behaviours* ($n = 122$, $\log\text{-likelihood} = 949.81$). In keeping with the use of *ED* to signify

anorexia, *behaviours* constitutes a superordinate, euphemistic term for the range of activities it signifies. However, unlike *ED*, *behaviours* constitutes an example of vague language that is required by the strictures of the forum; *anorexia.net*'s forum rules proscribe specific descriptions of purging, laxative use and intensive exercise regimes that are typical of individuals with anorexia. In response, the forum users adopt a general term when discussing such actions. Nevertheless, the disaggregated hypernym functions to amalgamate various unspecified activities and represent them as equally constitutive of the same condition. In parallel with *the ED*, then, the use of *behaviours* is suggestive of an attempt to construct a sense of common experience amongst forum users. Extended concordances of *behaviours* from the corpus allow a more detailed illustration of its use in the forum:

23. to go cold turkey on **behaviours** wouldnt work for me because i still feel i need them. but through therapy i'm slowly learning to replace them with new better coping skills. if they were taken from me on day one i would have had nothing to replace them with. in IP i've had this done to me and the minute i left **behaviours** were worse than ever.
24. I talked about that on another post, there is the underlying issues theory and the habit theory, yet you can stop, I stopped **behaviours** for several years.
25. There is no way that outside of IP I would have dealt with those feelings without resorting to **behaviors**.
26. I think for the **behaviours** to truly disappear, the thoughts have to change. Usually the **behaviours** are symptoms of an emotional state. Butttt i also think that as the **behaviours** get better, thoughts will start to become more positive.
27. It is true that thoughts precede feelings and **behaviours**, and this is the premise behind CBT.
28. What we want to know is how you are feeling, what you are using your **behaviors** to say, avoid, etc.,

As with *ED*, the excerpts above illustrate a naturalising discourse in which 'behaviours' are presented as a homogenous category and grammatically dissociated from their enactors. In extract 23, for instance, the zero-article nominalised form 'behaviours' in 'the minute i left behaviours were worse than ever' backgrounds any sense of agency and does not clearly attribute the deleterious anorexic practices to the author (van Leeuwen, 2008). Compared with a more active clause such as 'I engaged in anorexic behaviours more acutely than ever'

(invented example), extract 23 uses an existential process to state that ‘behaviours’ were ‘worse’ of their own accord. Congruent with this, the verbal metaphor of going ‘cold turkey’ (ex. 23) and claim that ‘behaviours’ may be part of a ‘habit’ (ex. 24) frame ‘behaviours’ using the lexis of drug use and addiction. The implication that ‘behaviours’ are a form of irresistible, self-destructive dependence clearly coheres with the obfuscation of agency behind ‘behaviours’ in extract 23.

Extracts 25-27 also illustrate a perceived relationship between anorexic *behaviours* and two of its lexical collocates *thoughts* and *feelings* (see table 4.3 below), in which mental distress precedes carrying out *behaviours*. Accordant with the forum users’ description of their *ED* voice as undermining their self-esteem and convincing them to act in undesired ways, the forum users ascribe precedence to their mental states and present these as precipitating particular behaviours.

Table 4.3 – Lexical collocates of behaviours

Word	Frequency	Collocational Relationship (log-likelihood)
<i>thoughts</i>	14	139.60
<i>ED</i>	12	79.60
<i>using</i>	7	77.11
<i>change</i>	7	62.78
<i>feelings</i>	7	58.55
<i>stop</i>	6	52.72
<i>rules</i>	5	49.77
<i>through</i>	6	46.38
<i>more</i>	7	41.61
<i>eating</i>	5	28.91
<i>up</i>	5	26.73
<i>think</i>	5	24.57

Forum messages associating ‘behaviours’ with ‘thoughts’ and ‘feelings’ support previous findings that anorexic practices function as mechanisms for managing stress and negative affect (Eivors *et al.*, 2003; Skårderud, 2007; Woolrich *et al.*, 2006). At the same time, presenting ‘behaviours’ as a means to ‘deal with’ (ex. 25) otherwise intolerable feelings offers an implicit justification for their use as a last resort rather than a wholly irrational practice. The author of extract 23, for example, constructs an extreme case formulation (Pomerantz, 1986) of resorting to ‘worse than ever’ behaviours ‘the minute’ she left in-patient care that left her with no other coping skills. Similarly, in extract 25, the author thematises a categorical adverbial clause – ‘there is no way’ – to exclude the possibility of managing certain feelings without resorting to behaviours. Where food restriction, exercise and compulsive weighing can seem specious to non-anorexics, the forum participants use such extreme case formulations to legitimise their ‘behaviours’ by constructing their actions as a reasonable means of controlling psychological distress in lieu of psychotherapy.

By representing anorexic ‘behaviours’ as a consequence of difficult emotions, the forum participants also engage in a psychological discourse, explicit in the references to ‘CBT’ and an ‘underlying issues theory’ above, in which conscious and unconscious thoughts are believed to give rise to external actions. As extract 28 demonstrates, members use this psychological model to engage in a proto-professional therapy with other users (de Swaan, 1990), attempting to identify psychological motivations behind their behaviour and framing anorexia within a model of individual psychodynamics.

Following *thoughts* and *ED*, the strongest lexical collocate of *behaviours* is *using* (table 4.3). Whereas behaviour is ordinarily considered a relatively unconscious activity, collocations between *behaviours* and *using* represent *behaviours* as deliberate actions. Examples of these

collocations are provided below, along with clauses in which *behaviours* are the object of other material processes.

29. No one would pretend that recovery is easy - in fact life will get much harder without **using ed behaviours** to cope
30. Taking a step back into **using behaviours** just keeps the cycle going and you dependent on them.
31. Maybe you can use the fact that you are under strict doctor's orders NOT to engage in **behaviours** to alleviate some of the guilt and talk down your urges.
32. i had tons of bad,scared thoughts but focused on eating and forced myself to trust her. as thoughts raced through my head and as i wanted to practice **behaviours** i hung on tight to her words and the words of my new t.

The transitive processes 'using', 'engage' and 'practice' in extracts 29-32 represent anorexic behaviours as actions that individuals actively engage in rather than carry out unthinkingly. Indeed, 'using' or engaging in 'behaviours' is presented in extracts 29 and 31 and in extract 28 above as a purposeful way of performing other activities; 'behaviours' are used 'to say', 'to cope' and 'to alleviate some of the guilt'. The purposeful 'use' of behaviours to achieve a desired end provides a relatively rare example in which forum members ascribe goal-orientated material processes to themselves and each another. This representation of agency stands in marked contrast to the discussion of *the ED* and *ED voice* above, in which users are often in the role of a grammatical patient affected by the actions of their eating disorder. Concordant with this agency are several claims that activities such as food restriction result in feelings of self-control, for example:

33. I feel as if **restricting** is making me more powerful. Like when i **restrict**, i am in **control** and when i eat, i lose all **control** [...].
34. my **eating** can get so out of **control**, so on the days that I can totally **restrict** it, and like go the whole day without **eating** anything, I feel so **IN control**.

Extracts 23-34 provide varying depictions of *restricting* and *behaviours* as both sources of control and accountable actions arising from thoughts and feelings that they deny any authority over (Giordano, 2005). The discourse of restriction and self-control exemplified in

excerpts 33-34 is therefore in tension with other users who claim that ‘behaviours’ arise in reaction to their uncontrollable ‘thoughts’, ‘feelings’, and ‘ED voice’ and serve only to entrench individuals in their condition. For example, responding to extracts 33-34, one user states ‘EDs take all the control so we dont have it even tho we have the illusion of control’. Whilst acknowledging her addressees’ perceptions of self-control, this forum member counters the foregoing posts by recasting dietary restriction as a divestment of control to anorexia itself. In reply to members who equate ‘behaviours’ with personal agency, this user’s response is to represent ‘behaviours’ as ‘a form of control that is itself out of control’ and ultimately initiated by anorexia itself (Malson, 1998: 145).

Instances of collocations between *behaviours* and its significant collocates *change* and *stop* (see table 4.3) offer examples in which forum members discuss ways to escape the cycle of uncontrollable thoughts and subsequent disordered behaviour:

- 35. The only way I have really ever been able to **change** my **behaviours** was by telling someone who could actually stop me.
- 36. I would have to be forced to **change** my **behaviours** externally. I don't see myself **changing behaviours** through any sort of will power of my own, without something big happening, just like you said.
- 37. I knew I couldn't deal with the thoughts until I had the support of a T to work through them, so I didn't **change the behaviours**.
- 38. I should add though, that as I was **changing** my **behaviours** I was receiving therapy and learning healthy ways to cope with my feelings.
- 39. It's possible to control and **stop the behaviors**, but it may never be possible to fully control our thoughts or feelings.
- 40. Yes but how are many of us able to step in and **stop the behaviors** when we realize the damage they've caused.....and then the illness slides back years later when we think we're recovered?

In keeping with the participants’ alleged powerlessness over their thoughts and actions, collocations between *behaviours* and *change* co-occur with reference to users’ incapacity to alter their behaviour by themselves. Accordingly, throughout these excerpts the forum members express a dependence on external help, professional interventions and therapists as

a means of altering ‘behaviours’ (ex. 37-38). Tellingly, the forum users do not clearly state that therapy prevents their psychological distress, but rather offers alternative coping mechanisms with which to manage it (Eivors *et al.*, 2003). This results in a sceptical position amongst some forum users over the potential for complete recovery from anorexia; as the author of extract 39 states, although anorexic behaviours may stop, the ‘thoughts or feelings’ that encourage dietary restriction may not. Similarly, the author of excerpt 40 raises the possibility that anorexia ‘slides back’ of its volition even after the anorexic has been able to ‘stop the behaviours’.

For those forum members who have not yet received psychotherapy sessions, the perceived prospect of discontinuing anorexic behaviours and the expected concomitant loss of control is viewed with acute trepidation. Directly following the content of excerpt 36, the same forum user states:

41. I would not, at this point, make the choice to relinquish control to someone else in an "IP" setting, or any other way. I would really, really not be ok if I did that. I would rather not live than give up control, at the state I'm in right now.

The notion that treatment necessarily entails surrendering control to healthcare professionals is also apparent in messages from forum members who are currently undergoing therapy or have done so in the past. These users identify discontinuing ‘behaviors’ and the identity shift involved in recovery as primary obstacles to improving health:

42. I went to treatment for six weeks. It was by far the hardest thing I've ever done. [...] I had to completely surrender control.

43. today i had one of those days... i miss my ed soooo much [...]right now i don't know who i am, i don't even know what i like. i don't have an identity. at least before i began the recovery process i was [username] the anorexic, i had something, i had a way to cope. now all i have is this huge confusion.

Extracts 43 demonstrates the additional difficulties for those forum users who define themselves through their anorexia or attendant body shape. In marked contrast to the discussion of *the ED* in section 4.4, in which anorexia is represented as a separate entity, the

author of extract 43 identifies directly with her condition, realising this through an intensive copular construction, 'I was [...] the anorexic'. In this case, recovery not only requires discontinuing her anorexic coping mechanisms but also necessitates erasing the basis of one's self-identity, resulting in a 'huge confusion' (Gremillion, 2003). This additional fear of identity loss illustrates a double bind involved in treatment and recovery from anorexia. That is, the identity crisis precipitated by giving up their anorexic subjectivity creates further anxiety towards recovery; for those who identify directly with their anorexia, 'the possibility of "recovery" collapses into the threat of self-annihilation' (Malson *et al.*, 2004: 483). Further, the increased food intake prescribed during in-patient care for anorexia requires patients to do the opposite of their habituated mechanism for dealing with stress by eating more at a time when they feel compelled to restrict their diets. Indeed, the posts above reiterate a fear of accepting professional dietary control and stopping anorexic practices that has been identified as a key factor in dropout from anorexic treatment services (Eivors *et al.*, 2003).

The *anorexia.net* community's use of *behaviours* and its collocates displays several contrasting perspectives on the performance of anorexic practices. The articulation of 'behaviours' as a nominalisation permits potentially unfavourable activities to be presented without reference to a performing agent (ex. 23 and 26) and, like *the ED*, as disconnected from the individual. Attempts to obscure responsibility for 'behaviours' or situate their practice within extreme case scenarios signify efforts by some users to distance themselves from their anorexic practices or discursively legitimise their conduct. Other users, however, explicitly encode their agency in using, practising or engaging in 'behaviours' in order to 'cope' and 'alleviate... guilt' (ex. 31). In conjunction with collocations with *thoughts* and *feelings*, *behaviours* are therefore presented as a psychological resource for controlling emotions and responses to external stress. When contextualised against the wider discussion

of the *ED* voice in section 4.4, the motivation to ‘use’ or ‘engage’ in ‘behaviours’ appears to stem from ‘ED’ thoughts that are experienced as uncontrollable. The eventual powerlessness over their own behaviour is reiterated in the users’ discussion of attempts to *change* or *stop* their disordered actions, which are consistently associated with receipt of external assistance. Despite this, forum members remain ambivalent about dispensing with their behaviours during professional treatment and perceive this as a direct threat to their ‘control’ and, in some cases, personal identity.

4.6 *Eating, eating more and not eating*

Having presented the forum discourse around anorexic weight loss practices, the following section considers the forum participants’ extensive accounts of food and experiences of eating. The analysis considers users’ ambivalence towards increasing their diets, feelings towards eating and obsession with food. I then examine representations of becoming ‘fat’ and the use of structured dietary ‘meal plans’.

Unsurprisingly, keywords relating to the process of food consumption pervade the corpus, most commonly *eat* (390 occurrences), *eating* (379 occurrences), *ate* (47 occurrences) and the more technical nominalisation *intake* (20 occurrences). Aside from its collocation with *food* (discussed below), the strongest lexical collocates of *eat* is *more* ($n = 29$, $\log\text{-likelihood} = 124.66$), which appears 14 times as the bigram *eat more* and in the three word cluster *to eat more* six times. Excerpts from posts containing this collocation are presented below.

- 44. the part of me that so desperately wants to feel safe keeps saying that I need to just **eat more** of what I am already doing.
- 45. i need to **eat more** i know i do but i find it hard to go against the ed but i dont want to be in hospital.
- 46. unfortunately, when you need to gain weight, you have to **eat more** than normal, which results in a lot more guilt.

47. I am scared to eat more and *****% of my meal plan, not only because of having to eat the food and gain the weight; but also because of the major fear of feeling my hidden, buried feelings.
48. everyone says trust your body so i think sometimes i am full ill stop now, they tell me over eating is bad yet i try not over eat and they tell me eat more that i have to eat what they tell me but yet trust myself im am sooooooooooooo confused ahhhhh!
49. I am really scared right now. I am confused about what to do. I really do want to eat more
50. I feel ashamed of it [anorexia] and think people will judge me/ question how it will impact on my children, try to make me eat more without really understanding that it wont help.

In contrast to ‘using behaviours’, eating and particularly eating ‘more’ could be expected to signify a step towards recovery from anorexia. Nevertheless, the forum members associate attempts to ‘eat more’ with negative emotions such as feeling guilty (ex. 46) and being ‘scared’ and ‘confused’ (ex. 47-49). In extract 47, the fear of eating more is not simply associated with food and weight gain but rather with ‘feeling my hidden, buried feelings’, implying a direct association between physical satiation and overwhelming emotions (Skårderud, 2007). Forum users’ attitudes towards eating more are also conveyed by the phrasal structures in which *eat more* appears. For instance, the excerpts above include two examples of ‘need to eat more’ (ex. 44-45) and ‘have to eat more’ (ex. 46). These are typical phrasal structures around *eat*, with *need to [just] eat* and *have to [learn to] eat* appearing 8 and 13 times respectively throughout the corpus. Both of these modal structures constitute eating as an act of obligation and necessity. The obligation to ‘eat more’ appears both as a means to meet a specific goal, for example ‘when you need to gain weight’ (ex. 46) and also as an unspecified end in itself (ex. 44-45). Despite the necessity associated with eating in these examples, extract 50 includes a claim that being made to ‘eat more’ ‘wont help’ her anorexia, which implies that simply increasing food intake is not, for this user at least, a route to recovery.

Ambivalence towards increasing eating is further conveyed through representations of internal conflicts around eating. In extract 44, the author refers to a ‘part of’ her that tells her

to keep eating, invoking a division of the self into conflicting parts that echoes the discussion of the *ED voice* above. Similarly, in extract 45, the author's chain of disjunctive clauses situates eating in a conflict between what she knows, going 'against the ed' and the overarching threat of hospitalisation. A similar pattern of contrasting coordinate clauses characterises extract 48, in which indirect speech representation is used to show inconsistencies in professional advice to simultaneously trust her body, not over-eat, and to eat what she is told. In both cases, clause coordination using 'but' or 'yet' demonstrates conflicts with 'the ED' and between competing desires and professional instructions which render trying to 'eat more' a complex process.

The strong collocations of both *eating* and *eat* with *feel* (*log-likelihood* = 66.32 and 57.47, respectively) provide further evidence that food consumption is semantically associated with emotional states in the corpus. Examinations of the concordances in which these collocations appear provide a clear insight into the forum users' attitudes towards food consumption:

51. *to be able to accept the attention of being made love to
 *to be able to **eat** and not **feel** ashamed and criminal afterwards
 *to be able to go out and not feel ashamed of myself
52. I really cant **eat** anything at this party, its a fondue party, and I really dont **feel** at all comfortable **eating** that, and i dont think it would match with my MP.
53. I do this all the time - especially when I'm homesick or **feel** ashamed of **eating**. It's just a spiral into feeling worse.
54. I really try not to **feel** guilty when I **eat** what I've allotted for that's my idea of GOOD and what I've craved....
55. I've stayed the same [weight] since I saw her last, which actually made me **feel** okay about **eating** "normally" tonight and having wine with my dinner, as she actually recommends for me.

The discussions of feelings in these posts associate the process of eating with powerful negative emotions of shame, guilt, and discomfort. These collocations establish a strongly negative semantic prosody (Louw, 1993) for *eat* and *eating* within the forum discourse, creating a semantic overlap between food consumption and difficult psychological states.

Repeated references to feelings of criminality, guilt and shame (ex. 51, 53 and 54) also associate eating with morality and represent food consumption as an act of moral transgression that must be balanced against the physical inclination to eat.

Extract 55 diverges from the prevailing negative semantic prosody of *eating*, with the author claiming to 'feel okay' about consuming food. However, this description is grammatically subordinate to stating that she has maintained her weight and is prefaced by the adverbial 'actually' to denote that this is in clear contrast to expectations (Carter & McCarthy, 2006: 28). Feeling 'okay' about eating is therefore presented as both unexpected and brought about – 'made' – by neither gaining nor losing weight. Consequently, despite representing a more positive experience of eating, this post reiterates the relationship between weight, food consumption and emotional responses that is characteristic of the other excerpts in this section. As with the forgoing analysis of *behaviours*, then, these posts exemplify a psychodynamic relationship between weight, eating and affect in which food is strongly invested with emotional significance (Malson, 2008).

Examination of concordance lines for other frequent collocates of *eat* and *eating* supports and extends this identified relationship between food and emotions. Examination of the collocations *not eat* ($n = 22$) and *not eating* ($n = 23$) suggests that experiences of 'not eating' coalesce into two categories. The first of these provides further evidence of the *behaviours* discourse above and situates eating in a system of emotional balance in which self-starvation helps counteract existing negative feelings. For example:

56. i was awful at everthing else except **not eating** and lossing weight, this for a second let me forget all my other inadeques.

57. [...] sometimes when things get really heated (mainly between me and my mom), my automatic response is to **not eat** [...] because it is the only way for me to feel some sense of "power" when I feel so stuck in terms of not being able to express myself in a healthy way,

These posts indicate an explicit awareness that food restriction functions as a means to cope with external stressors or feelings. This perspective is coupled with an awareness that the benefits which dietary restriction brings are fleeting – they last ‘for a second’ (ex. 56) – and that there are alternative ‘healthy’ ways expressing emotional difficulties (ex. 57). This contrasts sharply with the second range of attitudes:

- 58. -I am terrible at relaxing and whenever I try, the ED comes in full force, telling me that I am lazy, gross, unproductive and therefore should **not eat** or feel okay about myself
- 59. How do I make myself **eat** when the anorexic voices in my head are screaming at me that I don't deserve to eat?
- 60. this [exam disappointment] kinda caused me to **not eat** and restrict because I told myself I didn't deserve food if I didn't get good grades...
- 61. I was relying on ed now because I was mad that I got a ninety-five on a test. I wanted to get higher then that. And at my school that grade is only a B....which makes me very upset. [...]And when I consider that a failing grade then I wanted to punish myself..by **not eating** and resorting back to the eating disorder.

These extracts do not indicate that food restriction is a strategy for managing external difficulties or offers some ostensible emotional benefit. Rather, they represent restriction as a means of self-castigation for individuals who believe they are somehow unworthy of eating. These messages therefore reverse the beliefs above, in which food is viewed as a source of guilt, and instead portray eating as a reward that the authors feel they do not deserve (Skårderud, 2007). The responsibility for dietary restriction realised through clause transitivity in these excerpts is variable. In extracts 58-60, responsibility for ‘not eating’ is located outside the individual with ‘the ED’ or ‘anorexic voices’ telling the authors they do not deserve to eat, and with the exam results that ‘caused’ the author of extract 60 to ‘not eat’. However, later in the same message thread the author of extract 60, claims that she ‘wanted to punish herself’ (ex. 61), representing food restriction as a volitional, reflexive process that is contingent upon her perception of exam failure. Over the course of this thread, then, this forum member comes to implicate herself in her dietary restriction, seeing it as a deliberate punishment. Whilst only accounting for a small minority of the uses of *eating*, these two

posts provide a more severe construction of anorexia as a form of self-punishment and identify personal flaws – rather than disordered eating – as the cause of their difficulty. Accordingly, the author of extracts 60-61 elaborates her feelings later in the same thread, saying ‘No...i guess I never want to get better. I deserve to be miserable and unhappy.’

4.6.1 Food

Examples of collocations between *food* and *feel* ($n = 9$, $\log\text{-likelihood} = 22.42$) reveal a similar association between food and emotional discomfort, such as ‘The food can feel like so much and so uncomfortable’ and ‘I’m really embarrassed to admit that I eat junk food as I feel.... a bit lazy, to be honest, and greedy’. *Food* also has some unique collocates (and hence some connotative meanings) that are not shared by the verbs *eat* or *eating* (Orpin, 2005). Unlike *eat* or *eating*, *food* collocates with *fat* ($n = 5$, see section 4.6.2) and *mom* ($n = 6$), examples of which refer to mothers’ roles in the purchase and preparation of food. *Food* also collocates strongly with *obsessed* ($\log\text{-likelihood} = 63.97$), which occurs five times in the trigram *obsessed with food*:

62. I am **obsessed with food** even though I deprive myself of **food**. I only allow myself my "alloted" foods and no more than that.
63. I think some of the reasons why I am **obsessed with food** is b/c when I look at **food**, it makes me feel like I am "powerful" because I can say "no" to food that most people can't.
64. I guess what I want to say is this: being so constantly **obsessed with food** is a symptom of starvation.
65. When ever i was home i would make food for my sister and make sure that she ate it. I became **obsessed with food!**
66. I am **obsessed with food**. But I hate **food**.

This notion of obsession further elucidates the double bind of individuals with anorexia. This paradox is most succinctly articulated in the final example: a fixation with an object which is imbued with feelings of shame and self-reproach. The collocation of *obsessed with food* and

not with *eat* or *eating* appears to indicate that it is food itself, rather than the specific act of its consumption, that is the object of obsession for the users of *anorexia.net*.

Much of the corpus discourse around *eat*, *eating* and *food* reiterates a relationship between restricting the body and restricting difficult emotions found in the concordances for *behaviours* and *restrict* in section 4.5 (see also Skårderud, 2007). *Food* and *eating* are repeatedly associated with the experience of negative emotions, particularly guilt and shame (ex. 46, 54 and 53) and are also described as precursors to other difficult ‘hidden, buried feelings’ (ex. 47). The prospect of ‘eating more’ is regarded ambivalently; the recurring grammatical structures *need to eat* and *have to eat* construct eating as an obligation or necessity, while the extended concordance lines present *eat more* as the focus of conflicting impulses from parts of the self, ‘the ed’ and the prospect of coercive treatment. Some forum members also construct eating as a reward that they deny themselves if they feel unworthy (ex. 58-61). These messages indicate the danger of making generalisations regarding sufferers’ relationships with food and the degree of control they have over restricting their diets. Instead, the corpus data indicates that these experiences can vary between individual sufferers and over the course of an individual’s posts in a single message thread.

4.6.2 Encouraging eating: *Fat*

Faced with these anxieties towards food, the forum participants also encourage each other to overcome their aversions to eating or particular types of food. In particular, messages that feature the keyword *fat* ($n = 64$, $\log\text{-likelihood} = 162.61$) appear in 30% of the sampled threads and involve users voicing and responding to concerns about weight gain:

67. I believe a nutritionist or dietician is such an important part of the recovery process. I am so excited that you are considering this! It [seeing a dietician] will make a big difference in your recovery I promise! And remember that he/she is not out to make you *fat* or judge you.

68. You have to suck it up and try the food, sit with the feelings, and then come to grips with the outcome (which is ALWAYS that the one food will not make you fat!)
69. i spoke to my N about it and she said water cant make you fat and that long term not drinking fluids causes severe water retention and swelling.
70. Actually, I also have a fear that vitamins and healthy food will make me fat, but I know that candy has no nutritional value so it is not "food".
71. i'm just so afraid that i've permanently screwed over my metabolism and eating "normally" is going to make me fat.

[Next message post, different author:] you are not going to get fat if you honor your body and feed it. You are going to be healthy and grow. Llike you should.

As these excerpts illustrate, forum members posit a mechanistic link between eating and becoming fat and directly attribute agency to 'eating' or 'vitamins and healthy food' in 'making' them fat (ex. 70-71). Responding to these messages, other forum members characteristically negate this causal link, denying that it is the intention of dieticians to make patients fat or that food or water can 'make you fat' (ex. 67 and 69). These response messages are characterised by left-hand collocations of *fat* with *not* ($n = 8$) (ex. 67-68, 71) and negated auxiliary verbs ('cant', ex. 69). In the case of extract 71, 'get fat' is relexicalised as 'grow', a semantic amelioration that attaches positive connotations to eating, equating it with health and progress whilst eliding the fact that weight gain will likely involve at least some increase in body fat.

As these messages suggest, users attempting to challenge others' fears about eating or recovery characteristically do so by denying that eating or seeing a dietician will lead to becoming fat. Conversely, a noticeable absence in the discussion of *fat* in the corpus is any explicit suggestion that being fat constitutes an acceptable physique. Instead, the forum's discussion of *fat* illustrates the dilemma identified by Baker (2006: 114-115) that counter discourses often exemplify the arguments they intend to refute and, in doing so, validate them as worthy of denial. In the case of the messages reproduced above, the authors attempt to allay their addressees' fears about becoming fat. In doing so, they respond to these fears as if

there are legitimate, rather than denying that they are reasonable fears in the first place.

Therefore, even these supportive messages implicitly reproduce the belief that being fat is an undesirable state. To this extent, even while it may offer reassurance to anxious members, the discussion of *fat* in the forum fails to escape the esteem attributed to the thin female body that characterises anorexia and wider contemporary culture (Bordo, 2003).

4.6.3 Encouraging eating: *Meal plans*

A further significant facet of the forum members' discussion of eating was the concept of meal plans, which are referred to in over a third of the discussion threads. As with other recurrent nouns in the forum interaction, *meal plan* ($n = 50$) is frequently abbreviated to *mp* or plural *mps* (30 occurrences), with less frequent use of *food plan* (3 occurrences) and the compound *mealplan* (4 occurrences). Examples of these are presented below.

72. just know it can and will get better if you take the steps to follow a good **meal plan**.
73. So I can't go IP but I CAN start making more of a step forward. I mapped out a good **meal plan** that is healthy so I can follow it and I have set aside some time for each day to do something that I enjoy despite all the chaos with my classes.
74. I feel really proud of myself for yesterday and last night. I really did not want to follow-through on my **meal plan** [...]. But I then remembered all the things I want for myself and my life [...]
75. I am following my **mealplan** very well and have made great strides in letting go of rigid rules and ED behaviors.
76. I may still be able to pay for a few visits to get a good **meal plan**. I am actually willing to try a real **meal plan** which is real progress.
77. Well done for sticking to your **meal plan** and for being honest and open with your t.
78. If there is a specific reason you don't want to go [to hospital], keep reminding yourself that if you don't stick to your **mp**, you will eventually have to go.
79. I started worrying about what i had eaten (even though saturday was also over my 'normal/safe' **meal plan** i didn't let it affect sunday and ended up eating over my 'normal' **meal plan** anyway) [...]. Big mistake there and i shouldn't be surprised. The past few days have been pretty terrible **MP** wise and i have definitely noticed a difference.

As the extracts indicate, a number of the forum users construct meal plans as integral to the amelioration of their anorexia. This meaning is conveyed through the repeated presentation of

meal plans using a conceptual metaphor (Lakoff & Johnson, 1980). Recurrent references to users 'steps' (ex. 72-73) and 'strides' forward (ex. 75), having 'mapped out' a meal plan (ex. 73) and trying meal plans as 'progress' (ex. 76) each instantiate the conceptual metaphor RECOVERY IS A JOURNEY. While this conceptual metaphor is not exclusive to the *anorexia.net* community (Atkins, 2011), the metaphor is extended here by construing meal plans as a guide or facilitator of the journey towards recovery. Collocations between *meal plan/mp* and the verb of motion *follow/following* ($n=10$ and see ex. 72-75) further contribute to this conceptual metaphor, with meal plan adherence presented as a movement forward in accordance with a set route. This conceptual metaphor constructs professional dietary itineraries as symbolic guides that lead anorexics towards recovery. Along with being 'followed', extracts 77-78 present meal plans as the object of the process 'stick to'. In the British National Corpus's 10 million word spoken corpus, *stick to* collocates strongly with the *diet, principles*, and *rules*. Despite their name, the collocative association with *rules* and *principles* in general English suggests that meal plans are regarded more as normative strictures than as flexible 'plans'. Accordingly, meal plans are represented as the basis for praise when adhered to (ex. 74 and 77) and negative consequences when contravened (ex. 78-79).

Alongside this largely positive depiction there is also an alternative construction of meal plans as a source of potential anxiety:

80. i thought i had it under control again. and my dinner was items on my MP so i didnt feel too guilty.
81. Do try to stick to your **meal plan** during the day - regular eating means that you are less likely to guilt-eat and then get those voices nagging you about it.
82. I am telling my therapist and my nutritionist that I am struggling and not being compliant with my MP.
83. When I felt self-conscious about eating around others but wanted to maintain fidelity to my MP, I would pack a meal bar or two that fit my meal requirements and have veggies (salad) with others.
84. If I ate more than the allotted calories I would be breaking the rules.

85. I know you are right, but I feel like if I ate something, I would start to break down. I like sticking to my mp exactly.

As discussed in the collocational analysis of *eat* and *eating* above, references to guilt (ex. 80-81), 'fidelity' (ex. 83) and compliance (ex. 82) frame eating as an act of moral significance, obligation and potential transgression. Eating in excess of a meal plan is equated with 'breaking the rules' (ex. 84) and as leading to conflict with internal 'voices' and personal collapse – 'I would start to break down' (ex. 81 and 85). Non-prescribed eating is also associated with negative consequences when this eating is defined technically in terms of 'calories' or vaguely as simply eating 'something' (ex. 84-85). These forum participants thus present meal plans as both nutritional regulations and a moral index that assigns guilt to unplanned food consumption. Consequently, although they are discursively realised as a guide towards recovery, the dietary rules of a meal plan appear to constitute another avenue for investing eating with moral and emotional significance. In this regard, professionally sanctioned meal plans appear to reiterate the practices of the condition they seek to alleviate by codifying dietary control and providing an index of permissible and transgressive eating (Malson, 2008).

The last subsection illustrated that members of *anorexia.net* offer encouragement to those struggling to maintain healthy diets by denying a link between weight gain and an increase in bodily fat. As well as its questionable accuracy, this advice reiterates both symptomatically anorexic fears about becoming fat and conservative cultural attitudes that stigmatize body fat and 'fat' women in particular. This advice constitutes an unfortunate limit to the support group discourse, from which more emancipatory views on female body shape are notably absent.

The data in this subsection indicates that meal plans are repeatedly presented as a significant step toward recovery. However, other messages suggest that meal plans also offer a

professionally sanctioned means of assessing dietary success or failure and retaining an emotional investment in eating. This results in a further double bind for an individual with anorexia, in which a fundamental component of an individual's physical recovery from anorexia – regulated food consumption – perpetuates some of the debilitating psychological characteristics of the condition. Nevertheless, the change from regarding all food as taboo to seeing only non-prescribed eating as reprehensible would seem to be an important shift in anorexic patients' attitudes towards food.

4.7 *Anorexia.net* and medicalization

The foregoing analysis has considered the linguistic means with which the *anorexia.net* users commonly lexicalise anorexia, discuss their anorexic behaviours and convey attitudes towards eating and the use of meal plans. In doing so, it has touched upon the relationship between different concepts of anorexia and medical notions of disease, beliefs about professional treatment, and the use of medical technologies such as meal plans. This section draws on and extends this analysis to consider the forum members' discursive construction of anorexia in relation to medical discourses. I consider the forum users' dominant constructions of anorexia as 'the ED' or 'the ED voice', its relation to medical and psychological discourses and its implications for the users' identities as anorexics. I then consider occasions in which this dominant discourse is challenged by some forum members and the subsequent defence of a medicalised understanding of anorexia. In doing so, I aim to demonstrate that the medical understanding of anorexia represented by the 'the ED' discourse functions not only to shape the identities of individual sufferers but also as a resource for conducting sensitive interactional tasks and demarcating the parameters of the forum's support.

Traces of medical practices are evident on macro- and micro-linguistic levels of *anorexia.net*. For example, several of the different modules of the whole website in which users can post

messages are organised in accordance with the different eating disorder diagnoses in *DSM-IV* (APA, 1994). There are, for instance separate modules for discussions of anorexia, bulimia, Eating Disorders Not Otherwise Specified and binge eating disorder, which is included in the appendix of emerging diagnoses in the *DSM-IV*. Psychiatric categories therefore structure the macro-level discourse organisation for the entire forum, determining where topics should be raised according to professional diagnostic categories (Giles & Newbold, 2011).

The abundance of technical lexis in the corpus's keyword table (table 4.1) also provides a lexical indication that the forum discourse involves discussion of anorexia in medical or scientific terms. Alongside *food* and *eating* are the keywords *calories*, *intake* and *nutrition*. Similarly, professional *therapy* and *treatment* are frequently advocated for new forum members, a *meal plan* is construed as a guide to recovery and renewed intensification of anorexic practices are categorised under the medical label of *relapsing*. At a local grammatical level, the forum users prevailingly lexicalise anorexia using singular nominal forms *the ED* or *the ED voice* rather than as a state or identity of being *anorexic*. The depiction of diseases as definite, objectified entities is an attested characteristic of clinical discourse (Malson *et al.*, 2004; Nijhof, 1996; Warner, 1976) that establishes a distinction between the disease and the patient in whom it inheres (Cassell, 1976; Mintz, 1992). The numerous forum messages involving *the ED* therefore reify anorexia as a tangible entity that forms the basis for their virtual community and which the members share in common (Barker, 2008). The repeated personification of anorexia as *the ED voice* represents a more extreme version of the medical discourse of diseases as distinct objects. The notion of the *ED voice* not only depicts anorexia as separate from the individual sufferer but also presents anorexia as performing verbal and material actions. These personified representations of anorexia are not limited to the forum discourse. Freeman's CBT-based self-help book *Overcoming Anorexia Nervosa*, for example, contains similar agentive representations of

anorexia including, *inter alia*, ‘As the illness takes hold, it seems to squeeze out the ability to think’ (2002: 30) and ‘it is your AN that has taken over the reins and is controlling you’ (2002: 93). Similarly, on three separate threads on *anorexia.net* members refer to self-help books by Schaefer (2004; 2009) that personify anorexia from the outset. For example, in her recent text, *Goodbye Ed, Hello Me*, Schaefer claims that in recovery she ‘learned to think of it [anorexia] as a distinct being with unique thoughts and a personality separate from my own’ (2009: 1). Similarly, in a chapter subtitled ‘Separating from Ed’, Schaefer writes that ‘If I could just keep my weight low enough, Ed said that I could be in complete control of my life’ (2004: 3). This personification of anorexia as a distinct speaking agent clearly resembles the forum users’ discourse. Posts to *anorexia.net* therefore display intertextual parallels with examples of pro-recovery self-help literature that also construct a verbal separation of sufferer and eating disorder and attribute agency to anorexia itself.

The forum users repeatedly depict *the ED* or *the ED voice* as a speaking entity to convey having their actions and thoughts compromised by anorexia (see section 4.4). In this respect, these accounts of suffering from anorexia emphasise aspects of psychological impairment rather than, for example, socio-cultural interpretations of anorexia as a product of unfeasible cultural expectations of female bodies. According to Hardin, presenting anorexia as an issue of psychopathology ‘reinforces the idea that anorexia nervosa is a legitimate disorder deserving treatment’ (2003: 213) and aligns with the prevailing medical and psychological literature that a person with anorexia is ‘cognitively impaired’ (Boughtwood & Halse, 2010: 85; Jarman *et al.*, 1997). As noted above, aligning with a psychological understanding of anorexia also has implications for how the participants represent their responsibility for anorexia and their own actions. This is supported by Hardin, who claims that ‘having anorexia nervosa surface as the result of psychological problems [...] implies a lack of awareness/conscious choice and, paradoxically, unaccountability’ (2003: 213). The

participants' use of transitivity choices to present anorexia as autonomous and themselves as passive can therefore be situated within a wider psychological discourse that mitigates responsibility for their stigmatised condition.

There are, however, several occasions in which forum members explicitly challenge the dominant discourse that *the ED* is an independent entity that controls an individual's thoughts. Using extracts identified during manual reading of the corpus, I argue that responses to these challenges strongly reinforce the notion that anorexia is a biomedical problem and, moreover, that they do so using discursive strategies characteristic of healthcare professionals themselves. These instances of tension between forum members also demonstrate the contextual utility of *the ED* for managing interactional difficulties.

The most overt challenge to the concept of anorexia as a medical or psychological pathology appears in a message thread titled 'Anorexia: illness or choice?'. The thread consists of 28 messages posted over three days, of which four messages are written by the user who began the thread. As the thread title anticipates, the content of the first message interrogates the notion that anorexia is an involuntary illness:

86. I don't think it is fair to say that anorexia is an illness, because didn't I CHOOSE to do this to myself? It is not a physical sickness. There is nothing wrong with my body that is making me starve, or take laxatives, or puke, or exercise. You can't take an eating disorder blood test. It is not physical. So, that leaves it to personal responsibility, right? Or wrong? I would like to hear your opinions.

This forum user's argument that anorexia is not an illness is here premised on excluding anorexia from the category of 'physical sickness'. She claims that her engagement in anorexic practices does not arise from any bodily necessity and that anorexia is not amenable to medical assessments such as a 'blood test'. The absence of a physical problem, she argues, leaves 'personal responsibility' for anorexia and the notion that anorexia is a self-inflicted choice rather than an 'illness'.

Responses in this thread largely attempt to refute the first post, re-categorising anorexia as an illness and, therefore, also not a matter of individual choice. For example, the first reply opens with 'No one chooses to have an ED. It chooses you'. This universalised claim bluntly denies individual agency in the onset of anorexia. Like many of the excerpts reproduced above, this post attributes agency to 'ED' in choosing 'you' to be affected, once again encoding responsibility for anorexia through clause transitivity choices. Similarly, the acts of convincing, taking over, taking control, sliding back and coming upon the sufferer are attributed to anorexia throughout the course of the message thread, presenting the onset and maintenance of anorexia as determined by anorexia itself. An additional rhetorical strategy used repeatedly throughout the responses is to compare anorexia with an 'autoimmune disease' or 'cancer', which features ten times in six separate replies, for example:

87. I don't think it's a choice. That would be like saying "I want to get **cancer**!" and developing it. Doesn't work that way :-)

88. Was **cancer** any less real ***** years ago because medical technology had not reached the point of being able to test for it?

These responses both draw comparisons between anorexia and cancer as a means of claiming that anorexia is both non-voluntary (ex. 87) and that it is a 'real' condition even though it is not currently amenable to definitive medical assessment (ex. 88). In response to the original poster's claim that anorexia is 'not physical', these messages draw explicit parallels between anorexia and organic disease or argue that the absence of a definitive diagnostic assessment is only due to the present limits of clinical technology. The result is to categorise anorexia as a 'real' medical problem, even while claiming it is beyond medical assessment. Other forum users' responses draw on biomedical concepts:

89. People who are chemically balanced and don't have ED's know these are not normal behaviors and don't do them.

90. We don't choose our genes (Many people with ED's are pre-dispositioned because of heredity) and brain chemistry.

Rather than suggesting that anorexia is analogous to cancer, these excerpts go further in suggesting a fundamentally organic basis for eating disorders. In extract 89, practising anorexic behaviours is presented as determined by whether or not the individual is 'chemically balanced', constructing mental illness as a hormonal or neurochemical instability (Kangas, 2001). A few messages later (ex. 90), the same forum member denies that anorexia is a choice by repeating her explanation of anorexia in terms of 'brain chemistry' and genetic disposition. Both factors further situate anorexia beyond individual choice, presenting it in terms of unalterable chemicals or determined by hereditary factors predating the individual's birth.

In the face of questions over the status of anorexia as an illness, these forum members categorise anorexia as a controlling disease that is comparable to prototypical organic conditions and has a biomedical aetiology (Barker, 2008). This biomedical representation of anorexia excludes the possibility that the sufferer is responsible for developing anorexia. Having defined anorexia as a biomedical problem, the author of extracts 89-90 describes recovery in terms of contact with healthcare professionals and receipt of clinical treatments:

91. You get better by doing what anyone else with an illness does. You get help. If you have an ED you see a T, pdoc, and N. [...] You get medication for the chemical imbalances, and you get a MP to help you get your eating stabilized.

In describing recovery from anorexia, this forum user simultaneously constructs herself as competent and knowledgeable. She presents stages of recovery in a chronological, step-wise fashion that moves from the vague 'get help' to detailing specific aspects of recovery – 'stabilized' eating and chemical balance – and their clinical precursors. She also demonstrates awareness of various professional roles involved in eating disorder treatment – expressed using the forum's abbreviated sociolect 'T, pdoc, and N' – and suggests an awareness of physiology through reference to 'chemical imbalances'. In parallel with the presentation of anorexia as an individualised biological pathology, recovery is depicted as a categorical,

single course of action involving the adjustment to the individual's organic state through professional interventions. In doing so, this post provides paradigmatic examples of both medicalisation (Conrad, 1992) and Parson's (1951) model of 'sick role' and its obligation to accept professional intervention. Accordingly, later in this post, the author claims that patient with anorexia are accountable 'Not the illness, but the way you handle it'. Even though anorexia is constructed as biologically pre-determined and beyond individual choice, this user claims sufferers are nevertheless responsible for acting as patients by seeking and adhering to professional help.

As a 'pro-recovery' forum, the explicit rules of *anorexia.net* oblige users to support one another and proscribed discussion of anorexia as a positive condition or encouraging others to remain anorexic. Consequently, messages in which members express reluctance to recover or seek professional treatment create points of tension between the forum's guidelines and the experiences users choose to describe. Responses to these anti-recovery messages also risk infringing on the forum rules by being unsupportive or overtly critical of their authors (Sandaunet, 2008). In order to negotiate these interactional constraints, forum users again draw on the concept of the 'the ED' as a controlling, speaking entity. This occurs, for example during responses to a forum member describing ambivalence towards treatment:

92. She [therapist] is convinced I won't go back but says that if knowing I can will help take the leap now, I can think that way. Of course, then the ED comes back with "but then I would have to work so much harder to get back here" or "but what if I forget how to restrict or lose the (and I know this is an ED word for it) "willpower" to do it.

In challenging this message, the next message in this thread also draws on the presentation of anorexia as an active, speaking agent:

93. So ed is the epitome of accomplishment and control rather than recovery?

Or are you biologically and physically unique and the rules of the universe don't apply to you?

I say this out of care of course but it is really important. This is not your intelligent and sensible side that is speaking; it is totally ed using your voice to express itself.

Having topicalised the addressee's reference to 'willpower' by asking whether 'ed is the epitome of accomplishment and control', the author of excerpt 93 offers an indirect challenge using a rhetorical question and hyperbolic membership category to imply that the addressee is not 'biologically and physically unique'. Following this, the author performs several instances of face work (Brown & Levinson, 1987), claiming that her post is both said 'out of care' and 'really important' in order to categorise her disagreement as supportive. The author's final claim that describing anorexia in terms of willpower is 'totally ed using your voice to express itself' continues this strategy of indirect disagreement and serves several rhetorical functions. Firstly, rather than explicitly challenging the addressee, attributing authorship of her post to 'ed' serves to undermine its validity as another instance of anorexia 'talking'. That is, rather than a direct disagreement with the author of extract 92, the content of her message is ascribed to her ED voice, thereby displacing criticism from the individual onto a discursively separated anorexia. Secondly, attributing authorship of the problematic post to 'ed' simultaneously absolves the author of excerpt 92 of responsibility for writing an anti-recovery message and thereby breaking the forum's rules. A similar strategy appears in a separate thread, in which a forum user who claims to be gaining weight states:

94. I just don't understand why my body is not getting in shape like it did last time. [...]

As each day goes by it is getting harder and harder. I know I have come so far and was doing really well, but this has just pushed me over.

Again, the first response to this post orients to the addressee's difficulty with recovery:

95. Remember your ed is talking right now. It's not reality. Your body is trying to get healthier. Please don't fight that .

As with excerpt 93, the author of extract 95 uses the concept of anorexia 'talking' to respond to a forum user who claims to be struggling to recover and, as above, attributes authorship of the addressee's post to 'ed'. Categorising the addressee's message as her 'ed talking right now' also opens up the possibility of dismissing her account of failed recovery as simply 'not

reality'. In parallel with extract 93, then, the notion of anorexia 'talking' is deployed to indirectly disagree with another user and encourage her to disaffiliate from her own message by categorising it as a product of her eating disorder.

Extracts 92-95 indicate that forum members not only defend the concept of an autonomous, speaking anorexia but also use it as a resource for conducting facework when negotiating conflicts of opinion. By displacing overt criticism from the individual onto anorexia, group participants are able to delegitimise problematic messages without directly challenging another forum user or the supportive ethos of the wider group; the focus of criticism becomes 'ed' not another community member. At the same time, using the concept of 'ed talking' as a rhetorical strategy further reiterates the dualism of self and illness that is evident when the forum members are referring to their own experiences. Therefore, not only do forum participants define their own identities as anorexics using the concept of 'the ed', but also use it to interactively define others.

While the forum members do not claim to be medical professionals, their use of a particular notion of anorexia to destabilise resistance to treatment or recovery is a strategy associated with healthcare practitioners. As outlined in chapter 2, Guilfoyle (2001), argues that psychotherapists attempt to medicalise bulimic patients' resistance to treatment in order to overcome it. By persuading patients that their reluctance towards therapy is in fact a further symptom of a psychological problem, the patient's resistance 'becomes discourses as a psychological process within one person (the client) rather than a political struggle between two persons' (2001: 155). In therapy, Guilfoyle argues, the patient then reinterprets their reluctance as part of a mental health problem and becomes amenable to professional intervention. Similarly, in Malson *et al.*'s (2004) study, anorexic in-patients claim their doctors see their resistance to treatment as part of their 'illness talking':

Julie: Everything I say he [a doctor] just like, he laughs at you kind of thing. Like you say one thing and he just laughs and he goes: Oh it's not her talking, it's the illness.

Jessica: And they don't listen to you at all. And whenever you try and like rationalize anything with them they just, you get told to sort of shut up because it's the illness talking [...]

(Malson *et al.*, 2004: 482)

Malson *et al.*'s participants state that professionals use the notion of the 'illness talking' to strategically discount patients' attempts to negotiate treatment programmes. The result is to disempower the patient by claiming they are controlled by anorexia and therefore irrational. There are clear parallels between the present data and Malson *et al.*'s (2004) and Guilfoyle's (2001) research here. In each case, potentially legitimate claims about anorexia as a form of self-discipline requiring 'willpower' (ex. 92) or concerns over changing body shape and faltering recovery (ex. 94) are reconfigured as signs of psychological distortion and compromised self-control that characterise anorexia itself. In Guilfoyle's and Malson *et al.*'s research, attributing agency to a patient's eating disorder offers professionals a way to subvert patients' arguments during points of conflict and subject them to clinical interventions (see also Jarman *et al.*, 1997). In the *anorexia.net* forum, the discursive strategy of the 'ED talking' functions as part of an interactional repertoire (Wenger, 1998) for managing conflicting points of view, discrediting messages that problematise recovery, and mitigating direct criticism of others. In both cases, the notion of anorexia 'talking' is deployed to achieve contextually relevant interaction goals that underscore its discursive utility (Blommaert, 2005).

The analysis in sections 4.3 and 4.4 indicated that the forum participants present anorexia as an autonomous, speaking entity when recounting their own experiences of disordered eating. The statistically dominant notion of *the ED* is largely concordant with medical discourses of diseases as discrete entities and the focus on cognitive impairment in psychological anorexia research (Boughtwood & Halse, 2010). When used by the forum members, these concepts

linguistically distance the individual from their condition and emphasise its impact upon their thinking and actions and, in doing so, mitigate their agency and responsibility for a stigmatised illness. The analysis in this section suggests the forum members also explicitly defend the view that anorexia is a medical condition that should be treated through submission to professional therapy. Forum members also medicalise expressions of resistance to weight gain and claims that food restriction is an achievement by pathologising others' posts as examples of anorexia 'talking'. Consequently, as well as a means for forum members to populate their own narratives of suffering from anorexia, the concept of the 'ED voice' facilitates delicate interactional processes, such as tactful disagreement, which are specific to *anorexia.net*'s local rules and vital to its existence as a mutual self-help community. The polyvalence of the medicalised concept of anorexia for defining acceptable patient identities and negotiating disagreements provides a clear motivation for its predominance in the forum members' interactions.

4.8 Summary

Analysis of the *anorexia.net* corpus indicates that the forum participants prevalently refer to anorexia using a hypernym 'ED', with their attendant grammatical choices linguistically constructing 'ED' as an external, naturalised phenomenon. Presenting anorexia as a single entity serves to anchor the online community, homogenising users' respective pathologies into a common condition. The semantic profile (Orpin, 2005) of *ED* demonstrates that it is recurrently constructed as a speaking subject and directly personified as a voice. Although one forum user suggests this personification is empowering because 'it's easier to fight something when it has a face, so to speak', numerous other posts portray individuals with anorexia as passive objects of 'the ED's' actions. While correlating with representations of diminished personal agency, the discursive separation of anorexia from the self is used to

reassure some forum members that their self-identity will endure beyond their recovery from anorexia (Malson *et al.*, 2004).

The forum users present anorexic behaviours as a functional method for managing negative emotions and thoughts. Similarly, they also associate food with a range of negative emotions such as guilt and shame. Additionally, a minority of forum members present food as a form of reward and claim to punish themselves by not eating. Associations between food consumption and emotions appear to be perpetuated by users' 'meal plans'. Although meal plans are designed by clinicians to facilitate recovery, for the forum users they provide a resource for evaluating food consumption as positive or transgressive. Therefore, even though the forum participants' prevailing alignment with medical and psychological explanations of anorexia serves to dissociate it from issues of personal accountability or responsibility, meal plans represent clinical artefacts that are clearly imbued with moral significance.

Finally, forum users respond to claims that anorexia may be a choice rather than an illness by comparing anorexia to physical health conditions and suggesting biochemical and genetic factors have a causal role in its development. These responses explicitly frame anorexia as a biomedical disease and cue recommendations of professional treatment and a patient identity. Challenges to the 'pro-recovery' ethos of the forum are categorised as examples of users' 'ed talking', a strategy that undermines their legitimacy and reiterates the notion that anorexia is a cognitive distortion that precipitates behaviours including self-deception. These instances of conflict demonstrate the utility of 'the ED' and 'ED voice' for managing the forum's online interactions. At the same time, they indicate a collective intolerance of alternative conceptions of anorexia, including those that present anorexia as a choice and imply a more empowered role for the sufferer in their own recovery (Davison & Pennebaker, 1997;

Giordano, 2005 and see Sandaunet, 2008). A similar limit on the forum discourse is evident when members respond to each other's fears about becoming 'fat'. Rather than challenging the stigma associated with a 'fat' body, users choose to deny that weight gain and recovery of anorexia will lead to an individual becoming fat. While they may be intended for 'pro-recovery' support, the dominant representations of anorexia and recovery on the forum may therefore also preclude alternative understandings, prevent the expression of concerns that are meaningful for particular individuals and fail to challenge some symptomatically anorexic concerns.

5 Online discourses of depression

5.1 Introduction

This chapter presents the analysis of the *depressonline.net* sub-corpus. The analysis proceeds in a comparable way to the previous chapter, beginning with a semantic and lexical breakdown of the corpus's keywords before analysing the use of a number of these keywords in the forum's messages. This contextualised analysis centres on frequent collocations as a means of considering discourses around depression, using taxonomies from systemic functional linguistics to illuminate contextualised meanings of keywords. In an inevitably limited space it is only feasible to address a sample of these key discursive areas. In light of this, the subsequent analysis focuses on the discursive construction of depression, anti-depressant medication, suicide, and discursive signatures of medicalisation. These are salient topics of discussion for the support group participants and prevalent in existing literature (Cornford *et al.*, 2007; Epstein *et al.*, 2010; Galasiński, 2008; Schreiber, 1996; Schreiber & Hartrick, 2002; Stoppard, 2000). Although discursive evidence of medicalisation is examined in its own substantive section, medicalisation also provides a useful theoretical concept with which to interpret keywords in a number of other categories. Indeed, the ensuing analysis suggests that the forum users linguistically depict depression in a manner that frequently coheres with an objectifying medical model of depression, and use this concept to construct a separation between themselves, their condition, and its management.

A semantically and lexically grouped list of the corpus's keywords is presented in table 5.1. The keywords reflect an impressionistic summary of the forum messages, covering depression, suicide, medication, lexis related to emotions, healthcare professionals and treatment as well as keywords related to aspects of computer mediated communication. Analysis of negative keywords for the depression forum corpus revealed two identifiable

patterns. Firstly the forum users typically use numerals such as '4' rather than full homophones ('four') which are used in the reference corpus, resulting in negative key values for the orthographic forms. Secondly, the forum members make relatively infrequent use of contractions involving personal pronouns and auxiliary verbs, such as *they'll*, *I'll*, *you've*, *she's*, *we'll*, and *they're*. Characteristic of spoken discourse, these contractions have a very high frequency in the spoken reference corpus, resulting in a negative key value when compared with the written *depressiononline.net* corpus, in which the non-contacted forms are preferred. For example, whereas *you've* and *you're* occur only 74 and 155 times in the online corpus, comparable instances of *you have* and *you are* occur 169 times and 263 times respectively.

Table 5.1 – Key lexical and semantic categories of the depressiononline.net corpus

Lexical / semantic category	Associated keywords
Depression and mental disorder	<i>depression, depressed, mental, sleep, anxiety, mood, illness, bed, wake, bipolar, sick, symptoms, ill, depressive, disorder, normal, moods, manic, head, sleeping, nightmares, hallucinations, trigger, health</i>
Suicide and self harm	<i>suicidal, self, harm, suicide</i>
Anti-depressants and medication	<i>meds, medication, citalopram, tablets, seroquel, risperidone, diazepam, dose, taking, effects, depressants, anti, antidepressant, pills, venlafaxine, antidepressants, sertraline, depressant, drugs, overdose, extra, OD</i>
Feelings and emotions	<i>feel, feeling, depressed, thoughts, hope, pain, bad, worse, suicidal, anxiety, better, feelings, alone, scared, struggling, panic, felt, worthless, glad, stressed, tears, trying, hurt, low, suffered, understand, suffering, crying, miserable, thinking, hate, lonely, cry, tired, stress, angry, emotional, happy, worry, feels, esteem, sad, swings, stressful</i>
Healthcare professionals	<i>GP, CPN therapist, doctor, psychiatrist, pdoc, doctor, counsellor, seeing</i>
Medical and healthcare lexis	<i>depression, medication, depressed, mental, anxiety, therapy, appointment, counselling, CBT, dose, diagnosed, NHS, symptoms, prescribed, treatment, manic, brain, seizures, physical, mh, health, CMHT, hospital, diagnosis</i>
Support and recovery	<i>help, try, better, care, cope, support, helps, helped, advice, understand, treatment, normal, caring, supportive</i>
Abbreviations	<i>GP, meds, CPN [community psychiatric nurse], etc, lol [laugh out loud], CBT [cognitive behavioural therapy], pdoc [psychiatrist], NHS, TV, pm [personal message], weds [Wednesday], mh [mental health], CMHT [community mental health team], HR, OD [overdose]</i>
Forum-related lexis	<i>hugs, lol, posting, post, forum, thread, posts, [website name], online, email, replies, pm, xx, hug, internet, hun, journal, deleted</i>
Measures of time	<i>day, sometimes, weeks, time, days, years, moment, weds, months, posted, episode, hours</i>
Personal relationships	<i>friends, hubby, relationship, partner, boyfriend, girlfriend, friend</i>

As with the previous chapter, there is some overlap in the categories and their associated keywords. For example, many of the keywords in the ‘Anti-depressants and medication’ category overlap with the ‘medical and healthcare lexis’ group, though are separated here since they represent a distinctive class of the medical lexis employed on *depressiononline.net*. Similarly, keywords such as *anxiety* or *depressed* occupy an ambiguous position between non-medical descriptions of emotional states and professional diagnoses of mental disorder, and hence occupy several semantic categories. The ambiguity between lay and medical meanings of *depression* and *depressed* in the keyword groups is paradigmatic of the following analysis which, beginning with *depression*, identifies the negotiation of depression’s medical status as a recurrent feature of the forum interaction.

5.2 Verbalising a relationship to depression

The corpus contains an understandably high frequency of words relating to depression itself, with the most common being *depression* (442 occurrences) and *depressed* (126 occurrences). The following section uses concepts from functional grammar to analyse the specific lexicogrammatical patterns and associated meanings in which these terms occur, focusing particularly on the grammatical relations between the forum users and their condition.

5.2.1 Having and suffering from *depression*

The relative frequencies of *depression* and *depressed* demonstrate the forum users’ preference for referring to their condition with a noun rather than as a description of their feelings such as ‘I feel depressed’. This initial distinction coheres with Warner’s (1976) claim that Western cultures typically present illnesses as a noun rather than an adjective. When using this nominal form, the forum users present *depression* in a number of recurrent multiword constructions that encode grammatical relations between depression and themselves, summarised in table 5.2.

Table 5.2 – Recurrent multiword constructions involving depression

Phrase	Frequency
<i>suffering from depression</i>	12
<i>diagnosed with depression</i>	10
<i>have had depression/ I've had depression</i>	8
<i>suffered from depression</i>	6
<i>suffered with depression</i>	4
<i>suffer from depression</i>	4
<i>suffered depression</i>	3
<i>I had depression</i>	3
<i>suffered on and off with depression</i>	2
<i>suffering with depression</i>	2

With the exception of *diagnosed with depression* (see section 5.2.2), the forum users' attributions of depression coalesce into two main types. Firstly, they refer to depression using attributive clauses such as *have had depression*; secondly, they frequently refer to depression as an element of a behavioural process involving the process *suffer*. Both of these types of constructions are relatively unmarked ways of describing illness or psychological discomfort; Halliday (2002) observes that it is quite common to refer to 'having' some form of pain, and *depression* collocates strongly to the right of *suffering* ($\log\text{-likelihood} = 462.12$) and *suffered* ($\log\text{-likelihood} = 369.08$) in the British National Corpus. Despite this commonality, it is worth considering the specific grammatical relations each phrase encodes and the insights this grammatical analysis can offer into the experience of illness (Cheung & Pennebaker, 2007; Halliday, 2002). Those clauses involving *HAVE+depression* express a relational process in which depression is a possession attributed to the forum user. Those involving *SUFFER+from/with depression* present the forum user as a participant in a behavioural process – 'to suffer' – that is 'intermediate between material and mental processes' (Halliday, 1994: 128). In *SUFFER+from depression* constructions, depression plays a causal element in the clause. That is, depression represents the reason that the speaker's suffering takes place.

In the less frequent *SUFFER+with depression* clauses, depression occupies an accompaniment role, suggesting some form of joint participation in the suffering itself (Halliday, 1994: 140-141).

Common to both the relational and behavioural processes is an implied separation between the individual and their condition. In *HAVE+depression* and *SUFFER+from+depression*, depression is externalised and either possessed by or inflicted on the speaker, rather than being a change in their own internal processes (Fleischman, 1999; Warner, 1976). Dowrick (2004: 192) also suggests that *HAVE+depression* and *SUFFER+from/with depression* constructions objectify depression as a definite medical entity and, when they occur without modifiers such as 'post-natal' or 'severe', homogenise the numerous medical and personal forms of depression. Of these two grammatical structures, the forum users more frequently choose to refer to their condition as a process of 'suffering from' rather than 'having' depression. That is, the forum participants' more frequently express their relation to depression in terms of suffering rather than possessing depression, and simultaneously attribute this suffering to an externalised cause, depression itself. Galasiński (2008) argues that establishing a verbal separation between depression and the self is a recurrent feature of depression narratives in which individuals attempt to mitigate the stigma of illness by never explicitly identifying themselves with their condition. Since the forum participants demonstrate a preference for those grammatical constructions which convey the greatest distance between themselves and depression, Galasiński's reading would also seem a plausible explanation for these linguistic choices on *depressiononline.net*.

Concordance examples also suggest some contextual difference in the use of *SUFFER+with* and *SUFFER+from* phrases. As with the previous chapter, examples which exemplify wider trends across numerous concordances are presented throughout this chapter:

1. Hi there my name is [username] and i am from the uk. I have been **suffering with depression** for a number of years now and started to treat my condition around 6 months ago.
2. I'm new to all this so sorry if I should have put it elsewhere.
I have **suffered with depression** on and off for about 8 years now, and the latest episode (starting about 2 years ago) has been my most severe so far [...]. My question really is for those who have **suffered with depression** and then become pregnant
3. One of my college professors was epileptic and he also **suffered with depression**....that is until his doctors got the epilepsy under control. Apparently the worry about having a seizure, especially in public, was a big part of his depression.
4. Hi im new to this site
ive **suffered on and off with depression** for 20 years have just been diagnosed with it again after 2and half years being fine.

The forum extracts suggest that messages which present depression as something to be suffered *with* are authored by users who are posting their first message to the forum. These new forum members also include statements regarding the duration of their condition, in two of these instances seeing their depression as something that occurs 'on and off'. In the third example, 'suffered with depression' is ascribed to a third party but is seen as finite and successfully treated. These instances contrast with examples of *SUFFER+from*:

5. I've been **suffering from depression** for around three years and during this time I have managed to keep working, although not always as well as I would like. [...]but recently the meds have started to lose their effect and I can feel myself getting dragged down again.
6. Does it not make sense, then, that a fundamental change in one's behavior, ESPECIALLY someone **suffering from depression**, is going to take longer than 3 hours?
7. have you told your boss or anyone at work that you are **suffering from depression** i have as i was scared that if i broke down at work (which i have a couple of times) that they may think i was stupid
8. [...] he doesn't like me to talk to other blokes or go out at all but its ok for him to talk to other women its just got me all confused and i think thats why im **suffering from depression** again
9. I also found that people started to desert me when they found out I **suffered from depression**, but that was over 20 years ago, and times have changed I think more people are aware of the illness and what it entails.
10. I can't cope any more. I've **suffered from depression** on and off for 30 years but this time round it's been a 6 year spell that just won't seem to lift.
11. Some women really struggle during their pregnancies, sometimes even women who don't normally **suffer from depression**.

Participants' posts including *SUFFER+from depression* address issues arising from their condition, most noticeably regarding its effects upon their employment and interpersonal relationships, as well as seeking and providing emotional support for other forum members. Although the users do still refer to the duration of their suffering and, in one instance, see it as occurring 'on and off' (ex. 10), there is no instance in the concordance lines of seeing depression as permanently curable. Indeed, the progressive aspect of the most common form of this collocation, *suffering from depression*, indicates that depression is an on-going problem. In contrast to those suffering *with* depression, instances of *SUFFER+from depression* are also written by more established members of the *depressiononline.net* community. This suggests that long-term forum users begin to adopt linguistic choices which further distance themselves from depression, seeing it as an external cause rather than a co-participant in their unhappiness.

Depression's strongest and most frequent collocate is *the* ($n = 156$ log-likelihood = 573.16), with 35% of these collocations ($n = 50$) arising in the noun phrase *the depression*. As noted in the previous chapter, this collocation is somewhat surprising given that mental health conditions are less obviously amenable to grammatical concretisation; as Cassell (1976: 145) states, 'it would be odd to hear someone speak of "the depression" when speaking about his own depression'. Nevertheless, there are abundant examples of this discourse in the corpus, which in turn provide a rich illustration of users' experiences of depression:

12. After that it went completely to hell. **The depression** got a lot worse, my tutors were all supremely disinterested and the doctors up at uni all kept telling me I was just a 'little bit stressed', not depressed. Uh huh.
13. its **the depression** talking, i get that too when im not well. but [username] is making a good point, therapy might be a good option.
14. I have felt like that too, like an outsider looking in, and everyone seems to be happy, in a couple, going on holidays etc - just makes you feel worse, but I think **the depression** magnifies things also, because when you are 'well' it doesn't seem to upset so much, lol being around happy people, in my case, doesn't work [...].

15. Now, 11 years on..**the depression** is really taking its toll and ive got to do something about it.
16. The rest of the time I've struggled along with St John's Wort or nothing. (I was worried that if I admitted to **the depression**, after I had children, the social workers might take my children.)

These concordances further convey the personal difficulty depression entails for the members of the forum, again situating depression as a factor that problematises educational and professional activities (ex. 12), social relationships and maternal roles (ex. 16). As the above extracts indicate, examples of *the depression* frequently involve the presentation of depression in an active grammatical role, for example as 'talking', 'magnif[ing] things' and 'taking its toll' (ex. 13-15). Processes in which *depression* or *the depression* is a participant also encode forum members' perceptions of acquiring and recovering from their condition:

17. I think ,but did not realise it at the time, that was **the depression** starting .
18. I also feels there's not necessarily any reason for **depression hitting**: it may be that there was one event that tipped the balance and your mind could no longer cope, but there is probably a lot of underlying stuff that you may not even be aware of.
19. Strangely I never had post-natal depression with either of my children, and **depression didn't rear its head** again until I was in my early thirties.
20. prozac did wonders for next 2 years, then **depression came back**.
21. though it was after life events changed at the age of 12, I started to experience real senses of oppression, injustice, hatred and **depression came** after that.
22. Many doctors now recommend remaining on a maintenance dose for a full year after the symptoms of **the depression** lift.
23. I got depressed seriously after my first child was born nine years ago and it is only the past few years **the depression** has lifted but the anxiety is still here,now and again Damn panic attacks!!

Ordinarily we may euphemistically speak of catching, falling, or getting an illness in which we are, however involuntarily, agents (Johnson & Murray, 1985). On *depressiononline.net*, however, users repeatedly remove themselves from descriptions of the onset of their depression by using intransitive ('starting' and 'hitting' in ex. 17-18), reflexive processes (ex. 19) or spatial metaphors (ex. 20-21) to describe the start of their distress. Representing depression in this manner also constructs the forum participants as passive, with neither control nor responsibility for the onset of their condition (Fleischman, 1999; Karp, 1996).

This lack of agency during depression's onset is clearly demonstrated in extract 21: whereas the author constructs himself as grammatically agentive in experiencing feelings of oppression and hatred, depression comes by itself, seemingly beyond the forum user's control even if implicitly resulting from his feelings. A related pattern holds for the forum participants' descriptions of recovery in extracts 22-23. Rather than being an active process of struggling against depression, the figurative intransitive process 'lifted' presents the alleviation of depression as independent of actions taken by the speaker.

Further instances in which *depression* or *the depression* are presented in an active role reveal additional repeated discursive representations of depression:

24. Has anything happened? Or is it "just" **depression** biting hold? We are here for you.
25. I find I cannot make a sensible decision because I can't work out whether the need to make that important choice is being driven by **the depression** or by common sense.
26. Its so hard to recognise when your thinking is being skewed by **depression**, I know. I'm a great believer in writing things down, be it lists, posting on forums or journalling.
27. I've learned that when I'm depressed I make a lot of black and white judgements because that's the way **depression** makes my mind work.
28. I went a whole year of mapping my mood swings to my cycle and sometimes it fit and sometimes it didnt so I dont know what to think. I think maybe **the depression** makes the PMS worse, but the mood swings are also extra.

These forum extracts offer an insight into the ways in which the forum users present depression as affecting their subjective experience. As well as four examples of depression 'talking' (such as ex. 13 above), depression is presented as impairing sufferers' assessment of themselves and their capacity to make informed decisions (ex. 25-27). The forum members' lack of overt involvement in depression's actions is also noticeable throughout the above extracts. For example, in extract 24 and extracts 15 and 18 above, the figurative material processes of 'biting hold', 'taking its toll' and 'hitting' are each expressed without a direct or indirect object role that could be filled by an explicit reference to the forum member. Likewise, in extracts 25-28, depression's actions directly affect 'choice', 'thinking', 'my

mind' and 'the PMS', but never explicitly the forum participants themselves. Extract 27, for example, could have been articulated as 'that's the way depression makes me think', thereby encoding a transitive relation between the speaker and their depression. Instead, the clause constructions frequently hold depression at a remove from the forum members, articulating its influence over their actions or, in extract 30, a discursively separate 'mind' (Galasiński, 2008). This separation is particularly clear in extract 28 above, in which 'the depression' is said to 'make the PMS worse'. Not only is depression objectified using a definite article rather than a possessive pronoun, but it affects 'the PMS' which is also grammatically disowned by the speaker. Congruent with these posts, there are few instances in which the support group members present *depression* as directly affecting them:

29. Can't say may **depression** gives me those sort of symptons although I do often feel very detached from what is going on around me and regularly get the exhausted feeling.
30. Sometimes, reading over what I've written, I can see what **depression** is doing to me. Everything becomes black or white. I obsess and over analyse. I get a little paranoid that there are 'rules' out there for social interaction and I just don't know them.

Extracts 29 and 30 provide the only instances in the corpus in which forum participants explicitly encode themselves as an object of a process attributed to *depression*. Of these, extract 29 contextualises this interaction with a negated modal verb, and thus refers to something which depression in fact does *not* do to the author. Extract 30 is therefore the only example in which a forum member explicitly positions his/herself as the recipient of *depression*'s action. As noted above for extracts 25-27, this extract also refers to the effect of depression upon the speaker's perception and cognition.

Extracts 12-30 offer numerous instances in which the forum participants describe some form of interaction with depression, typically through its effect on their thinking. However, whilst depression is discursively formed as a volitional entity, its agency is only seldom presented as directly extending to the depressed individual themselves. In parallel with the forum

participants' accounts of *suffering from depression*, their descriptions of depression's actions typically distance it from their own identity; depression may 'take its toll' or 'bite hold' but the group members seldom present themselves as the direct recipients of these actions and their passivity is implied rather than explicit in the text.

In much the same way as avoiding use of 'I am depressed', this discursive distance seems intended to mitigate the stigma of depression by enabling forum members to depict their identity as at least partially independent of depression (Galasiński, 2008: 53-55; Johnston *et al.* 2007). Therefore, even as forum participants disclose the effects of depression on their thoughts and behaviour to the support group, they simultaneously make transitivity choices which distance themselves from the stigma of illness by constructing depression as distinct from their identity.

In contrast to messages involving *the depression*, which objectify the condition and verbally distinguish it from the speaker, *depression* also collocates strongly with *my* ($n = 47$, *log-likelihood* = 185.76), of which 32 (68%) instances form the collocation *my depression*. The relative frequencies of *my depression* and *the depression* here are comparable with those for *my ED* and *the ED* in the *anorexia.net* forum (see section 4.4) with nominalisation using the definite article occurring more frequently in both corpora. *Depression* also has several other frequent L1 collocates, including *of* ($n = 32$) and *with* ($n = 51$). These recur in a number of repeated clusters involving *diagnosed with* and *SUFFER+with* (see table 5.2 above) and the noun phrases *symptoms of depression* ($n = 6$), *signs of depression* ($n = 2$), *episode(s) of depression* ($n = 3$) and *bout(s) of depression* ($n = 2$).

Concordances for *my depression* indicate that it is often situated in a particular discursive context which is not shared by *the depression*:

31. My sister spent such a long time making me feel like this and even telling me I was using **my depression** to act badly towards others whenever I tried to stand up for myself
32. Thats exactly the reason why my parents don't know of **my depression**, I saw it with my brothers wife who was in a horrible condition, psych wards etc for a few years, they just don't understand.
33. Only three people know the extent of **my depression**, one of which is my boyfriend, who just this evening said "I am fed up with your moods" which doesn't really help.
34. I tried that with my ex. I sat her down on our third meeting and told her all about **my depression**, the treatment, the psychiatrist - all of it. I was convinced that she would run a mile, but she didn't.
35. However, I do now feel resolved to do something. Having taken such positive steps to deal with **my depression** and stop drinking [...] then it would be silly not to deal with all the other issues at the same time.
36. My therapist is honestly heaven sent [...]. She helped me realise what it is that I need/want to do to be able to put the initial cause of **my depression** behind me.

These extracts indicate that, whereas *the depression* is employed when forum members are discussing the indirect effects depression has upon them personally, forum users adopt *my depression* when discussing its impact on their personal relationships. The authors of extracts 31-36 (as well as seven further messages in the corpus) all make reference to *my depression* in relation to its effect on their relationships with family members or partners. Depression is presented as having an adverse effect on these relationships due to uncomprehending or unsympathetic responses from others (ex. 31-33) or anxiety about divulging the secret of mental illness – ‘I was convinced that she would run a mile’ (ex. 34). Forum users who report witnessing the stigma of depression also claim that the expectation of non-comprehension from others leads them to remain secretive about their condition (ex. 32).

Messages involving reference to *my depression* provide some counter to concern that online support groups lead their members to neglect supportive relationships in their daily lives (Baker & Fortune, 2008; Wright & Bell, 2003). Following an account of a failed relationship, one forum participant asks if he should refrain from romantic engagements altogether. The responses, including the message from which extract 34 is taken, acknowledge the fear engendered by revealing depression to a loved one but suggest that this anxiety can be misplaced and the relationship worthwhile:

37. I was pretty scared about that conversation before hand, but i thought if he backs off afterwards at least i've saved myself the heartbreak [...]. That was 19 months ago, and we're about as perfect as a couple gets.

In these cases, the choice of *my depression* suggests a greater proximity between the speaker and condition but does so in a more positive context. Using a possessive determiner also validates the author's attendant advice by signifying its foundation in subjective experience of her own personal illness. *My depression* is also used in a positive discursive context in extracts 35-36, in which forum members explicitly verbalise their ownership of depression while referring to steps they are taking towards recovery. Similarly, one forum member uses *my depression* three times in a post describing the onset, duration and management of his/her condition, before using *my depression* in a subsequent post five days later in which s/he states:

38. I guess I'm lucky as most of the time nowadays I cope pretty well although I still have down days. [...] Anyone who has read my post about how **my depression** began will recognise that I imagine.

These examples suggest that *my depression* may have a more positive semantic prosody if the collocation is examined in the wider context of the messages in which it appears. That is, as with examples of *my ED* in section 4.4, *my depression* correlates with users reporting a movement towards recovery or with those who have developed the ability to keep their depression at a manageable level. In contrast to the objectifying instances of *the depression* above, these examples also suggest that some of those forum members who explicitly verbalise their possession of depression are those for whom it is currently less problematic.

5.2.2 Being depressed

Depressed occurs 126 times in the *depressiononline.net* corpus across 34% of the sampled message threads. *Depressed* functions most frequently as a complement in intensive attributive clauses, predicating depression as a feature of the speaker, rather than a possessed object. For example, by incorporating depression into the speaker's identity rather than

constructing it as a distinct phenomenon, phrases such as 'I am depressed' posit a closer relationship between speaker and condition than 'I have depression' or 'I suffer from depression' (Fleischman, 1999; Warner, 1976). During focus groups with depressed patients, Epstein *et al.* (2010: 958-60) found that sufferers deliberately avoid expressing this closer relationship, with one participant explicitly comparing 'having depression' and 'being depressed' to 'having cancer' and 'being cancerous'. The latter of each pair was believed to construct the condition as an enduring trait and was explicitly identified as more stigmatising than the possessive clause. The stigma associated with 'being depressed' by Epstein *et al.*'s participants provides a feasible explanation for the frequency of *depressed* in the corpus, which occurs 316 times less than *depression*.

Other than *I*, the two strongest collocates of *depressed* in the *depressiononline.com* corpus are *was* ($n = 33$, $\log\text{-likelihood} = 190.13$) and *been* ($n = 19$, $\log\text{-likelihood} = 111.33$), examples of which are below.

39. The first time I **was depressed** was when I was 13, I was terribly shy and self conscious and was tall and fairly advanced for my age. [...]I eventually got through that phaze after a few years, without it ever really being diagnosed as depression, at the time it was said that I had an inferiority complex.
40. I've **been depressed** since I was in my late teens/early 20's. Back then, I just assumed everyone felt the same way and dealt with the same feelings, etc. It wasn't until I was in my 40's that I began to discover what was going on and not until lately have I gotten counseling with a psychiatrist and proper diagnosis and medication which has helped a lot. I just have to accept the fact that my brain chemicals don't work like most people's and that I react differently to stimuli differently because of that
41. I think I have **been depressed** from about the age of 15 when I used to lie on my mums bed and cry for hours. I would plead with her to take me to the doctor as I knew something wasn't right
42. I realise now with the benefit of much reading and soul searching that I have **been depressed** most of my adult life but not been able to properly articulate what I was feeling.

In the messages above and other concordance lines for *depressed*, *was* and *been* collocate to the left of *depressed* as part of copula constructions of the form *have+been+depressed* or *was+[adverbial intensifier]+depressed*. These account for 88% of left collocations between *been* and *depressed* and 90% of left collocations between *was* and *depressed*. Expressions of

previous uncertainty over the nature of depressed experiences are consistently apparent in the concordances containing *been depressed*. For instance, the author of extract 40 states that it took two decades 'to discover what was going on'. Similarly, extract 41 refers to knowing only that 'something' wasn't right and the author of extract 42 describes the 'soul searching' that helped him to realise he is depressed. These three posts thus all suggest that depression may not immediately present itself as an explanation for personal unhappiness (Wittink *et al.*, 2008).

As these extracts indicate, *been depressed* and *was depressed* frequently occur in messages where forum participants are discussing the duration of their depression. As a result, *depressed* collocates significantly with words such as *when*, *since*, *years* and *life* that signal recurrent and chronic periods of unhappiness. Over half (56%) of occurrences of *was depressed* and *been depressed* appear in one message thread that also contains 30% of the total instances of *depressed*. This is the third longest thread sampled from the forum and contains 73 message posts in which forum members offer short narratives of their condition. For members who describe depression starting during their childhood, these narratives often include reference to unstable family lives, physical and/or sexual abuse or unspecified 'stuff that happened' during childhood, as well as incomprehension from their parents. Those who identify the onset of depression during adolescence describe feelings of sadness, anxiety, shyness and social isolation but do not often offer any causal explanations for their feelings (ex. 39-41). Forum members who describe the onset of depression in adulthood frequently refer to post-natal depression, parental death, abusive relationships and the demands of work. The majority of these narratives recount engagement with health professionals followed by antidepressant and/or talking therapies which have not helped the authors to recover. Three further examples are offered in extracts 43-45:

43. Looking back myself I really have **been depressed** since I was about 15. I also had slight anorexia at the time [...] It was left untreated till I was about 22 my previous job didn't help and made it worse, that's when I realised I actually had depression and anxiety.
44. Although I was dx'ed with depression when I was 18, I think I **was depressed** for some time before that. I was actively suicidal throughout my teens, and my first attempt was when I was 16.
45. I was diagnosed with depression in my teens.....I had trouble sleeping too. [...] I've **been depressed** since but although I'm taking Anti-depressants now, I have no current diagnosis.

Within these narratives, forum participants draw on medical and psychological discourses to contextualise their experiences with reference to depressive symptoms of sleeplessness (ex. 45) and suicidal ideation (ex. 44) or psychological concepts such as 'an inferiority complex' (ex. 39). These narratives thus frequently take on the form of proto-diagnoses, in which participants adopt a position of rational self-observation over their past lives and integrate medical concepts within their 'unique biographical frame of reference' (Pilgrim & Bentall, 1999: 268). Finding a similar tendency among depressed interviewees, Galasiński (2008) argues that the process of retrospective self-diagnosis positions depressed individuals as rational and capable of detached reflection on their condition. This in turn permits forum members to demonstrate a rational capability and to reframe previous difficulties as symptoms of depression rather than personal imperfections. Schreiber (1996) also suggests that situating depression within a wider personal history that includes periods of relief and instances of positive behaviour is an important aspect of recovery. A recovering individual, she argues, is more likely to accept depression and internalise it as part of their personality, eventually being 'able to see herself as a whole person, complete with inconsistencies, strengths and shortcomings' (Schreiber, 1996: 486). Copula constructions such as *have been depressed* that actively reduce the distance between speaker and condition offer a verbal index of this integration in the context of participants' self-reflection.

However, the high frequency of *was depressed* in this one thread is particularly surprising given that the title of the thread to which forum participants are responding, 'How long...

...have you suffered from depression?’, verbalises depression as an external entity. Forum participants who use *was depressed* in this thread are therefore opting to express their relationship to depression in a way which differs from that established by the thread’s title as well as the community’s verbal norms more generally. Extracts 39 and 43-45 above provide explanation for this. In each extract, forum participants establish a distinction between being or feeling *depressed* and subsequently having *depression*, a grammatical change associated with their interactions with clinicians. This distinction is reflected in the respective semantic profiles of *depressed* and *depression*, established by the unique lexical collocates each word carries (Orpin, 2005). These are summarised in table 5.3.

Table 5.3 – Unique lexical collocates of depressed and depression, based on their top 50 strongest collocations

Node	Unique lexical collocates
<i>depressed</i>	<i>feel, feeling, life, people, say, think, time</i>
<i>depression</i>	<i>anxiety, cause, diagnosed, illness, natal, post, suffer, suffered, suffering, symptoms</i>
Shared lexical collocates	
<i>years</i>	

Their distinctive sets of lexical collocates suggest that, despite an ostensible similarity, *depressed* and *depression* have significantly different semantic profiles in the forum discourse. *Depressed* is represented as an affective state associated with feeling and thinking and with measures of time. By contrast, *depression*’s unique collocates situate it firmly within a medical register through collocation with specific diagnostic labels such as *post-natal* and reference to *symptoms* and diagnosis. The movement from being *depressed* to having or suffering *depression* thus involves resituating depressed feelings and their relationship to the self within a medical discourse, via a process of professional medical diagnosis. Likewise, the narrative presented in extract 40 recounts the author receiving

‘counselling with a psychiatrist and proper diagnosis and medication’, before he defines his depression as ‘my brain chemistry doesn’t work like most people’s’. In this case, contact with healthcare professionals clearly correlates with the uptake of a biomedical model of depression.

Grammatically, the process of medical diagnosis in the extracts above correlates with a change in users’ identities from ‘being depressed’ to ‘having’ or ‘suffering from depression’. This change alters depression from a personal attribute to an externalised possession or antagonist. The analysis in section 5.2.1 above indicates that messages which construct depression as an external object frequently also depict depression as autonomous and having a powerful, deleterious effect upon their lives. In this respect, the forum interactions suggest that a diagnosis which concretises subjective distress into a definite clinical entity called depression may also exacerbate individuals’ concept of their unhappiness and their control over it. However, I am cautious of suggesting a causative rather than correlational relationship between diagnosis, a medicalised view of depression and a diminished belief in one’s ability to recover (Knudsen *et al.*, 2002). As Karp (1996) suggests, adopting a medical understanding of depression and regarding it as beyond individual control are potentially independent characteristics of chronic depression, in which the condition endures despite the sufferer’s efforts to recover.

Rogers *et al.* (2001) argue that the experience of becoming depressed deeply affects an individual’s ideas about their self and engenders a need to reconfigure an acceptable self-identity in relation to their condition (Galasiński, 2008; Karp, 1996). The foregoing analysis has focused on the use of a relatively small number of keywords and collocations used on *depressiononline.net*, arguing that the grammatical relations established with these collocations facilitate significant identity work on the part of participants. Foremost amongst

this identity work is the construction of a distinction between depression and the self and the objectification of depression itself. By using transitivity choices to present depression as an actor, the forum users grammatically encode an experience of uncontrollable distress (Karp, 1996). This process distances the sufferer from responsibility for their condition and absolves them of the attendant stigma of illness (Johnston *et al.*, 2007). In line with Cassell's (1976) claims, collocations in which forum members verbally reduce the distance between their selves and depression, such as the copula construction 'I have been depressed', are comparatively uncommon in the corpus. However, as Schreiber (1996) argues, these copula clauses may also signify forum members coming to terms with their condition.

The following section addresses the discursive construction of medication, finding a similar construction of depression's separation from the individual in relation to medical treatment.

5.3 Anti-depressants and 'the right medication'

Although *depressiononline.net* has a separate 'Medication' module, the 'Depression' module from which the corpus is compiled is replete with references to anti-depressant and mood stabilising pharmaceuticals. Questions about dosages, latency periods and side effects as well as discussions of the desire to overdose and decisions to stop taking anti-depressants were apparent even during the process of corpus compilation. The range of specific antidepressant brands appearing in the keyword list provides *prima facie* evidence that the forum members have a sophisticated biomedical repertoire (Stephens *et al.*, 2004) that differentiates various branded SSRI antidepressants (*citalopram*, *venlafaxine*, *sertraline*), antipsychotics (*risperidone*, *seroquel*) and sedatives (*diazepam*). References to medication, dosages or effects using the keywords listed in table 5.1 occur an average of around once every 200 words in the corpus, indicating that they are a recurrent feature of the forum interaction. Of these keywords, by far the most frequent are *meds* ($n = 175$) and *medication* ($n = 145$).

Notably, the forum users prefer these superordinate nouns over the specific *antidepressants/anti-depressants/anti depressants* (43 occurrences in total), and their abbreviated forms *AD* or *ADs* ($n = 8$). The use of *medication* permits speakers to refer to the various differing antidepressant, bipolar, and antipsychotic products using a single term that emphasises their medicinal purpose. It also offers an alternative to the superordinate term *drugs* ($n = 38$), which is used in the forum to refer to both prescription and recreational narcotics and hence carries a less positive semantic prosody and the risk of misinterpretation.

Despite both *meds* and *medication* appearing a total of 320 times throughout the corpus, there are only nine instances in which either collocates with *depression* itself, examples of which are reproduced below.

46. You are tackling the **depression** with **medication** and hopefully, you will feel physically better and begin to put on weight etc, which is step 1.
47. Are you currently taking any **medication** for the **depression**?
48. R u on any **meds** for ur **depression**?
49. 3 months ago i was feeling depressed but didn't want to take **medication** because i feel **medication** long term changes the person. Obviously hormone related **depression** can benefit from **medication**.

Both extracts 46 and 47 utilise the *the depression* bigram which is identified above as establishing a discourse of depression as a separate entity. In each case it is for *the depression*, rather than the individual patient, that antidepressants are taken. Extract 49 also divorces depression and medication from individual sufferers, suggesting that hormone related depression itself benefits from antidepressants rather than the individual sufferer. This reduction of the therapeutic process to one between medicine and illness rather than medicine and patient is a well-documented characteristic of medical discourse (Poirier & Brauner, 1988; van der Geest & Whyte, 1989). Extract 48 uses the common rebus 'ur' to represent possessive 'your' and, in doing so, makes explicit that medication is for depression which is

associated with her addressee. Nevertheless, the implied target of antidepressants remains depression itself, rather than the individual or their subjective feelings of unhappiness.

This medical discourse is further suggested in extract 49 by the statement that medication benefits ‘hormone related depression’. The author specifies an explicitly organic basis for unhappiness and suggests that antidepressants work to alleviate a chemical imbalance. This forum user also presents antidepressants as a threat to their sense of self – ‘medication long term changes the person’ – with this danger offering a justification for avoiding medication (McMullen & Herman, 2009). This reasoning also encodes a separation of depression and antidepressant effects from the individual. That is, rather than seeing personal alteration as, in fact, the aim of antidepressants, a change to ‘the person’ is constructed as an adverse effect of ‘long term’ medication use that should ideally only affect depression. The forum member thus orients towards medical conceptions of depression as a distinctive, organic disease whilst also viewing antidepressants as a potential danger to the individual subject (Maxwell, 2005). The result is a mixed discourse of antidepressants, combining characteristically medical representations of the therapeutic process with lay concerns about a self who will be changed in the process of recovery (Stephens *et al.*, 2004).

These examples contrast with instances in which antidepressants are ascribed as being directly ‘for’ sufferers, instantiated in collocations between *meds*, *medication* and personal pronouns:

50. you have made the first steps and got help from your GP so well done - lets hope these are the right **meds for you** in the end.
51. what works for one person doesn't work for the next and it may take a few attempts before you find the right **medication for you** X
52. If you get the right **medication**, and help, **for you** then things will improve
53. [...]because I have been on quite a few diff meds over the years I have been referred to a psychiatrist to sort out best **meds for me**.

54. I agree with [username]. -- I think you need to find another doctor that is willing to listen and work toward finding the right meds for you.

The repeated collocations *right meds* and *right medication* are apparent in the extracts above.

Along with 'right dose and medication', these collocations appear eight times in the corpus.

Whilst the antidepressants discussed in extracts 46–49 above were intended for 'the depression', medication which is intended for an individual is pre-modified as the *right medication* or *best meds*. Repeated references to the *right medication*, defined in extracts 51 and 52 as that which 'works' and improves 'things', demonstrates that the forum users are aware there are different antidepressants available, including those that could, by implication, be 'wrong' for the individual. The above concordances construe finding the *right medication* as a valuable goal for the forum members, even if this can mean a process of trial and error with ineffectual drugs lasting 'years' (ex. 53) and where the benefits are only vaguely defined. The repeated discussion of the *right medication* also suggests a faith in antidepressant therapies that explains a lack of improvement as a mismatch between the individual and a specific pharmaceutical product or dosage. Accordingly, the *right medication* is something to be hoped for (ex. 50), is a precondition for improvement (ex. 52) and is worth breaking continuity of care to pursue (ex. 54).

The encouragement to seek a personally suited antidepressant parallels the ethos of patient consumerism noted in Barker's (2008) study of a fibromyalgia support group whose members suggested that other users change clinicians and therapies until they were satisfied. Whilst promoting the notion of a *right medication* may usefully encourage patients to be proactive in their healthcare choices, it may also lead to conflict when doctors prescribe treatments with which the patient disagrees. For example, in extract 54, a forum user who has been refused antidepressants by her doctor is encouraged to change doctors in order to pursue the *right meds*. While criticising the forum member's GP for not listening, this response nevertheless conveys the forum members' dependency on medical professionals who act as drug

gatekeepers. This extract is also typical of responses in this thread, which endorse changing GP in order to fulfil the member's medication preferences. None of the responses suggest that the doctor may be correct and pharmacological therapy may in fact be unnecessary. The forum's collective emphasis on finding the *right medication* may therefore risk conflict with clinicians who are less convinced of the need for medication than the patients are themselves.

5.3.1 *Side effects*

The keywords *side* and *effect* (*side effect*, $n = 53$) demonstrate that the adverse effects of antidepressants are a recurrent topic of the forum's message threads. *Side effects* collocates specifically with the keyword *citalopram* ($n = 5$, *log-likelihood* = 47.37), a commonly used SSRI antidepressant. Concordance lines involving *citalopram* and *side effects* reveal common experiences of those at early stages of medication therapy:

55. Does anyone here suffer bad **side effects** from **citalopram**?
Im agitated, lethagic and fatigued all the time. Its doing my head in, as the **side effects** seem worse than the actual benefits that I am supposedly getting.
56. im on **citalopram** and unfortunately the **side effects** are awfull to start of with i lost 3 days when i started taking them was so spaced out
57. Im on **citalopram** at the moment, which is terrible. I am not sure if I expect it to magically fix me but I feel worse than I did before I started taking it.
58. I took anti-d's for the best part of a year but then slowly took myself off them as the **side effects**, (including confusion and memory loss) became far too much to cope with.

As the above extracts indicate, concordances around both *citalopram* and *side effects* convey a near-universal negative experience of initial antidepressant treatment. Extracts 55-57 describe these experiences as 'awful', 'terrible' and 'doing [the user's] head in'. The author of extract 55 also articulates his side effects as a list of three symptoms, using technical terminology rather than comparable lay terms. Following Jefferson (1990), Drew avers that triplet lists convey that 'the *totality* of something is represented' (2006: 72). In the case of extract 55, then, the three-part list 'agitated, lethagic and fatigued' defines the speaker's

entire experience using adverse medical symptoms. The list construction contributes to an extreme case formulation (Pomerantz, 1986) in which the side effects are constructed as all-encompassing and experienced 'all the time'. These side effects are then summarised as 'doing my head in', a metaphor that concretises the speaker's psychological distress in terms of physical injury.

These extracts present the side effects of antidepressants – and explicitly Citalopram – as exacerbating the lived experience of depression by engendering symptoms which are themselves characteristic of depression. In the case of extract 58, side effects are also offered as the reason for the author discontinuing drug therapy. The construction of this post suggests an attempt to legitimise the author's decision to unilaterally manage his medication. For example, he specifies the duration of his adherence using an upgrading adverbial of time, 'best part of a year', and his claim to have stopped antidepressants 'slowly' signifies cautious rather than impulsive behaviour. This 'defensive detailing' (Drew, 1998) continues in his specification of particular side effects, the effects of which are upgraded by the adverbial 'far' to emphasise the severity of his psychological burden and hence rationalise his non-adherence to antidepressants.

Messages which respond to the accounts of side effects above also orient to the possibility of non-adherence by encouraging compliance. The following extracts are taken from responses to messages in which users describe their difficulties with side effects.

59. When first taking new medications for depression it does seem that the **side effects** are worse than the depression itself. But usually they do subside and assuming you've got the right dose and medication [...] they can help and are of a benefit to you in the long run.
60. I'm on citalopram, and i've suffered all of the **side effects** you can get- complete with it actually making my illness so much worse for a few weeks!!
It generally gets worse before it gets better [...], so my advice is to stick with it!! At least the **side effects** show it's doing something!
61. Fatigue and nausea are really common **side effects** of citalopram and other antidepressants of that type, but they usually go away a few weeks after you start.

62. I have tried various different meds and seem to have found one for me that keeps me stable most of the time. I do get **side effects** but compared to me at my most depressed they are a walk in the park. [...]Just want to reassure you it can and will get better, even if it takes some time.

These messages employ a number of consistent linguistic features to allay their addressees' doubts regarding the adverse effects of medication and encourage them to maintain their drug regime. Extracts 59-61 each orient to the accounts of debilitating side effects put forward by their addressees by initially acknowledging the difficulty of taking antidepressants. In suggesting that the side effects will diminish, each forum member uses the adverb 'usually' or 'generally' and, in doing so, constructs themselves as having knowledge of typical therapeutic trajectories. Similarly, by describing fatigue and nausea as 'common', the author of extract 61 implies a personal knowledge of reactions to antidepressants and places the addressee's symptoms within this category. Further, by describing Citalopram as an example of 'antidepressants of that type' he implies knowledge of the side effects of SSRIs more generally, and hence sufficient expertise to offer worthwhile advice. Likewise, the author of extract 60 claims to have endured 'all' the side effects, constructing her own extreme case formulation to convey that her advice to 'stick with it' is founded on extensive personal experience. The author of extract 62 also establishes credibility by describing her experience of 'various different' antidepressants. This forum member then draws a direct comparison between her experience of side effects and her pre-medication experience that rationalises adherence to antidepressant therapy as a balance between medicated and non-medicated experiences. Responses to group members who report giving up antidepressants display similar discursive strategies. This is evident in one thread in which an individual claims to have unilaterally discontinued her medication. Asked why she stopped taking antidepressants, she responds:

63. Not sure why I stopped. Just decided to, and I guess I wanted to feel in control. I also did it as an attack on myself, on my stability I guess. So you see its all my own fault, I did it to myself.

After an initial expression of ignorance, the forum member tentatively cites a desire for self-control as a reason for non-compliance, eventually claiming 'all' responsibility for discontinuing antidepressants and twice presenting non-compliance as a deliberate reflexive act, carried out 'on myself'. This emphasis of personal agency and self-control represents non-adherence as an attempt to regain autonomy from antidepressants (Karp, 1996; McMullen, 1999). A comparable finding is noted by McMullen and Herman (2009), who observe that accounts of non-compliance repeatedly employ 'I' and 'myself' to represent the author as the active locus of change. In responding to this post, another forum member writes:

64. I've taken anti depressants and felt so much better that, after a while, I thought I didn't need them any more. I soon found out how wrong I was! [...] And choosing to take them is control - you are choosing to deal with what's making you ill.

As in extracts 59-62, this forum user explicitly foregrounds her first-hand experience of non-adherence before attempting to recategorise the use of medication as an act of personal control. After equating 'choosing to take' medication with 'control', the repetition of 'choosing' with a second person 'you' as subject emphasises the volitional, self-determining nature of drug taking. Rather than a threat to autonomy, psychotropic medication is reframed here as a grammatical object of individual choice. A similar discourse of medication is identified by Adams *et al.* (1997), who argue that viewing medication as a means of self-control helps to manage illness stigma and correlates with the uptake of a medical model of disease. This correlation is evident in extract 64, where the author suggests medications 'deal with what's making you ill', thereby implying that biology rather than individual circumstances are the cause of depression. This reconfiguration of antidepressants as a source of personal autonomy ostensibly presents an acceptable interpretation for the addressee, who subsequently replies 'Thanks. You are right. All of you.'

The forum's discussion of medication and its side effects present several perspectives on antidepressants. Group members construct the *right medication* as beneficial but indicate that it can require a process of trial and error with different pharmaceuticals – and potentially different clinicians – to obtain. The forum users frequently describe their side effects in terms of diagnostic symptoms, thereby representing the effect of medication as itself a medical syndrome. These discussions of side effects may represent the forum members' attempts to rationalise their use of medication by seeking advice on a public forum and evaluating antidepressants in terms of expectations, perceived benefits, and adverse effects. Responses to these posts (ex. 59-62) foreground the authors' first-hand experience of medication and encourage antidepressant use in spite of its side-effects (Shoemaker & Ramalho de Oliveira, 2008). As demonstrated in extracts 63-64, the opportunity for forum members to publicly evaluate their new medication and reach an informed decision based on peer feedback may well encourage treatment adherence. Conversely, patients who do not have access to the experientially validated advice available online may be less inclined to continue a difficult drug regimen. Publically questioning antidepressant adherence may also enable forum members to reclaim a sense of autonomy that is challenged by their long-term dependence on medication (Knudsen *et al.*, 2002).

5.4 Discussions of *suicide*

Depressiononline.net contains a specific module intended for the discussion of suicide that was not used to compile the corpus. Nevertheless, the corpus contains 38 instances of *suicidal* in 19 message threads and 26 instances of *suicide* over 13 threads, with either term occurring at least once in 26 (17%) of all the threads sampled. In 12 (46%) of these threads, *suicidal* or *suicide* appears in first message of the thread. In addition, the phrases *kill myself* and *hang myself* occur 6 times and once respectively.

As initial findings, these figures suggest that explicit references to different self-injurious behaviours are by no means uncommon in the forum interaction. Despite the social taboos that might proscribe references to suicide (Allan & Burrige, 2006), discussion of these activities often appears in the opening message of a thread. This surprising candour means that the discussions on *depressiononline.net* represent a valuable source of first-hand, naturally-occurring accounts of suicidal ideation. This is particularly the case given that ethical considerations have forced previous studies to rely on simulated discussions with actors (Feldman *et al.*, 2007; Reeves *et al.*, 2004). These foregoing studies identify that discussion of self-injurious behaviour is often approached indirectly, which prompted a search for additional euphemistic references to suicide. This revealed two instances of the euphemism *topped myself* and phrasal constructions such as ‘go to sleep and never wake up’. Forum participants also employ spatial metaphors for suicide and death such as ‘wanting out’ and ‘I’m still here, although I’m getting close’. Finally, more ambiguous intimations of suicidality are evident through phrases such as ‘sick of it’ and 7 instances of *end it [all]* in which endophoric antecedents for ‘it’ are not explicit. This lack of definite reference renders such expressions ambivalent, particularly in lieu of any other verbal context. For example, one long thread of messages entitled ‘me again...’ begins with a post comprised solely of ‘.. sick of it.’, in which ‘it’ has numerous possible exophoric referents. Nevertheless, forum members constitute this message as an example of suicidal thinking by responding with imperatives to ‘try and stay safe and focus on each hour separately’. This – admittedly single – example offers some indication that the support group participants orient to suicidality in the interpretation of ambiguous posts.

The diversity of constructions through which the forum participants lexicalise suicide renders them less amenable to corpus-driven analyses that are designed to identify recurrent single words and n-grams rather than single phrases such as ‘drive somewhere remote and never

come home'. The variety of these expressions also results in each having a lower frequency, thereby problematising quantitative assessment of this discourse. The following analysis is therefore based on predominantly qualitative investigation of concordance lines and whole messages, and includes analysis of messages identified through manual reading and corpus-driven methods.

A notable absence in the forum participants' use of *suicide* and *suicidal* is any collocation with *commit* or *committed*. These verbs account for 53% of L1 collocates of *suicide* in the BNC's 10 million word spoken corpus and have collocational strengths (*log-likelihood*) of 300.29 and 280.43 respectively. This suggests a strong association between *commit*, *committed* and *suicide* in general spoken English. Tellingly, however, *commit* and *committed* also co-occur with *crime*, *crimes*, *offence*, *murder* and *incest* in the BNC's spoken sub-corpus, suggesting a legalistic and strongly negative semantic prosody to their verb forms (Fairburn, 1995). The absence of collocations between *suicide* and *commit* in the *depressiononline.net* corpus may indicate an attempt to construct an alternative discourse that avoids presenting suicide and as an act of deliberate transgression. Indeed, as the extracts below suggest, the forum members frequently present suicidal ideation as a non-voluntary behaviour.

The concordance lines for *suicidal* signal that suicidality shares close discursive space with lexis related to medication:

65. So they have messed my **medication** around a little makin me poorly and **suicidal**!
66. i was on **citalopram** for cuple of years low **dose** then increased it made me very **suicidal** and i ended up in hospital i had a knife to me [...]
67. In the not so good times I have experienced **suicidal** thoughts and feelings (which I know to be completely unjustified) and **paranoia**. Other **side effects** include yawning, tiredness and sudden anxiety.
68. Although depressed I have never had **suicidal** thoughts until I started my **tablets**. [...] I have twice had serious **suicidal** thoughts and can thinking about the pleasure of dying on a regular basis.

These messages articulate a clear association between the individuals' suicidal thinking and medication (Bennett *et al.*, 2003). In the case of extracts 65-66, this association is represented by a transitive relationship in which the individual is grammatically passive and 'made' suicidal by antidepressants. Extracts 67-68 encode similar causal relations but do so less explicitly, with 'unjustified' suicidal thoughts being renominalised as a 'side effect' of medication in extract 67. In extract 68, 'until' is used as a subordinating conjunction, implying a causal relationship between suicidal ideation and the start of drug therapy. The verbal relationships between clause participants in extracts 65-66 encode the relationship between antidepressants and suicidal ideation more explicitly than the use of relexicalisation and adverbial clauses in extracts 67-68. Interestingly, they also articulate a more intense suicidal experience: whereas the authors of extracts 65-66 are 'made' suicidal (an intensive, totalising experience of suicidality) the authors of extracts 67-68 detail 'experiencing' or 'having' suicidal thoughts that presumably occur amongst non-suicidal thinking. The messages show that the forum users utilise a range of lexical and grammatical configurations to articulate nuanced experiences of antidepressants and suicidal thinking.

Aside from references to medication, *thoughts* is the sole lexical collocates of *suicide* ($n = 5$, $\log\text{-likelihood} = 45.56$) and *suicidal* ($n = 18$, $\log\text{-likelihood} = 201.53$). These collocations suggest a strong association between suicide and patterns of cognition:

69. I'm really at the end of my tether now, **suicide thoughts** are dominating and I feel like it's only a matter of time. I'm terrified.
70. **Suicidal thoughts** seem to be returning, and that is not very welcome.
71. I stay at work for 10 hours, plagued constantly by fatigue and **suicidal thoughts**.
72. **Suicidal thoughts** are with me almost constantly [...] unless they are extremely graphic or I feel compelled to take some kind of action, I generally pay them very little attention.
73. Cannot deal with stress at all and any type of pressure just makes me have **suicidal thoughts**.
74. If I get twisted in them thoughts [about his children] it always seems that **suicidal thoughts** are not far behind.

75. I never told her this last time but i've had **suicidal thoughts** since I was 16. I just get so lonely.

These posts consistently illustrate the persistent nature of suicidal ideation. This is realised through adverbials such as 'constantly' and 'always' (ex. 71-72 and 74) and also by choice of tense and aspect. Extract 75 uses the present perfect to express the continuity of suicidal thoughts since the author's teens while extracts 71-73 use simple present verb forms to present suicidal ideation as part of a general, unchanging state of affairs (Carter & McCarthy, 2006; Crystal, 1996).

As with the discussion of anorexia in section 4.4 and depression in section 5.2.1, the forum users here attribute a range of processes to their suicidal thoughts, which are presented using transitive and intransitive processes as 'dominating', 'returning', 'plaguing', and being 'with' the forum member. These processes convey a lack of agency on the part of the authors to prevent their suicidal ideation, which acts upon them in a seemingly physical – 'dominating' – manner. Extract 73 employs the absolute qualifier 'at all' and determiner 'any' to frame the author's suicidal feelings as an extreme case (Pomerantz, 1986) in which the onset of suicidal ideation is an inexorable result of a complete inability to manage stress. Similarly, the author of extract 74 makes use of the absolute adverbial 'always' to indicate the unavoidable nature of suicidal ideation which arises from concerns over the welfare of his children. Despite their particular articulations, the authors of these posts each construct suicidal ideation as an inevitability, regardless of whether it is caused by prescribed medication (ex. 65-68), the apparent volition of suicidal thoughts themselves (ex. 69-72) or seemingly insurmountable external factors and emotions (ex. 73-75). In doing so, they present suicidal thinking as the result of their particular circumstances rather than a volitional process (Bennett *et al.*, 2003).

A similar rationalising process can be identified when the forum users discuss the influence of other people on their suicidal behaviour:

76. i often feel like just **throwing myself under a bus** but then the thoughts of **others** who will be hurt keep me here i dont know why i feel like this
77. Only reason i haven't **finished myself off** is because i'm staying with my **mum** and what it would do to her
78. Why am I here, why do I exist etc. Then come thoughts of **suicide**, followed by tears, followed by guilt as to how it would hurt my **children** so much if I were to carry these thoughts out.
79. What I do when I think about **suicide** is try to think of 1 good thing in your life, or one **person** who would care if you went.
80. I'm scared that if I mess up [marital relations] again I will be left with nothing. It seems that **dying** would be the best solution for **everyone**.

As demonstrated by extracts 76-78, the desire to avoid hurting family members and social relations is the most frequently cited reason for resisting suicidal impulses. This finding runs parallel to a number of existing studies, in which participants who have attempted suicide identify familial and interpersonal responsibility as inhibiting further suicidal behaviour (Chesley & Loring-McNulty, 2003; Roen *et al.*, 2008). A comparable preventative measure is advocated by the author of extract 79, who advises another forum member to think of 'one person who would care if you went' as a guard against suicidal desires. As a caveat to this however, it is important to note that a sense of obligation to spare others pain is not presented as helping to resolve depression or suicidal ideation, but only as inhibiting suicidal actions. Additionally, extract 78 complicates the value of this familial obligation, indicating that it can be a source of guilt for suicidal ideation and thereby increase negative affect. In the case of extract 80, the same obligation to others is reversed and considered a reason for pursuing suicide, clearly demonstrating the risk of justifying continuing life in terms of responsibility to others (Roen *et al.*, 2008; Reeves *et al.*, 2004).

The discussions of suicide in the *depressiononline.net* corpus reveal a number of discourses around self-injury that differ in the degree of personal agency and responsibility they attribute to individual speakers. Suicidal ideation is described as occurring both acutely (ex. 69) and chronically (ex. 71-72) and originating in factors beyond forum members' control. Even

though the forum members present the onset of suicidal impulses as unwelcome and unplanned, the decision to act upon them is evaluated in terms of its effects on others. For example, the frequent use of the epistemic modals ‘will’ and ‘would’ and if-conditional structures in extracts 76-80 signal the consideration of the potential effects of a suicide. In contrast to the view that suicidal individuals are incapable of rational thought, the forum members attempt to construct identities as rational agents by situating suicidal acts against their consequences for family and social relations (Fairburn, 1995). Whether or not suicide is ultimately presented as a favourable outcome for the forum users and their relations, these messages highlight that sufferers’ descriptions of profound subjective crisis are underpinned by efforts to construct identities as reasoning and considerate parents, children and friends (Drew, 2006).

5.5 *Depressiononline.net* and medicalisation

This chapter has analysed verbal and discursive patterns in the *depressiononline.net* corpus across the salient topics of depression, antidepressant medication, and suicide. A recurrent motif throughout the discussion of the first two of these domains is the negotiation of medical perspectives of mental illness. The issue of medicalisation is examined substantively in the following section, along with evidence of anti-medical discourses of depression identifiable in the corpus.

As outlined in section 5.2, the members of the *depressiononline.net* depression forum demonstrate a clear preference for referring to depression nominally as *depression*, rather as adjectively using copula constructions such as *was depressed*. Karasz (2005) argues that this linguistic preference is common in people who believe depression is a psychiatric condition rather than a temporary reaction to life events. This correlates with the notable shift from *depressed* to *depression* in the forum participants’ accounts of professional diagnoses in

section 5.2.2. Further evidence that *depression* is considered a primarily psychiatric rather than non-clinical condition is offered by the semantic profile of *depression* (see table 5.3 above), which is characterised by medical lexis. Additionally, instances in which forum users offer definitions of depression using the copula construction *depression is* (figure 5.1 below) provide seven examples in which depression is referred to as an illness or disease. Depression is also compared to physical conditions such as ‘pneumonia or diabetes’ and a ‘broken limb’ to affirm its clinical relevance (lines 4 and 15), whilst the first concordance line explicitly posits an organic aetiology for depression as ‘an imbalance of chemicals in our brain’.

N	Concordance
1	train ourselves to do this kind of thing. Something that I try to remember, <i>depression</i> is an imbalance of chemicals in our brain... good things
2	difficult in the last year or so, my new partner has tried to understand but <i>depression</i> is hard to understand if u have never had it. even though iv
3	k with it. (Not sure how long you've been taking it) Often, but not always, <i>depression</i> is triggered by an experience you've had. It may help to have
4	s: it is very much a case of trial and error. Welcome to <i>Depression</i> is as real an illness as pneumonia or diabetes. And like
5	seems easier to sort them out if they are visible on paper/screen. <i>Depression</i> is a strange disease and it comes and goes. It seems to
6	lyrics/poetry he is still alive and living in my hometown. wow yes <i>depression</i> is normal to me also... forgotten what it is like the other side
7	. Its good that you are enjoying time with them. You ARE normal. Having <i>depression</i> is an illness simple as that. Hope things are getting better for
8	down. I'd also say that the therapeutic community's view was that <i>depression</i> is a symptom of a personality disorder/problem. As for the
9	. When depression gets you it is often hard to see straight, my <i>depression</i> is / was largely due to job and relationship issues, I still think
10	only it talking. I'm so very sorry to hear you're feeling so bad. <i>Depression</i> is truly a miserable condition, as you and so many of us
11	their surroundings which can lead to accidents -- sometimes fatal ones. <i>Depression</i> is a very real illness, and like most other illnesses, it can be
12	s latched onto? Is she afraid of him? I live in the US, but isn't <i>depression</i> is covered under your disabilities act? Maybe Human
13	. A difficult one, I think, because one of the major symptoms of <i>depression</i> is losing all interest in the things you once enjoyed, so
14	an embarrassment to her and also makes it quite clear that she thinks <i>depression</i> is a fake illness and I'm just either being lazy or otherwise
15	a broken limb, you and everyone else would expect you to take time off. <i>Depression</i> is just as serious and just as deserving of sick leave. I am
16	elf more than I do already! Not sure I like either option..... <i>Depression</i> is a real pain for making us feel we have to carry on, and
17	treatment I could return to normal, trouble is I don't know what normal is, <i>depression</i> is normal to me. Rob.....the days are dark the nigh
18	where we were living, so that's how I know how old I was. Wonder if <i>depression</i> is just what is 'normal' to me too. Not sure I know. I'd kind of
19	if you have one ? If not, please do so, it can't do any harm and can help. <i>Depression</i> is a recognisable illness now under the Disability
20	in a museum so I understand that. Hello Tom. Welcome to <i>Depression</i> is an illness that can strike anyone, anytime. Fortunately,
21	lives in the same area. yet because that is classed a serious problem (<i>depression</i> is not serious apparently) she has a support worker who
22	most of the classic symptoms of depression. Please get help, dear. <i>Depression</i> is a very real illness, no different than another other illness

Figure 5.1 – Copula constructions involving depression is

Using both implicit semantic prosody (Hunston, 2002) and the explicit descriptions of depression presented in figure 5.1, the forum users repeatedly construct their condition as a medical phenomenon. As illustrated in section 5.2.1, the members of the forum also frequently distinguish their condition from themselves grammatically, referring to it as *the depression* and presenting it as self-determining. A distinction between the patient and their health problem and the objectification of disease labels are also recurrently identified features of medical discourse (Cassell, 1976; Mintz, 1992; Nijhof, 1998; Warner, 1976). According to

Barker (2008), this naturalising discourse is central to the discursive medicalisation of health concerns and cues the treatment of illness through professional measures.

In dissociating the illness from the patient, a medical model of depression is also useful in negotiating issues of stigma and responsibility for depression (Johnston *et al.*, 2007). In accordance with Parsons' long-standing notion of the *sick-role* (1951), presenting depression as a distinct medical condition nullifies individual responsibility for illness and recovery and mitigates blame for depressions' effects. In addition, it permits forum members to dissociate themselves from dispreferred aspects of their own identities, as one user writes:

81. Never being sure anything will work. Deep distrust of people. All that stuff that I like to think is part of my depression and not me.

As this post lucidly demonstrates, the grammatical choice to describe oneself as a person with depression rather than a depressed person offers a way to relocate unfavourable personal traits away from 'me'. In the narratives of personal illness that constitute much of the corpus interaction, this model of depression functions to neutralise the stigma of mental pathology by justifying continued illness and potential personal failings (Kangas, 2001). As well as managing their own perceived stigma, an organic model of depression is also employed by forum users to reassure others:

82. you might be feeling like you can't cope BUT this is what depression (for me anyway) feels like. Its a disease, a chemical imbalance in your brain. Be kind to yourself, you're ill!

Here, defining depression as a malfunction of brain chemistry provides a means of countering others' self-criticism and is used to support the advice to '[b]e kind to yourself'. A further function of the medical model of depression, therefore, is in facilitating mutual peer support and encouragement on the forum, offering a way of caring for others through alleviating their self-reproach. The utility of a medical model of depression for protecting one's self-image

and supporting other forum users provides a clear motivation for its uptake and discursive deployment on *depressiononline.net* (Blommaert, 2005; Horton-Salway, 2004).

Linguistically, the prevailing tendency to refer to depression nominally as *the depression* permits it to partake in a wider range of grammatical relations than *depressed*, which is limited to copula constructions and behavioural processes such as ‘I don’t feel depressed anymore’. Crucially, *depression* is frequently represented as a grammatical actor, performing transitive processes that affect an aspect of the depressed individual. This in turn means that the forum users represent themselves (or at least aspects of themselves) as grammatical objects and discursively construct passive identities for themselves in the process. Similarly, although ascribing agency for the onset and alleviation of depression to depression itself is characteristic of medical models of patienthood, it simultaneously presents depression as beyond the individual’s influence (Schreiber & Hartrick, 2002). Consequently, although this representation of depression reduces the stigma of mental illness, it concomitantly establishes positions of diminished personal agency for sufferers. This passive subject position is repeatedly demonstrated in the forum users’ accounts of passivity to their depression, medication side-effects and thoughts of suicide.

There is also a notable convergence between the forum users’ prevailing conception of depression and their discussion of antidepressant treatment. As Mintz (1992: 226) avers, when diseases are regarded as distinct objects which happen to people, ‘treatment is likely to be directed at the disease rather than the person’. Accordingly, throughout extracts 46-49, antidepressants are said to be ‘for the depression’ and not for the individual or their feelings (Poirier & Brauner, 1988). Indeed, in the case of extract 49, any interaction between antidepressants and ‘the person’ is a reason to avoid medication. Where medication is construed as being designed for the individual rather than their condition, it is

characteristically in terms of being the 'right medication'. Although the notion of right and wrong medication may simply reflect many forum users' negative experiences of different antidepressants, the search for an elusive, uniquely suited antidepressant may also lead patients to approach therapy as a matter of consumerism, demanding medical commodities from clinicians in pursuit of recovery (Barker, 2008; van der Geest & Whyte, 1989). Pursuing the right medication and believing that taking antidepressants constitutes 'choosing to deal with what's making you ill' (ex. 64) may also preclude individuals from addressing situational, relational or psychodynamic issues which contribute to their psychological distress (Lewis, 1995). The prevalence of discussion of antidepressants on the forum is also somewhat surprising in light of the narratives users provide of their first depressive experiences. That is, whilst depression is situated in relation to family dysfunction, histories of abuse, bereavement and work-related stress, it is medication rather than employment advice or familial and psychosexual therapies that comprise the bulk of treatment discussions. The disconnection between the situational factors that the group members cite as causes of their depression and the biomedical interventions used to treat it may well reflect their experiences of healthcare. That is, the forum users' discussion of antidepressants rather than talking therapies correlates with the relative prescription rates and availabilities of these interventions in primary care (Chew-Graham *et al.*, 2002; Conrad, 2005).

A process of medicalisation is also apparent during the threads in which new forum members describe their experiences for the first time. These initial posts seldom invoke the category of depression explicitly. The subsequent responses therefore present a clear opportunity for negotiating whether or not the individual is categorised as having depression and, by extension, the category of depression itself. In one such instance, a new member discusses feeling 'down', lacking in motivation or interest in activities, having 'trouble sleeping' and 'all kinds of irrational thoughts', but claims her GP diagnosed her as 'just tired'. Although the

post concludes with the question 'Does anyone have any suggestions as to what to do?', a response from one of the forum moderators begins by diagnosing the individual:

83. It sounds like you are experiencing a number of the classic symptoms of depression. You've lost interest in things you used to enjoy, have felt really down for several months, and continue to feel tired even after sleeping. I agree, a second opinion is in order...the sooner the better.

The brevity of this post belies the sophisticated ways in which it constructs the addressee's experience as one of depression. Although this proto-diagnosis is initially hedged ('It sounds like'), the pre-modifier 'classic' signals knowledge of established diagnostic criteria and, in doing so, implicitly validates the categorisation of the addressee's experiences as 'symptoms of depression'. The subsequent description summarises the addressee's account as a tripartite list, using intensifiers ('really down') and adverbials ('for several months', 'even after sleeping') to emphasise the prolonged and anomalous nature of her experience. This description also presents the addressee's experiences in the form of the diagnostic criteria in the *DSM-IV* (see section 2.2). By imitating official psychiatric discourse (Antaki, 1994), this diagnostic formulation further warrants the moderator's medical opinion – 'a second opinion is in order... the sooner the better' – which presents the need for further medical attention as a matter of urgency. The advice to seek a second opinion is persistent in this thread, with six out of the seven responses from other forum participants advocating a change in doctor and one recommending seeking support within the addressee's workplace. By situating the original message in terms of symptoms of depression and constructing their own medical expertise, responding participants are able to frame the new member's experience as one of medical pathology even when this contradicts the report of a trained medical professional. As a result, the non-diagnosis of depression is constituted as a deficit of the original doctor's clinical acumen rather than as an indicator that the original poster is not depressed. Such interactions constitute clear examples of lay-driven medicalisation in which non-professional forum members employ medical knowledge to define a new member's experience as one of

pathology, even whilst paradoxically denying the view of a medical professional (Barker, 2008).

This phrase ‘classic symptoms of depression’ is used by the same forum moderator in relation to another new member of *depressiononline.net*. This new participant describes weeping, ‘feeling very alone’ and thinking ‘about how rubbish i am’ and describes a reluctance to seek medical help. Again, although the new forum member does not explicitly request a diagnosis, she receives the following response from the forum moderator:

84. You have most of the classic symptoms of depression. Please get help, dear. Depression is a very real illness, no different than another other illness other than the fact there are no outward signs such as a broken bone or a horrid cough with fever. Depression can be successfully treated. But you need to be in the care of a physician to get the diagnosis and the proper treatment.

This post directly attributes the ‘classic symptoms’ of depression to the new forum member. This interpretation is, in fact, not supported by the original post which does not mention anhedonia, weight changes or trouble sleeping. The moderator then orients to the addressee’s reluctance to seek medical help by legitimising depression as ‘no different than another other illness’. By conveying an apparent knowledge of depression’s symptoms, nosology and amenability to treatment, the forum moderator is able to warrant her diagnosis and construct a position of expertise in matters of depression (Drew & Sorjonen, 1997). Further, her designation of depression as an illness which has ‘no outward signs’ makes a diagnosis of depression virtually unavoidable: a lack of visible signs of depression is itself regarded as a sign of depression and external normality is reconfigured as evidence of internal pathology. The lay forum moderator thereby medicalises the new group member by categorising her experience as one of depression by using quasi-professional knowledge claims and an inclusive, rhetorically sophisticated definition of depression. In doing so, she reiterates the notion that depression is a medical condition with specific symptoms and that the successful treatment of the illness – rather than the individual – is the preserve of medical professionals.

In both the above illustrations, proto-diagnoses of depression are used to encourage treatment-seeking. Although the addressee of extract 83 does not contribute further to the thread, in the case of extract 84, the original poster subsequently responds by describing her trip to her GP and new prescription of Citalopram. These interactions therefore clearly support existing studies that claim online health communities promote the categorisation of emotional difficulties in medical terms (Barker, 2008; Conrad, 2005) and increase demands on healthcare services (Bartlett & Coulson, 2011).

5.5.1 Mixed and resistant discourses of medicalisation

Although the forum members prevailingly frame their condition in a manner consistent with medical nosology, this medicalising tendency is not universal across the corpus. While depression is repeatedly presented as a medical illness, explicitly biomedical descriptions of depression as a chemical imbalance are relatively rare in the corpus (figure 5.1 above; Kangas, 2001). Similarly, although professionally prescribed antidepressants are a recurrent topic of discussion, forum users express doubts over their utility and potential risks. Extract 63 above, for instance, construes antidepressants as a threat to self-control. Similarly, the author of extract 49 differentiates between types of depression on the basis of organic aetiology but also presents medication as a threat to her self-identity, indicating both medical knowledge and a concern over medical therapies. There are also several occasions in which the forum participants refer to successful non-medical ways of managing their depression. These were identified during manual reading, when noticing the phrase ‘really helped’ in relation to Paxil prompted a further search for other instances of the phrase in the corpus (figure 5.2):

N	Concordance
1	I'm on my own, I have some very lovely notebooks to write in. Getting it out really helped me during some of the worst times over the past year - I wish I
2	near me etc goes wrong... Go spend some time with a councillor, it has really helped me become a stronger person. I put it off for years because i
3	Reading 'The Power of Now' by Eckhart Tolle was life changing for me and really helped me get those under control or at least quietened down. You are
4	feel about maybe phoning the samaritans or other help line but they have really helped me in the past. Please please dont do anything rash and keep
5	as a way to keep your nutrient levels up? When I couldn't eat I found they really helped . Mind, because I didn't feel up to making them I cheated and
6	to feel good about myself and the heatwave we were having at the time really helped too. Unfortunately as high as I was, it doesn't take much to
7	closers to yours than those of realists . Fortunately, Paxil (paroxetine) has really helped me overcome most of those problems. My daily life BP and BS

Figure 5.2 – Concordances for really helped

The handful of resulting concordances indicate that participants also find relief in the weather, dietary changes, talking therapies, self-help literature, help lines and writing down problems. Supplementary to the antidepressants whose discussion saturates the corpus, these concordances suggest some awareness of non-medical approaches to managing depression, though they remain focused on the individual sufferers, rather than environmental factors.

Finally, a single post directly challenging a medical concept of depression was identified during manual reading of the corpus. While detailing an upcoming psychiatric evaluation ahead of gastric bypass surgery, one forum participant writes:

85. I just wanted to say, for myself, I am tired of all the labels and all the changes and all the fighting I do inside myself to "feel better" or to feel what MY wacked out docs is normal. I absolutely hate the word normal because no ones.. not one single persons, normal is the same as the next person. [...]
- I have found, that for myself, with each label the docs gave me, was enabling to me, meaning making it easy for me to give up the power in myself to feel better... One doc would say, "[username], you have depression, take this and you will feel better" another doc saying, "oh [username]you need this and you will be better, just give it time" "[username] do this and this feeling will disappear" and then I would sit and wait for the miracle to happen with much dispair because, even though the meds help, they don't cure if we don't fix and take back some power and responsibility for our lives.

In marked contrast to many of the foregoing extracts, this post foregrounds several assumptions implicit in much of the forum interaction and wider medical discourse. Rather than a concrete entity, a diagnosis of depression is lexicalised as a ‘label the docs gave me’; it becomes a non-naturalised term ascribed by particular social actors (‘docs’) that differentiates ‘normal’ from abnormal individuals (Schreiber & Hartrick, 2002). By explicitly challenging an idea of normality across individuals, the author also undermines the idea of medical

pathology as a form of deviance and the idea that unhappiness is a form of abnormality (Dowrick, 2004). This message also highlights the connection between medical diagnosis and subsequent passivity speculated in section 5.2.2, claiming that medical diagnoses make it 'easy for me to give up the power in myself to feel better'. The use of direct speech to quote multiple doctors ('One doc would say, [...] another doc saying,'), constructs a picture of experience of clinical encounters with several healthcare practitioners and foregrounds the contradictory prescriptions they have offered (Hamilton, 1998; Myers, 1999). Finally, the passivity of patienthood is identified as a barrier to healing from depression, with recovery dependent on taking 'back some power and responsibility for our lives' and where the individual *and* medication bring about healing. This isolated account stands in marked contrast to the verbal constructions of individual powerlessness discernible across a number of the corpus's dominant linguistic patterns. The post directly contests the objectivity of diagnostic 'labels' and the authority of doctors who use them, as well as encouraging others to 'fix and take back some power and responsibility' for their lives. However, the three forum participants who respond to this post pay scant heed to its criticism of medical explanations and treatments for depression. Rather, they inquire into the outcome of the psychiatric evaluation and offer advice on the outcomes of gastric band surgery and resulting weight loss, thus shifting topic from a challenge to patient subjectivity to the practical realities of undergoing clinical procedures.

5.6 Summary

What emerges from the forum interaction is ultimately not a single discourse of depression but several mixed and at times contradictory ones (Kangas, 2001). Depression is frequently verbally separated from the individual as *the depression* but is also represented as a possession, *my depression*, in the context of discussing strained relationships friends and

family members. The difficulty of personal relationships to which depressed forum members testify provides a clear warrant for their use of online media in which disclosure, empathetic understanding and community solidarity are explicitly encouraged and repeatedly demonstrated (Cheung, 2000; Morrow, 2006). While forum members present suicidal thoughts as involuntary, they are also able to rationalise suicidal actions and identify the effects of a possible suicide on close relations as a preventative factor.

Although the *depressiononline.net* participants identify situational and psychodynamic antecedents of their illness, their discussions of treatment options focus on individualised interventions such as antidepressants, self-help literature and dietary changes (Lewis, 1995). Antidepressants are recurrently associated with debilitating side effects although members also advocate finding the 'right medication'. The confidence expressed in the *right medication* on the forum is particularly surprising given that individuals for whom the *right medication* facilitates recovery are less likely to use a depression forum for continued support. Given that the very vast majority of forum members do not claim to be recovered, the value of the *right medication* may lie in its capacity to partially relieve depression, rather than cure it outright (Knudsen *et al.*, 2002). Forum members encourage compliance with antidepressant treatments by presenting medication as a form of self-control and side-effects as temporary and worth enduring. Forum members warrant these recommendations by describing positive personal experiences with medication and, in doing so, implicitly endorse the biomedical treatment of depression. The medicalisation of unhappiness is also realised through the community diagnosis of new forum members, whose descriptions are invariably construed in terms of medical pathology. Constructing depression as a legitimate medical problem is used to encourage forum to seek professional help and to present depression as separate from and beyond the control of individual members.

I further discuss these findings and their relation to the *anorexia.net* users' discourse in chapter 8.

6 Professional discourses of anorexia

6.1 Introduction

Following analysis of the anorexia and depression support group sub-corpora this chapter considers the discussion of hypothetical cases of anorexia by three groups of general practitioners. Each focus group was comprised of four GPs and lasted for an average of 35 minutes, 35 seconds, resulting in a mean of 6,760 spoken tokens transcribed per recording. As outlined in chapter 3, the group discussions were not moderated but participants were provided with two case scenarios (see figure 6.1). The patient scenarios included open-ended questions asking participants what else they would like to know about the patients as well as how they would feel and what they would consider doing. The group conversations also included discussions of anorexia and eating disorders more generally and at least one participant in each group also referred to a current or previous eating disordered patient.

The first hypothetical patient (henceforth, Patient 1) was intended to represent a case of a woman who has been dieting, believes she is fat and does not perceive any difficulty with being underweight. In the case scenario, Patient 1 attends with her mother, which was intended to allow discussion of potential family tension. The second patient scenario (Patient 2 hereafter) was designed to represent a case of uncertain diagnosis in which a patient with a possible history of abuse experiences disordered eating, purging and laxative use, and emotional difficulty whilst having a normal weight. Patient 2's scenario is complicated by a recent overdose of prescribed antidepressants, although the attending hospital mental health team have not concluded that she is depressed.

Anorexia Scenarios

The following scenarios are intended to trigger discussion about the problems raised. What else would you like to know? How would you feel about this situation? What would you think about doing?

Have you had patients similar to this in the past and what happened? Are there any issues arising in the management of anorexia which you would like to discuss?

Case Scenario 1

Julia Bryant is 18 and is an administrative assistant in a solicitors office. Her mother comes into the consultation with her. Julia wants another prescription for the contraceptive pill, but her mother then tells you that she is worried about her weight. Julia has apparently been losing weight over the past few months by 'dieting'. However her mother feels that she is 'overdoing it' and wants her to stop. There is clearly tension between the two of them and you ask to see Julia on her own.

Julia says that she doesn't know what the fuss is about – she is just trying to look good. She used to be quite overweight as young teenager but now feels that she is getting to the weight she wants although she still thinks she is fat. She admits to missing meals and tries to avoid eating at home because her mother tries to push her to eat more. You check her weight and she has a body mass index of 17.

Case Scenario 2

Ellie Cobb has just been discharged from hospital following taking an impulsive overdose of fluoxetine. She had been assessed by the on-call mental health care team as low risk. However they commented on the fact that she shouldn't have been on fluoxetine as she wasn't suffering from depression and actually may have an eating disorder.

You know that Ellie has suffered with depression on and off for years; you suspect that Ellie has been abused in the past but there has been no disclosure. She was started on fluoxetine by a GP in the past. Every time she stops it her mood deteriorates and she stops eating.

When you see her today with her grandmother Ellie has low mood and regrets taking the overdose following an argument with her boyfriend. She admits that she feels fat when she gets low and takes laxatives to help her lose weight as well as making herself sick if she feels she has eaten too much. Her BMI is 21.

Figure 6.1 – Anorexia discussion scenarios

The scenarios are designed to encourage discussion around several areas both pervasive in foregoing literature and perceived by their clinical author to be relevant to managing anorexia in primary care. These include potential conflict with patients denying a problem with their

weight and dieting to ‘look good’ (Currin *et al.*, 2009), borderline or uncertain diagnoses; other mental health comorbidities (Boulé & McSherry, 2002), and working relationships with services outside of primary care (Reid *et al.*, 2010b).

The keywords derived from comparing the focus group transcripts with the BNC’s spoken sub-corpus indicate that these issues are indeed salient aspects of the groups’ conversations. All keywords from the keyword analysis are provided in table 6.1. Grouping these keywords into non-exclusive semantic categories allows for some preliminary insights into the GPs’ discussions. For example, the ‘diagnosis and symptoms’ category includes keywords related to diagnostic tests and physiological measurements such as *BMI*, *bloods*, and *potassium*; psychological lexis such as *personality*, *compulsive*, *impulsive*; and characteristic anorexic behaviours *laxatives*, *binging* and *purging*. These various keywords suggest the participants discuss anorexia in relation to physical and psychological symptoms, patient behaviours and potential causes indicated by the keywords *abused* and *relationships*. The key lexical items *referral*, *referred*, *secondary care*, and *psychiatrist* in the ‘treatment’ category indicate that the involvement of other healthcare services is a salient component of the GPs’ discussions. At this relatively decontextualised level, these ‘treatment’ keywords suggest responses to the hypothetical patients reflect contemporary clinical guidelines for anorexia, which state that it should often be managed through specialist services (NICE, 2004: 64). Concordance analysis of *mental* ($n = 13$) indicates four instances of *Mental Health Act(s)* and *mental capacity* ($n = 3$), suggesting that the participants’ discussions of patient management also refer to legal measures.

A number of keywords span several semantic categories. *Personality*, for instance, is used in reference to personality traits of eating disordered patients and in the bigrams *personality disorder* and *personality problem* ($n = 3$). *Personality* therefore appears in both the diagnosis

and medical conditions categories. Concordances for *problem* indicate that it is used to discuss specific conditions such as a *thyroid problem* but also in expressions such as ‘they don't admit there's a problem’. In light of this, *problem* appears under the ‘medical conditions’ and ‘diagnosis’ domains in the table below, as well as under the patient management category. As I argue in section 6.4.2, the negotiation of what constitutes a ‘problem’ with a patient emerges as a recurrent discursive feature across the anorexia focus groups.

Table 6.1 – Key lexical and semantic categories and associated keywords of the GP anorexia focus groups

Lexical/semantic category	Associated keywords
Medical conditions	<i>eating, anorexia, disorder, overdose, depression, anorexics, bulimia, disorders, problem, depressed, bulimic, thyroid, anorexic, anorexia's, illness, personality [disorder]</i>
Diagnosis and symptoms	<i>BMI, weight, impulsive, low, bloods, problem, BMI's, purging, unwell, underweight, potassium, laxatives, thin, digestion, weigh, seventeen, weighed, calories, symptoms, abused, fat, bingeing, problems, proactive, relationship [difficulties], personality [traits], abuse, borderline, paracetamol [overdose], compulsive, disclosure</i>
Treatment	<i>fluoxetine, referral, referred, therapy, secondary [care], prescribe, antidepressants, therapies, psych [team], prescribing, Sando [potassium supplement sachets], psychoeducation, refer, adolescent [health team], family [therapy], psychiatrist, talk, sachets, ENT, healthy, positives</i>
Patient management	<i>patient, problem, difficult, normal, mental [health act], GP, patients, rapport, secondary [care], mum, engage, denial, adolescents, family, GPs, talk, proactive [treatment], manipulative, young, consultation</i>
Abbreviations	<i>BMI [body mass index], BMI's, ENT [ear nose and throat]</i>
Modality markers	<i>maybe, kind of, probably, quite, suppose, really, actually, often, obviously, sort of, anymore, you'd</i>
Response tokens	<i>mm, yeah, hm, mmm</i>
Stimulus-related lexis	<i>scenario, Julia, mum, grandmother, scenarios</i>
Negative keywords	<i>the, er, oh, did, in, he, right, up, no, one, all, were, two</i>

At 20,279 and 20,600 tokens respectively, the size of the GP-anorexia corpus and the GP-depression corpus analysed in the following chapter mean that their respective keywords occur relative infrequently. Combined with the low lexical density of spoken language (McCarthy, 1998), these keywords are therefore less amenable to analysis through semantic profiling (Orpin, 2005) and consideration of the prosody of their lexical collocates that was used in chapters four and five. Nevertheless, these keywords provide an effective means of identifying salient areas of meaning in each corpus (O’Riordan *et al.*, 2008; Seale *et al.*, 2006) and, as in previous chapters, the analysis below considers a number of semantic categories to which these keywords contribute. Similarly, examination of colligational structures and expanded concordances in which keywords arise remains a central method of conducting close analysis of the data (Skelton & Hobbs, 1999a), with the comparisons enabled by viewing keywords in concordance lines proving to be analytically expedient. As in the previous chapters, I use insights from systemic functional linguistics and comparisons with reference corpora to consider how anorexia and, in the following chapter, depression are constructed as objects of discourse in the clinicians’ talk. I also draw on research in spoken discourse analysis (Myers, 1999; Richards, 2006) and discursive psychology (Edwards, 1991; Potter, 1996) to consider the discursive construction of BMI, specialist referral and ‘problem’ eating. Because of the smaller corpus sizes, however, it is possible to provide a more exhaustive account of instances of keywords in the professional sub-corpora compared with the larger patient corpora, in which the choice of extracts reproduced for analysis was necessarily more selective.

As the *de facto* topic of the focus group discussions, the analysis in this chapter initially considers keywords relating to anorexia and eating disorders more widely. Through comparison with the preceding analysis of the *anorexia.net* forum, I argue that although both

the forum users and the participating GPs frequently use similar lexical items to nominalise disordered eating, distinctive grammatical and discursive patterns in each corpus realise differing perspectives on anorexia. A transcription guide for extracts from the spoken corpora is provided in table 6.2 below.

Table 6.2 – Transcription key for spoken corpus extracts

Example	Key
<A1M>	Anorexia discussion group participant number and sex (M/F)
<D6F>	Depression discussion groups participant number and sex (M/F)
<A?F>	Uncertain who is speaking (M/F)
<D?F>	
<D6F?>	Uncertain who is speaking, guess D6
<A9F> the {the diagnostic. Yeah.}	Text enclosed in aligned {curly brackets} indicates simultaneous talk between two or more speakers
<A12M> {The the BMI } it'll	
<inaudible>	Undecipherable speech
<A6F> but do you know what I mean	+ indicates a 'latched' turn with no gap between the previous speaker's turn
<A5F> +Mm.	
<A6F> +long standing anorexics.	= indicates an unfinished word. Here the speaker begins to say 'good appointment' before breaking off and rephrasing.
<D12F> you know really good appoi= good consultation	
<pause>	A pause up to a second. Longer pauses are noted specifically.
<A11M> you just think "Oh".	" " indicates reported speech or thought.
<laughs>, <coughs>, <sighs> ,<whispers>	Instances of non-verbal features or transcriber's comments.

6.2 Eating disorders and anorexia

As table 6.1 indicates, the GPs frequently use a number of lexical items to refer to ill health, including specific labels *anorexia*, *bulimia* and their adjective forms *anorexic* and *bulimic*. In addition, the less specific labels *disorder* and *illness* are also used with relatively high frequency in the GP-anorexia corpus. *Eating* is the strongest lexical keyword in the corpus ($n = 78$, $\log\text{-likelihood} = 490.1$) and forms the bigrams *eating disorder* ($n = 28$) and *eating disorders* ($n = 11$) in 50% of its occurrences. *Anorexia*, by comparison, occurs 34 times in the corpus ($\log\text{-likelihood} = 353.45$) and *anorexics* and *anorexic* occur 11 and 5 times respectively. These frequencies indicate that the GPs employ a superordinate term to nominalise disordered eating more frequently than they use the specific label *anorexia*, a pattern that mirrors sufferers' preferential use of *ED* on *anorexia.net*. However, whereas analysis of the *anorexia.net* forum indicated that *ED* is used to homogenise anorexia and other conditions involving eating difficulty, examples of *eating disorder(s)* in the GP discussions suggest the opposite function:

1. <A1F> [...]you know she didn't wouldn't have a label of anorexia
<A2M> +Mm.
<A1F> +but she had an **eating disorder**.
2. <A12M> And first of all she hasn't got anorexia by any sort of definition has she she might have an **eating disorder** but
<A9F> +Mm.
<A12M> +not with a BMI of twenty one she hasn't.
3. <A11M> +actually anorexics or those with **eating disorders** believe that their their pursuit is for a healthier shape and life.
4. <A1F> So there are these weird **eating disorders** aren't there mm.
<A2M> Yeah.
<A1F> They probably are anorexia rather we just we just don't <pause 2 seconds> grasp the nettle {with <inaudible>}
5. <A7F> And there= they'll be such a huge proportion of young people that we wouldn't see that might have similar
<A6F> +Mm.
<A7F> issues [to Patient 1] anyway because it's so common. And it's deciding I suppose when it's an **eating disorder** and when it's not.

6. <A11?M> I think you could speak to the mum even without her permission but not about her.
 <A10M> No no.
 <A11M> +You could talk to her as a carer of somebody with an **eating disorder**
 <A9F> +Mm.
 <A11M> +and talk what happens theoretically.

The co-occurrences of *anorexia* or *anorexics* in close proximity to *eating disorder(s)* in extracts 1-4 above illustrate explicit attempts to distinguish between a diagnosis of anorexia and eating disorders more generally. In extract 1, speaker 1 refers to anorexia as a diagnostic 'label' that a specific patient does not match, though uses 'eating disorder' to define this patient's eating behaviours as problematic nevertheless. Similarly, speaker 12 (ex. 2) claims that Patient 2 'hasn't got anorexia' but 'might have an eating disorder'. In this instance, speaker 12 subsequently refers to the BMI of Patient 2 to warrant the exclusion of anorexia (the parallel repetition of 'she hasn't' is understood here as an elliptical reiteration of 'she hasn't got anorexia' rather than 'she hasn't got an eating disorder'). The use of a BMI score to warrant a non-diagnosis of anorexia indicates the perceived centrality of patients' weight for categorising eating disorders and patients (I discuss this further in the following section).

In extract 3, 'those with eating disorders' and 'anorexics' are distinguished by 'or', suggesting that the speaker also regards the two noun phrases as identifying different individuals. In contrast, in extract 4, anorexia is equated with 'weird eating disorders'. However, the distinction between anorexia and eating disorders here is constructed as an artificial one; the speaker claims that anorexia remains unidentified because clinicians are unwilling to 'grasp the nettle' and pursue difficult questions about disordered eating with the patient. Rather than a patient's BMI, in this account a specific diagnosis appears dependent on GPs' willingness to diagnose when they recognise some symptoms of disordered eating in patients.

Rather than conflating anorexia with other eating disorders, these first four examples establish an explicit distinction between anorexia and the superordinate term. In cases such as

extract 5 where *eating disorder* appears without reference to anorexia, the participant also refers to the difficulty of determining an eating disorder from common experiences of wanting to lose weight to look good. In this respect, an overlap or gradation between eating disorders and typical dieting is suggested, before the speaker presents the clinician's decision between 'when it's an eating disorder and when it's not' as a binary one. In extract 6, whilst the participant uses the generic term *eating disorder* to refer to the diagnosis of anorexia in Patient 1, this appears in the context of discussing the patient 'theoretically' with her mother. In this hypothetical instance, the superordinate category *eating disorder* is used in an attempt to respect patient confidentiality by being talking non-specifically to the patient's mother. Where the use of *ED* in the anorexia forum amalgamates medically distinct conditions under the same noun, the focus group participants foreground distinctions between anorexia and other eating disorders and between anorexia and dieting. Whilst discursively differentiated from anorexia, *eating disorders* is used as a vague category for patients who nevertheless have some eating-related difficulties. The superordinate noun therefore provides a linguistic resource for negotiating the issues of borderline or uncertain diagnoses instantiated in the scenario patients, a function that plausibly explains its frequent use in the corpus.

Further differences between patients' and professionals' discussions of *eating disorder(s)* are apparent from their respective grammatical collocates. References to *ED* in the *anorexia.net* forum were dominated by the bigram *the ED*, with *my ED* and *an ED* making up only 11.4% and 13.5% of the L1 collocates of *ED* respectively. The analysis in chapter 4 suggested that the *the ED* bigram is the primary linguistic feature with which forum members construct anorexia as existing distinct from themselves and beyond their control. In contrast, the focus group participants most frequently refer to *an eating disorder* ($n = 15$), examples of which use relational processes and post-modification to present eating disorders as a possession or attribute of an individual:

7. <A1F> Mm. I've got a friend a consultant and his daughter's **got an eating disorder**.
8. <A6F> I've got another one that's similar to this who <pause> must be in her thirties now and [...] this young woman has obviously **got an eating disorder**.
9. <A2M> [...] If I was working for CAMHs and I saw a sixteen year old **with an eating disorder** obviously I'd want to help them and want them to get better
10. <A6F> [...] going to see all sorts of secondary care consultants about other problems and they know she **has an eating disorder** but just won't

The above extracts instantiate the prevailing grammatical patterns around *an eating disorder*, principally that it is something which an individual has *got* (4 occurrences), is *with* (2 occurrences) and *has* (5 occurrences, including *had* and *have*). All of these phrases present *an eating disorder* as a possession of an individual and, consequently, linguistically imply some separation between patient and condition (Fleischman, 1999; Warner, 1976). As in the anorexia forum, *the eating disorder(s)* is a recurrent cluster ($n = 9$) in the GP corpus. However, it occurs in over 50% of cases as part of the longer noun phrases, *the eating disorder(s) service(s)*, and not as a complete noun phrase as is the case in the online community. All instances in which *the eating disorder* occurs as a complete noun phrase are provided below.

11. <A5F> [...] she's trying to medicalise {potentially} medical problems which aren't really they're just a result of **the {eating disorder.}**
12. <A12M> [...] there's a sort of there's quite a lot of stuff under the surface and **the eating disorder's** actually I would say appears to be relatively peripheral [...] to the core function
13. <A5F> Yeah because then it doesn't mean **{the eating disorder's}** going to be challenged.
14. <A1F> Every interaction is about
 <A3F> Mm.
 <A1F> about that and then mum wants to take her out to lunch because that's what mums do when they visit their daughters at university and then they go and then the daughter doesn't eat anything or pushes her food round the plate you know.
 <A2M> Yeah.
 <A1F> The whole visit <pause> is consumed with **the eating disorder**. Even if at that time it's not a problem.

In extracts 11-12, *the eating disorder* occurs where speakers are again attempting to differentiate the effects of disordered eating from comorbid medical problems. In these cases, using a definite article constructs the diagnosis of an *eating disorder* as a definite, discrete

entity for the purpose of considering its relation to a patient's other health problems. Extract 13 presents *the eating disorder* as both a distinct entity and a direct participant in a verbal process: describing a patient who avoids sustained contact with healthcare professionals, speaker 5 represents *the eating disorder* rather than the patient as the direct object of the 'challenge' process. *The eating disorder* stands metonymically for the patient here, with the described clinical interaction occurring being between consultant and condition rather than patient (Mintz, 1992, and see section 7.2.1 for a further example).

Extract 14 represents the most clearly reifying instance of *the eating disorder* in the GP-anorexia corpus. The speaker narrates a case in which a young girl's eating disorder has become a fixation for her mother, irrespective of the girl's current experience of difficulty. This construction clearly separates *the eating disorder* from the experience of the sufferer, presenting it as an enduring aspect of the mother-daughter relationship. It is notable that, despite representing the daughter's anorexia as independent of the daughter herself, the speaker does not ascribe agency to *the eating disorder* in a manner typical of the anorexia forum users. For example, the final turn in extract 14 could have started with 'the whole visit is consumed by the eating disorder', resulting in a passive clause in which the transitive process 'consume' is attributed to 'the eating disorder' as subject. Instead, the use of 'is consumed with the eating disorder', grammatically backgrounds any obvious agency, resulting in an existential clause. Consequently, although it is portrayed as independent of the sufferer, *the eating disorder* is not verbally constructed as animate or agentive in a manner characteristic of the *anorexia.net* users.

Analysis of the GPs' use of *eating disorder* demonstrates a discursive construction largely different to that found in the *anorexia.net* forum. *Eating disorder* is discursively situated in relation to specific medical diagnoses – particularly anorexia – but not equated with them

unless for contextually strategic reasons (ex. 6). The GPs most frequently use *an* as a determiner for *eating disorder*. Whilst constructing eating disorders as identifiable, countable entities, the participants predominantly use *an ED* in reference to individuals who ‘get’, ‘have’ or are ‘with them’, thereby grammatically binding eating disorders to their sufferers. The doctors display a slight tendency to naturalise eating disorders, grammatically constructing them as separate from the individual and amenable to direct intervention by clinicians on four occasions. However, the reifying discourse exemplified in the *the eating disorder* extracts represents a statistically infrequent, ‘resistant’ discourse in the focus groups (Baker, 2006). Further, although it is represented as the object of the process ‘challenge’, the GPs do not obviously ascribe agency to *the eating disorder* nor present it as actively controlling patients or situations. These differing constructions of *eating disorder(s)* are sustained when considering its lexical collocates; rather than *voice*, *talking*, or *behaviours*, the only lexical collocate of *eating disorder* is *service* ($n = 6$, $\log\text{-likelihood} = 62.48$), which appears in case as part of the trigram *eating disorder service* (and one *eating disorder services*). In the GPs’ interactions, the sole lexical collocate of *eating disorder* reflects talk of a condition requiring specialist professional services (see 6.4.1), rather than an independent, controlling entity.

6.2.1 *Anorexia* and *anorexics*

Grammatical collocates for the keyword *anorexia* reflect those identified for *eating disorder* above (see table 6.3). *Anorexia* is nominalised as a condition patients ‘have’ (5 occurrences), have *got* (2 occurrences) and as *people with anorexia* (2 occurrences), each of which encode the possession of *anorexia* by individuals.

Table 6.3 – Frequencies of grammatical relations between patients and an eating disorder and anorexia

	<i>an eating disorder (n = 14)</i>	<i>anorexia (n = 34)</i>
HAVE (<i>have/had/has</i>)	5	5
<i>got</i>	4	2
<i>with</i>	2	2

As demonstrated in extract 2 above, *anorexia* is frequently used when participants are providing diagnostic descriptions:

15. <A1F> [...] And erm it was stopping her going out and seeing her friends and she'd only eat things which were liquid and so she had some fixed ideas about eating but she wasn't you know she didn't wouldn't have a label of **anorexia**
16. <A8M> [...]I'm more reading that she feels low and that's when she feels she's o= she feels overweight and that's when she takes laxatives.
<A?F> Right.
<A8M> That's not necessarily bulimia that sounds more
<A7?F> Mm-hm.
<A8M> **anorexia**.
17. <A12M> [...] Well I guess probably import= you know s= I mean sometimes it's easy you can tell they look skeletally thin and think "Yeah the diagnosis is {likely} to be **anorexia**
18. <A12M> And it's interesting i= cos I think generally sort of bulimia EDNOS type stuff is much more <pause> is much more linked to external stuff and {low self esteem whereas **anorexia**} generally sits much more within itself. Yes you know there might be some family issues
<A10M> {Mm. Mm. }
<A9F> {Mm. Mm. }
+Yeah but often there aren't.
<A12M> +Often there aren't.

These extracts illustrate occasions on which participants attempt to offer diagnostic descriptions of patients and distinguish the diagnostic category of anorexia from other conditions. In extract 15, for instance, having ‘fixed ideas about eating’ and only consuming liquids are offered as candidate justifications for a patient having ‘an eating disorder’ but not ‘anorexia’ *per se*. Although the speaker does not offer further grounds for discounting anorexia, her description implicitly specifies a positive diagnosis as requiring more than ‘fixed’ eating practices. In contrast, speaker 8 (ex. 16) delineates anorexia from bulimia on the basis of the relationship between Patient 2’s emotions and behaviours. Further, speaker 12 (ex. 17) presents a patient’s emaciation as a strong diagnostic indicator, suggesting it makes

diagnosing anorexia 'easy'. In the final extract above, this participant also attempts to classify anorexia as distinct from bulimia and other unspecified eating disorder diagnoses, claiming that it is 'generally' not related to self-esteem and external factors such as past abuse, which has been mentioned in the previous turns. This speaker and speaker 9 then present 'family issues' as a possible but not definite indicator of anorexia. Taken in sum, the participating GPs offer a multifactorial picture of anorexia's clinical diagnosis, relating it to eating behaviours, emotional difficulties, possible social issues and physical appearance.

However, these diagnostic descriptions are also articulated in a demonstrably tentative fashion. In extract 15, speaker 1 performs several self-initiated repairs (Schegloff, 1977) of verb phrases in her developing account of the patient, repairing first 'wasn't', then 'didn't' before continuing with 'wouldn't have a label of anorexia'. These repairs involve a downgrading of modality from a categorical assertion, 'wasn't', to a hypothetical one, in which anorexia is also downgraded from a personal attribute ('wasn't anorexic) to a type of 'label' that is not possessed ('wouldn't have a label of anorexia'). Similarly, speaker 8 (ex. 16) interprets Patient 2's eating behaviour as only 'not necessarily' bulimia and even when a patient is 'skeletal thin', speaker 12 claims anorexia is only 'likely' rather than more certain. Speaker 12 also offers a highly tentative classification of other eating disorders prefaced by 'I think generally sort of', relating bulimia and EDNOS diagnoses to the vague noun 'external stuff' before hedging his description of anorexia as 'generally' sitting 'within itself'. The prevalence of these linguistic hedges and repairs indicates considerable expressed uncertainty around the diagnosis of anorexia and characterise patients' weight, behaviour and family circumstances as evidence for only uncertain diagnoses.

Extract 18 also provides an instance of *anorexia* acting as a subject in a reflexive process sitting 'within itself'. Representing anorexia as an agentive clause constituent in material and

verbal processes was a frequent occurrence in the anorexia forum corpus. The two other examples of this presentation in the GP-anorexia corpus are reproduced below:

19. <A12M> So that= that's the logical process w= you'd think is normal but **anorexia doesn't work like that**. So you've got to get put the weight on so if they don't put the weight on they ain't getting better.
20. <A11M> The things that <pause> in my experience with **anorexia** and John's alluded to it you know it is about it's about control **it does give them some form of positive feedback** and that often as you say it's triggered by something.

In extract 19, the negated material process 'work' is attributed to anorexia. Reference to the British National Corpus reveals 47 instances of *DO not [adverbial] work like that* and *DON'T [adverbial] work like that*, all of which are principally used to indicate a difference between expectations and reality rather than to personify abstract phenomena. This prosody is confirmed in speaker 12's description of recovery from anorexia as a process that does not follow 'logical' or 'normal' expectations. Speaker 11 (ex. 20) also refers to reasons why anorexia is problematic to treat, attributing a metaphorical material process of 'giv[ing...] positive feedback' to anorexics. Grammatically, this extract mirrors discourse in the *anorexia.net* corpus (see section 4.4) in which a singular anorexia, 'it', performs a process of providing emotional control that affects plural sufferers, 'them'. The association of *anorexia* with control expressed here supports previous research that identifies control as an important aspect of both patients' (Eivors *et al.*, 2003; Skårderud, 2007) and professionals' (Jarman *et al.*, 1997) experiences of anorexia and its management. Notably, speaker 11 also suggests that anorexia is often 'triggered by something', a point contradicted by speaker 12 later in the same focus group (see ex. 18 above).

Both extracts 19 and 20 attribute agency to anorexia in the wider verbal context of discussing its recalcitrance. In each case, verbally constructing anorexia as independent of patients coincides with conveying the difficulty of its treatment. In conjunction with extract 18 above, these excerpts provide a notable point of similarity between the GPs' talk and the

personification of anorexia in the *anorexia.net* sub-corpus. However, with only three instances in the corpus it represents an infrequent representation of anorexia and one seemingly tied to a specific verbal context. In addition to extract 20, *anorexia* also appears as the direct object of a material process in the following example:

21. <A5F> Yeah I mean the traits that enable people to **develop anorexia** are obviously you know child {perfectionism} then can stand them in good stead in other ways once they decide they want {to get over their disorder.}

The claim that individuals ‘develop anorexia’ ostensibly assigns some responsibility for anorexia to patients, who are positioned as actively fostering its progression. However, checking this interpretation of the GP talk against the British National Corpus also suggests a less clear picture of agency (O’Halloran & Coffin, 2004). In the BNC – and particularly in its Academic Medical subsection – *develop* collocates frequently with *patients*, *skills*, and *care* but also *disease*, *symptoms*, *cancer* and *gall stones*. Where these collocations relate to medical patients, the attendant concordance lines indicates that patients are seldom described as developing anything desirable, and that *develop* is often a physiological process over which the patient has no control. In this respect, the genre-specific semantic prosody of *develop* (Hunston, 2007) suggests that speaker 5 does not necessarily implicate responsibility to anorexic patients for their condition. Indeed, agency in this clause is also attributed to personality ‘traits’, which are less clearly under an individual’s control.

However, this speaker does explicitly claim that recovery from anorexia is determined by the patient’s decision that ‘they want to get over their disorder’. Further, the spatial metaphor of recovery as ‘getting over their disorder’ represents anorexia as a physical object that can be voluntarily surmounted rather than an independent coercive agent or a disease to be cured through medical care. This metaphor is in keeping with Semino’s (2008) finding that non-sufferers adopt illness metaphors that imply patient responsibility for recovery. Consequently, while this extract may not verbally attribute responsibility to a patient for the onset of their

condition, patients are held responsible for their recovery, which is construed as a process of deliberate movement.

Contrasting with post-modified noun phrases such as *people with anorexia*, the GPs' use of *anorexics* ($n = 11$, $\log\text{-likelihood} = 122.16$) identifies patients solely by their condition and removes the need to refer to them using 'people' or 'individuals' as a head noun.

Accordingly, Warner argues that categorising individuals by their illness is used to imply they have a 'chronic illness which is intimately entwined with the patient's way of life' (1976: 65). This suggestion of permanent, all-encompassing illness is indeed evident in corpus examples of *anorexics*:

22. <A12M> T= to go on because you actually need to sort of oh you know all the= all the books y=we all know it you know the basic **anorexics** are dieters who are over successful.
<A9F> Mm.
<A12M> And then you get the starvation function coming in {which drives it along.} And then it becomes a set pathway and behaviour that [...] is extremely difficult to <pause> [...]treat.
23. <A6F> I think the ones I find I mean these are quite difficult but the ones I find are difficult I've got a two or three very ha= hardened **anorexics** that sounds awful but do you know what I mean
<A5F> +Mm.
<A6F> +long standing **anorexics**.
<A5F> Mm.
<A7F> +Mm.
<A6F> Major health problems with it an=an= and you just {feel they're not} certainly one of them not disclosing.
24. <A11M> +actually **anorexics** or those with eating disorders believe that their their pursuit is for a healthier shape and life.
25. <A12?M> {But what do you anticipate I mean course} cos **anorexics** do not think they have a problem do they.

In extract 22, speaker 12 is continuing his description of the aetiology of anorexia from extract 18. He defines *anorexics* as 'dieters who are over successful' and thereby locates the origins of anorexia in a common cultural practice. This speaker goes on to offer a physiological account of anorexia as 'drive[en] along' by the body's reaction to starvation rather than by wilful actions of the individual. Speaker 12's account is introduced by a change of footing (Goffman, 1981), which frames his description as a reflection of 'all the

books' and credits his proposition using an external authority (Adolphs *et al.*, 2004). The rhetorical force of his description is also bolstered by his claim that it is a 'basic' one and that 'we all know it'. His definition of anorexics as dieters who become impaired by a physiological reaction is therefore presented as externally authorised and already accepted by the other group participants. The result is a rhetorically robust description of anorexia as a physiological condition that is resistant to treatment (c.f. Strober & Johnson, 2012).

In extract 23, speaker 6 refers to several of her own patients as 'hardened anorexics'. Her immediate meta-discursive comment 'that sounds awful' indicates that she perceives 'hardened' to be an unfavourable description of these patients. Her self-interpretation is indeed supported by further examination of 'hardened', which collocates strongly with *criminal(s)*, *black marketeers*, and *prisoners* in the BNC. These collocates indicate that *hardened* has a strongly negative semantic prosody (Louw, 1993). Speaker 6's subsequent reformulation of these patients as 'long standing' carries a more neutral semantic prosody; instances of *long-standing* in the BNC collocate significantly with both *tradition*, *relationship* and *friend* and *dispute*, *problems*, and *illness*.

Even whilst it is immediately rescinded, the semantic prosody of 'hardened' frames 'hardened anorexics' in terms of illegal or dishonest behaviours, an interpretation supported by speaker 6's subsequent claim that these patients are 'not disclosing' their condition. 'Hardened anorexics' are therefore portrayed as unwilling to admit to their difficulties despite having 'major health problems'. This discourse of *anorexics* also appears in the final two extracts, in which they are portrayed as having false beliefs about their pursuit of thinness and not believing they have a 'problem'. Across each of these concordance lines, *anorexics* are characterised by misplaced beliefs and a reluctance to see their condition as medically problematic. Congruent with Warner's (1976) longstanding contention, the GPs depict

anorexics as long-term sufferers who are consumed by their condition, unable to perceive its risks, and ‘extremely difficult to treat’. This construal also mirrors that found on *anorexia.net*, where participants consistently refer to *ED thoughts* and *ED voice* that encourage their disordered eating and convince them that they are overweight. In the clinicians’ talk, however, these thoughts, beliefs and the unwillingness to disclose a problem are clearly attributed to patients, and not a displaced *ED voice*.

Analysis of the GPs’ use of *eating disorder(s)*, *anorexia*, and *anorexics* reveals a range of perspectives on the condition and disordered eating more widely. The GPs repeatedly distinguish between *anorexia* and *eating disorders* and most frequently present anorexia as a possession that is ‘had’ or ‘got’ (Semino, 2008). Diagnostic claims are made in reference to patient body mass, behaviour, emotions and possible family circumstances, although diagnoses themselves are typically hedged. Similarly, anorexia is described as arising from personality ‘traits’ and dieting practice, as well as being ‘often... triggered by something’. Finally, varying notions of patient responsibility arise in the GPs’ discourse; although its onset is attributed to both personality ‘traits’ and a physiological ‘starvation function’, recovery is also described in terms of a voluntary decision to ‘get over’ anorexia. In contrast to the foregoing patient discourse, anorexia is seldom constructed as agentive or as controlling individuals. Rather, *anorexics* are characterised, through both explicit descriptions and implicit collocation, as being potentially dishonest and holding false beliefs that perpetuate their illness.

6.3 BMI

Throughout each focus group transcript there is frequent reference to *BMI* ($n = 31$, *log-likelihood* = 385.25). BMI is an abbreviation of ‘body mass index’, a widely used scale for assessing body weight. According to the WHO (2012), a BMI of below 18.5 in adults

represents underweight, 18.5-24.99 represents normal or ideal body weight, 25-29.99 indicates overweight and a BMI of 30-40 and above corresponds to clinical obesity of increasing severity. Diagnostic criteria for adult anorexia stipulate a BMI maintained below 85% of an individual's expected body mass for their height (APA, 1994; WHO, 1992) or a BMI below 17.5 (WHO, 1992). Although the doctors in the present study also refer to 'normal BMI', the body mass that they regard as 'normal' should not necessarily be understood to equate with that stated in the WHO definition.

Although the keyness value for *BMI* in the GP-anorexia corpus is inflated by its non-occurrence in the BNC reference corpus, it nevertheless occurs frequently across the anorexia focus group transcripts. In combination with the contracted copula *BMI*'s ($n = 6$) and fully lexicalised *body mass index* ($n = 3$), there are a total of 40 lexical references to body mass index in the corpus, a figure higher than that for *eating disorder(s)* or *anorexia*. In terms of frequency, then, *BMI* is an important feature of the GPs' discourses of anorexia and its management.

The lexical collocates of *BMI* and *BMI*'s are *know*, *think*, *twenty*, and *normal*. In all but one case, *know* features as part of a discourse marking 'you know' and *think* occurs in the hedging marker *I think*. These are both highly frequent bigrams in the corpus and spoken language more widely and are not considered in detail here. I examine instances of *BMI* collocating with *twenty* and other numbers below, following examination of examples of collocations between *BMI* and *normal* ($n = 5$, *log-likelihood* = 42.15):

26. <A1F> Well <pause> she's got a **normal BMI**.

<A4M> <quietly> Mm.

<A2M> So we can't diagnose.

<A1F> So. Yeah. <pause>

<A2M> Well can't officially diagnose

27. <A2M> Bu= it= my my. The teaching I have is always you know if they're a **normal BMI** or overweight it's bulimia if they're underweight it's anorexia.

28. <A1F> But her BMI is **normal**. So either <pause> she is doing that and is losing weight and has got an eating disorder.
 <A2M> Yeah.
 <A1F> Or she's manipulative.
29. <A5F> +Yeah cos I guess with bulimia that if you can eyeball and see they're a fairly **normal BMI** you can be less worried
30. <A12M> They [anorexia clinics] get them up to close very close to exactly what they should be some of them will go a little bit below their
 <A9F> +Mm.
 <A11M> +Mm.
 <A12M> +sort of **normal BMI** but you know the clock really starts

In extracts 26-29, a *normal BMI* is associated with various aspects of diagnosis. Most explicitly, in extract 26, a *normal BMI* is invoked as evidence that a diagnosis of anorexia cannot be made for Patient 2. Speaker 2's subsequent turn, 'Well can't officially diagnose', relates body mass scores to official diagnostic guidelines, perhaps implying that an 'unofficial' diagnosis could be made in lieu of low body weight. In extract 27, a *normal BMI* is also presented as a basis on which to diagnose bulimia and rule out anorexia, which is said to require the patient to be underweight. However, this rather simplistic reduction of the diagnostic process to solely a matter of body weight is footed as a consistent aspect of the speaker's 'teaching' rather than his own belief. A *normal BMI* is again invoked in extract 28 as an aspect of diagnosing Patient 2 and, more specifically, is used as evidence to doubt the diagnosis of an eating disorder. However, in this case, a *normal BMI* is offered as evidence to propose that Patient 2 could be lying about engaging in purging and laxative use. In this instance, the utility of the patient's BMI score appears to be its objectivity; it offers an impartial assessment that belies the patient's claims of trying to lose weight, potentially revealing them as 'manipulative' as well as negating a diagnosis.

This association between *BMI* and diagnosis is maintained in extract 29. Specifically, speaker 5 construes a 'fairly normal BMI' as a means of establishing clinical severity for patients with bulimia. Weight is presented here as the determining factor of a GPs' management of a patient, and *BMI* functions as a metonymy for the patient's health and hence a metric of how

‘worried’ the clinician should be (Malson, 2008). As with extracts 26-28, then, *BMI* and particularly a *normal BMI* is constructed as a core component of monitoring and managing patients with eating disorders. Indeed, the centrality of BMI to the management of eating disordered patients is reiterated elsewhere by this participant, who claims ‘you need to know what their weight is and their BMI as a starting point cos the bottom line of looking after them is their weight’.

In contrast to the other extracts, the final example above (ex. 30) involves reference to *normal BMI* in the discussion of inpatient treatment for anorexia. Reaching a *normal BMI* is here identified as the point in the recovery process at which the ‘clock really starts’. That is, a *normal BMI* is portrayed as a precondition for recovery from anorexia, rather than signifying its achievement. In this respect, this instance diverges from the other examples of the *normal BMI* bigram, which each constitute BMI as a primary indicator of the presence or absence of anorexia and the severity of bulimia. In extract 30, speaker 12’s discussion of inpatient treatment constructs anorexia as enduring *beyond* BMI recovery. Over its five instances in the corpus, *normal BMI* is thus used to denote acceptable evidence for excluding anorexia during the process of diagnosis but not during the process of recovery.

In addition to the non-specific category *normal BMI*, the focus group participants refer to particular numerical values for body mass. In parallel with *normal BMI*, examples of co-occurrences of *BMI* with numbers suggest that the participants regard body mass as a key aspect in the management of patients with anorexia:

31. <A9F> [...]is it **sixteen and a half or seventeen** <pause> the crit= the {the diagnostic. Yeah.}
 <A12M> {The the **BMI** } it'll
 be **seventeen**. I think it's about **seventeen and half** actually strictly speaking
32. <A1F> Cos I think if their **BMI** say it's on **sixteen**
 <A2M> Yeah.
 <A1F> +you're supposed to consider admission aren't you.
 <A2M> Oh I didn't know that.
 <A1F> I think so.

<A2M> Yeah. I think **seventeen point five**'s the cut off for referral isn't it?

33. <A11M> I've never seen admitted under the Mental Health Act {with a **BMI** above **thirteen**.}

34. <A5F> [...]it used to be a **BMI** of **fifteen** before they'd accept girls [...] you can you know ask for a referral or=or or consider somebody going to see them even if they're not quite at a **BMI** of **seventeen point five** if it looks as though they're erm

<A7F?> +Mm-hm.

<A5F> +really falling into problems. So they're they're less strict about their diagnostic criteria.

<A7F> That's helpful mm.

The above extracts situate specific BMI figures in relation to a range of practices in the clinical management of anorexia. As in cases of *normal BMI*, extract 31 involves participants jointly establishing what BMI score is required for diagnosis, with speaker 12's self-repair of 'seventeen' to 'seventeen and a half actually' indicating a desire to anchor diagnosis in relation to a highly precise figure (Potter, 1996). The remaining extracts relate particular BMI scores to different processes of hospital admission (ex. 32), referral to specialist services (ex. 34) and use of the Mental Health Act to treat patients involuntarily (ex. 33). Ostensibly detached from any reference to patients' psychological state or clinical treatment, specific BMI scores are presented as prerequisites for legitimating bureaucratic processes of formal diagnosis, referral to specialist healthcare professionals or legal procedures to sanction involuntary treatment.

The construction of *BMI* as a basis for organising clinical activities is also realised at a phrasal level through its position in 'If... then...' turn constructions. At a discourse level, 'If... then...' constructions are a syntactic resource for constructing logically structured verbal accounts that demonstrate causality between phenomena (Da Silva & Dennick, 2010). Within the GPs' discourse, *BMI* recurrently features in the antecedent ('If...') unit of these logical structures while processes of diagnosis and assessment (ex. 27 and 29), and admission and referral (extracts 32 and 34) are presented as its logical consequents ('then...'). The participants therefore repeatedly use this syntactic structure to construct *BMI* and particular BMI scores as consequential measurements that logically entail specific clinical and

administrative outcomes (Rosenberg, 2002). As well as simply occurring *during* talk about clinical and administrative processes, the corpus therefore provides some evidence of a phrasal grammar that specific situates *BMI* in a cause-effect relationship with these aspects of medical management and signifies its importance to the participants' treatment of patients.

However, although this recurrent phrasal structure constructs *BMI* as clinically consequential, the participants do not always depict the role of *BMI* in patient management favourably.

Speaker 7 (ex. 34), for instance, states that it is 'helpful' that the local eating disorder service will accept patients on the subjective appearance of 'falling into problems' rather than a specific *BMI* score. Similarly, speaker 2's account of his teaching as 'if they're a normal *BMI* or overweight it's bulimia if they're underweight it's anorexia' is subsequently directly challenged by another participant, who states 'But it's not is it?', with which he concurs. This group's discussion further problematises *BMI* in the following extract:

35. <A2M> I think I think *BMI*'s a difficult indicator though isn't it cos <pause> to you and I seventeen is low. [...] You kind of think "Well you know I'm only just under"
<A1F> Yeah.
<A2M> Is what you would perceive I imagine.
<A1F> {Yeah.}
<A3F> {Yeah.}
<A2M> "Maybe when I go down to ten I'll start worrying."
[...]
<A1F> Yeah {I think that's true} you know we have a good feeling of what other people
<A3F> {Yeah that's true. }
<A2M> Yeah.
<A1F> +don't. Yeah. Yeah.

Over the course of several turns speaker 2 and the other participants develop a critique of *BMI* scores based on the way in which they can be differently interpreted by patients and professionals. Speaker 2 contrasts the understanding of professionals with that of a hypothetical patient, using direct thought representation ("I'm only just under") to illustrate a lay understanding of *BMI* that is attributed to a generalised 'you' anorexic patient by the reporting clause 'you kind of think' (Myers, 1999). The responses of speakers 1 and 3 both strongly affiliate with this account by claiming its factuality. Speaker 1 goes on to formulate a

gist of speaker 2's turns, stating that clinicians 'have a good feeling of what other people don't', with which speakers 2 and 3 express further agreement. Speaker 2's thought representation of lay anorexic patients – "“Maybe when I go down to ten I'll start worrying”" – highlights that the interpretation of an objective BMI score is nevertheless a subjective process in which patients may not share their doctor's concern with a supposedly low score. This group's co-constructed account of the BMI suggests that it may be more for determining diagnoses and treatment decisions than it is for convincing patients that their weight is a medical concern. Indeed, having problematised BMI scores as a tool for encouraging patient concordance, this group's conversation immediately shifts to discussing treatment decisions determined by BMI score (ex. 32) and then the difficulty of persuading the patient to accept referral (see section 6.4.1).

Analysis of the use of *BMI* in the focus groups demonstrates its representation as the determinant of a number of primary care activities. In keeping with established diagnostic criteria (WHO, 1992), the participating GPs refer to BMI as evidence for the diagnosis of the hypothetical patients and as part of received teaching for differential diagnosis. BMI scores are also constructed as a means of assessing the severity of bulimia, grounds for doubting a patient's claims about their behaviour, and a metonymic assessment of a patient's overall health. One instance of *normal BMI* also portrays weight recovery as a precursor (rather than signifier) of overall recovery from anorexia. Repeated co-occurring references to specific BMI scores, diagnosis and referral discursively situate body mass as central to patients' administrative management and present precise numerical figures as a basis for organising standardised healthcare (Rosenberg, 2002). However, the rationalisation of healthcare decisions in terms of BMI figures is also questioned, contrasted with subjective evidence for making referrals and constructed as unhelpful in persuading patients to accept care. These alternative accounts of BMI echo Malson's critical account of the function of BMI in in-

patient care, in which she argues that body mass becomes ‘metonymic of everything’ (2008: 38) when used as a shorthand assessment of the patient’s treatment needs, well-being, and moral standing. A relentless focus on body mass by healthcare practitioners, she argues, continues and exacerbates anorexics’ existing obsessions with weight, making the practices of the treatment closely resemble the practices of the disease itself. Participants who interrogate the utility of BMI levels and represent diagnosis, referral and recovery as determined by more than body mass indicate some divergence from this discourse in the present study.

6.4 Referral, problems, and the difficulty of treating anorexia

This final section considers a number of keywords used during the groups’ discussions of patients’ treatment and management. I first consider the recurrent description of treating anorexia as a *difficult* process. Thereafter, I focus on two pervasive topics in the GPs’ accounts of managing anorexic patients: conducting referrals and establishing anorexia as a ‘problem’ for patients. The participants present these processes as both central aspects of their role in managing patients and as sources of particular difficulty.

6.4.1 ‘So it’d be really quite a difficult thing to talk about’: Treatment and *referral* as a *difficult* process

A group of keywords in the ‘Patient management’ category suggests that the treatment of patients with anorexia is evaluated negatively during the focus groups. The keywords *manipulative* ($n = 3$) and *denial* ($n = 4$), for instance, index the description of patients in terms of dishonesty and non-compliance (King & Turner, 2000; Reid *et al.*, 2010b). While these keywords are infrequent in the corpus, the keyword *difficult* appears 32 times across the focus groups ($\log\text{-likelihood} = 74.41$). At a simple level of frequency, the recurrence of *difficult* throughout the GPs’ discourse points toward a repeated construction of anorexia as a

demanding condition. While this may seem unsurprising given the complexity of anorexia as a mental health problem, it is worth noting that *difficult* appears only five times in the slightly larger depression focus group corpus analysed in the following chapter. Difficulty, therefore, appears to be a particularly salient facet of the GPs' understanding of anorexia (Reid *et al.*, 2010a). Examination of the concordances for *difficult* (see figure 6.2) reveals that several areas of patient management are repeatedly described as challenging.

N	Concordance
1	. Mm. I've had two in nineteen years as a GP. +Mm. And they've both been really difficult to manage. And they have been older anorexics. Mm? So kind of in their
2	I'm seeing her this afternoon Oh. Yeah. And like she d= yeah that sh= she is quite difficult one patient she's very stubborn and She's very difficult to treat yeah. Yeah.
3	yeah that sh= she is quite difficult one patient she's very stubborn and She's very difficult to treat yeah. Yeah. fixed on her ideas. +She's probably a good example of
4	the gym. Mm. +And I thought "Is it up to me to say something to her" and then it's difficult because I know her professionally as well. +Mm-hm yeah. And I didn't I
5	for three months Mm. +and for a bloke that's Yeah Yeah yeah yeah. +really quite difficult isn't it. So I suppose there's a historically it's been a Mm. Mmm. +it's an
6	+Mm. they're eating if if they're a bit happier though they eat a bit better. Mm. Mm. Difficult to extract the two isn't it. I suppose. Mmm. I'm very worried for the families
7	like that who just I can't even put myself in that position. +Mm. +I find it very difficult to +Mm mm. +anyway. Mm. I've got a friend a consultant and his
8	members of the family that also have pick up on +Mm. Mm. any any worries. It's difficult cos Julia's eighteen isn't it. +Mm. +And there's obviously some maternal
9	themselves they know what a BMI is and Mm-hm. Mm mm. I think I think BMI's a difficult indicator though isn't it cos to you and I seventeen is low. Mm. +Mm. But
10	what to say how to get that kind of idea across that I'm concerned and It it's it's difficult if she thinks she's fat and you're and you're going to be trying to Yeah +talk
11	admission she'll probably really be against it. Yeah yeah. +So it'd be really quite a difficult thing to talk about and I think it would take a bit of actual time to And I
12	came out towards the end and they thought she was going to die and it was really difficult cos sh= they turned up in A and E I was like I found it really difficult w=
13	it was really difficult cos sh= they turned up in A and E I was like I found it really difficult w= dealing with the family because er this'd= this had been going on for
14	of calling the psych team or anything like that. But I could it was just really quite difficult +Mm. +because cos cos er I=I think that erm and this=this=this
15	we're talking we seem to perceive it as an intractable long term thing that's very difficult to treat I don't know. But maybe I've not had enough experience in it to see
16	it. +Yeah. +Or is it just impulsive behaviour. Mm-hm. It's=it's=it's quite er +Yeah. +difficult one so Mm. +erm yeah I'd probably like to do a screen for depression
17	I don't know er it may take a bit of time with this CBT. I find I= Yeah I find it difficult with with medications that someone's taken an overdose of. Mm. Erm
18	+doing a marathon and +Mm. Mm. Mm. +yep that seems you know Mm. It's difficult. And how do you guys feel about secondary care erm commenting on your
19	therapies that work it's nev= unless it's really severe. Mm-hm. Yeah I agree. Yeah. Difficult to do something with it. I mean this bit about "She admits that she feels fat
20	ago that was dragged in by her father. Mm-hm. And it was one of those really difficult +Mm +ones where she obviously didn't identify there was a problem at all
21	saying "I think she's getting too thin". And her BMI was eighteen. Well I think it's difficult this this so that one it's just it's when it's a parent that perceives there is a
22	know when what kind of help are we able to offer? Is something I sometimes find difficult and also when they should be referred and not referred and they= there are
23	consequences and I don't know what the consequences will be anyway. Mm. It's a difficult one. Because you can get somebody ad= admitted to the clinical nutrition
24	way in with this girl might be to just talk to her about I mean it's it's a bit like it's difficult to to kn= to know how to approach it but in terms of trying to point out to
25	erm relationship problems as well so +Mm-hm. +I mean that can inter mix and difficult to know if that's why she'd been marched in or whether that was a cause of
26	why she'd been marched in or whether that was a cause of the problem it's very difficult to know. Mm. Mm. Shall we do this second one case two. Yeah. It's
27	. Mm. I think the ones I find I mean these are quite difficult but the ones I find are difficult I've got a two or three very ha= hardened anorexics that sounds awful but
28	bone profiles calcium phosphate. Mm. I think the ones I find I mean these are quite difficult but the ones I find are difficult I've got a two or three very ha= hardened
29	ever accepted anything I= I very long standing I think it's harder to address Mm. Difficult to address. Mm yeah. I said I think I'm at the point with her if the next time
30	. Erm but she obviously doesn't think there's a problem so that's immediately difficult cos she's not she's not coming But what do you anticipate I mean course
31	a different matter but. Yeah. Mm. You'd want her to go. I= er well I'm would find it difficult to decide yet whether she was going to be referred it would depend on what
32	a set pathway and behaviour that Mm. Which drives it. Mm. +is extremely difficult to Yeah. treat. Yeah sometimes the psychology with anorexia it's=it's more

Figure 6.2 – Concordances for difficult in the anorexia focus groups

Lines 15 and 32 in figure 6.2 show that the treatment of anorexia is described as ‘difficult’. In contrast, difficulty with the management and treatment of patients themselves is expressed in lines 1 and 2-3 respectively, with a difficult eating disordered patient being described as ‘stubborn’ and ‘fixed on her ideas’. Aspects of diagnosis are also described as ‘difficult’, with the participants referring specifically to identifying the causes of patients’ disordered eating (figure 6.2, lines 16 and 25-26), and discriminating between disordered eating behaviour and a patient’s life-style choices such as marathon running (line 18; Reid *et al.*,

2010a). Participants in different focus groups also claim they ‘find difficult’ the decision over when a patient should be referred. Speaker 11 (line 31) qualifies his statement with an adverbial ‘yet’, indicating that the decision over referral can be deferred until a later consultation in the case of the second patient scenario. In contrast, speaker 7’s turn (line 22 and see ex. 39 below) indicates that referral decisions and treatment provision are ‘sometimes’ difficult, suggesting problems with these aspects of management are recurrent, albeit infrequent.

Finally, ‘talk’ appears three times in the concordance lines of *difficult* (lines 10-11 and 24). In each case, participants are referring to negotiating the need for medical care with Patient 1 and the demands of overcoming the patient’s resistance to treatment, a process deemed to require ‘time’ in line 11. Speaker 5 (line 24) begins her turn with ‘I guess one way in with this girl might be to just talk to her about’ before discontinuing her on-going clause at the precise point where representation of the speech to the patient would begin:

36. <A1F> Yeah I mean I guess one way in with this girl might be to just talk to her about <pause 2 seconds> I mean it's it's a bit like it's difficult to to kn= to know how to approach it but in terms of trying to point out to her what the consequences might be for carrying on losing weight

The remainder of her turn features a cluster of false starts, a self-repair beginning with ‘I mean’, and a further incomplete, hedged clause, ‘it’s a bit like’, before acknowledging that ‘it’s difficult [...] to know how to approach it’. She then offers a possible topic of discussion, and specifically the implications of continued weight loss. Although she does ultimately proffer a ‘way in’ with the patient, the breakdown in the speaker’s turn at the precise juncture where indirect speech representation would occur neatly reflects the challenge of identifying an appropriate angle of discussion with the patient.

The concordance for *difficult* demonstrates a repeated portrayal of the management of anorexia and anorexic patients as a challenge. In particular, various participants note

difficulty with the related issues of making referrals to specialist treatment and encouraging resistant patients to accept medical care. Because previous qualitative research into clinicians' attitudes towards eating disorders has overwhelmingly used participants in secondary care contexts, difficulties with deciding when and how to encourage patients onto specialist care pathways are scarcely documented in existing studies. In light of this, and the salience of lexical items associated with these issues in the corpus, I discuss them in more detail below.

Referred and *refer* are both keywords in the corpus and occur a total of 36 times in relation to the patient scenarios and the participants' own patients. Examples of these terms in the corpus illustrate the GPs' experiences and expectations of a recommended practice in the treatment of patients with severe anorexia (NICE, 2004):

37. <A2M> you're kind of thinking well "She's reached the threshold of my **referral** so how can I <pause 2 seconds> persuade Julia that she needs **referral** or what what tools would I have" and again that's where I'd probably come up against a bit of a wall really. <pause> With my sort of communication in this area.
38. <A2M> [...] To know that someone's having blood tests seems to me to be a good thing. Erm <pause> I don't know but again I suppose that's in the same way of trying to suggest a **referral** and if she's saying "Well there's nothing wrong with me though doctor".
 <A3F> Mm.
 <A1F> Yeah.
 <A2M> +You know you know could say "Well you know worth checking making sure you know all these kind of things"
39. <A7F> [...] I suppose the other thing is you know when <pause> what kind of help are we able to offer? Is something I sometimes find difficult and also when they should be **referred** and not **referred** and they= there are guidelines and things and
 <A6F> Mm.
 <pause 2 seconds>
 <A7F> But I= I sometimes worry about checking people's weights and things about how what influence that's having on on their eating disorder.
40. <A9F> [...] I saw a lady today that's come had lots of support but hasn't engaged in any of it.
 <A10M> Yes.
 <A9F> And she is not wanting to be **referred**
 <A12M> Mm.
 <A9F> +She just wants some medication and pills.
 <A12M> +See I think the not **referred** is quite common.
41. <A9F> +So I would ha= I would **refer** {her early. }

<A10M> {Yeah. Whether she'd go} or not as you say whether she
 would engage
 <A9F> +Yeah but
 <A10M> +is a different matter but.

Extracts 37 and 38 follow on from discussion of the BMI score required for referral to local eating disorder services (see ex. 32 above). Speaker 2, however, indicates that referring a patient is a more complicated matter than their BMI score, juxtaposing the 'threshold of [his] referral' with the idea that he must also 'suggest' and 'persuade' the patient that referral is something she 'needs'. Although the nominalised form of *referral* otherwise elides the fact that it is a largely professionally-driven process of allowing patients access to specialist services, its use by this participant foregrounds that referral also depends upon a patient's cooperation. Indeed, it is attempting to secure a patient's assent that, this speaker claims, brings him 'up against a bit of a wall'. The notion that this process of persuasion requires particular 'tools' is expanded in extract 38, where the same speaker suggests that conducting blood tests may help when 'trying to suggest' referral to an otherwise reluctant patient. As well as assessment of physiological function, medical tests are therefore constructed as an interactive resource for responding to a patient's claims that they are healthy. That is, they serve a rhetorical as well as clinical purpose in defining the patient's condition as needing specialist medical attention.

Extract 39 also provides a more complicated picture of referral to specialist services. Speaker 7 specifies her difficulty as a conflict between 'guidelines' on when patients should be referred and the process of measuring the patient. This participant's account illustrates a double-bind for the GP who is both sceptical of the services primary care can offer (Lester *et al.*, 2005) but wary of reinforcing a patient's fixation with weight by weighing them to ascertain the need for referral (Gremillion, 2003; Malson, 2008). As well as indicating further problems with weight-dependent referral criteria, this account suggests GPs encounter

difficulties with adhering to clinical guidelines in practice, when the procedure for making specialist referrals is perceived to be detrimental to a patient's health.

Whereas extract 38 addresses overcoming resistance from a hypothetical patient, speaker 9 (ex. 40) briefly describes a real patient who is refusing to be referred. Again, a contrast is established between the 'support' offered by healthcare professionals and the actions of a patient who does not 'engage' with it, a contrast that is further specified with the claim that the patient 'is not wanting to be referred'. Speaker 9 then characterises the patient's perspective as wanting 'some medication and pills', with the adverbial 'just' signalling that these are insufficient in comparison with referral (I consider *medication* in detail in the following chapter). Speaker 12 then suggests that patients who refuse referral are 'quite common'. In extract 41, two speakers again construct the disparity between professional actions and patient responses. Speaker 9's claim that she would 'refer [Patient 1] early' is immediately contrasted with the issue of '[w]hether she'd go or not as you say whether she'd engage' by speaker 10. Speaker 10's signalled repetition of 'engage' previously used by speaker 9 (ex. 40) can be interpreted as performing face redress for his challenge to her proposed clinical management. Nevertheless, the repetition of 'engage' also ratifies patient involvement as a central component of their management (Richards, 2006). As in the other examples, therefore, the members of this group discursively align around the notions that anorexic patients refuse to be referred or do not engage in services they are offered.

As the above concordances demonstrate, the participants depict referral as a desirable yet difficult process and identify specific problems with ascertaining a patient's weight, knowing when to refer (ex. 39) and patients who resist the referral process (ex. 37-38, 40-41). For speaker 2 (ex. 38), medical assessments are presented as interactive resources that help counter a patient's denial by offering empirical evidence of morbidity. Accordingly, he goes

on to claim, 'maybe that's going to add weight to your argument that you know in the same way that "your BMI is low your salts in your blood are low and you're anaemic so"'. These professional assessments are construed as rhetorical tools in which blood test results and body mass scores help constitute and legitimate the reality of the patient's condition as a medical pathology (Potter, 1996; Rosenberg, 2002). At the same time, this speaker indicates that formulating the patient's condition in terms of observable biological indicators could be a persuasive approach to referral while attending to a patient's social, relational and psychological concerns is not mentioned (Lester *et al.*, 2005; Rich, 2006). In the face of patient opposition, this participant therefore recommends emphasis on the physiological signs of anorexia to which the clinician has privileged access and which situate the patient's experience within the remit of specialist medical services.

6.4.2 Anorexia as a *problem*

The participants' use of the keyword *problem* ($n = 44$, $\log\text{-likelihood} = 85.38$) provides additional evidence of the difficulties of treating patients with anorexia. *Problem* is used recurrently by the participants and occurs more frequently in the corpus than *eating disorder*, *anorexia* and *BMI*. Despite *problem* and *difficult* sharing common semantic ground, the two keywords display divergent use in the GPs' discourse. Whereas *difficult* is used to denote an aspect of anorexia or patient management that the speakers themselves find demanding, *problem* is used to refer to a feature of a patient or their situation in 40 (91%) of its occurrences. For example, several L1 collocates of *problem* indicate that it is used to refer to medical conditions experienced by a patient (table 6.4). These are *thyroid problem* (4 instances), *eating problem* (3 instances), *medical problem* (two instances), *digestion problem*, *ENT problem*, *health problem*, and *personality problem* (one instance each) as well as *problem with digestion*.

Table 6.4 – L1 collocates of problem in the anorexia focus groups

L1 collocate	Corpus frequency	No. of focus groups in which collocate arises
<i>a</i>	17	3
<i>the</i>	9	3
<i>thyroid</i>	4	1
<i>eating</i>	3	1
<i>medical</i>	2	2
<i>digestion</i>	1	1
<i>ENT</i>	1	1
<i>health</i>	1	1
<i>major</i>	1	1
<i>on-going</i>	1	1
<i>particular</i>	1	1
<i>personality</i>	1	1
<i>relationship</i>	1	1
<i>their</i>	1	1

However, *problem* is also used as the head of an unmodified noun phrase 26 times; that is, *problem* occurs more frequently in an unspecified form as simply *a problem* or *the problem*.

Handford (2007) identifies *problem* as a key lexical item in professional discourse, and claims that it functions to categorise an issue as categorically negative while allowing speakers to avoid specifying the nature of the issue itself. Instances of an unmodified *a problem* or *the problem* in the GP-anorexia corpus appear to share this function, enabling the participating GPs to label a patient’s health condition in unconditionally negative terms while remaining vague over the precise source of difficulty. *Problem*, in effect, functions as a vague euphemism for unspecified ‘pathology’. During the discussions, the unquestioned use of *problem* to refer to patients’ health suggests that it nevertheless constitutes an acceptable degree of imprecision for the participants (see Skelton *et al.*, 1999).

Collocation analysis reveals that *problem* appears in the recurrent trigram *there's a problem* ($n = 5$). Examination of the concordance lines also reveals the grammatically related clusters *there was a problem*, *there might be a problem*, *there is a problem*, *there was no underlying thyroid problem* and *there's a medical problem*. Instances of these clusters are reproduced below.

42. <A9F> Erm but she obviously doesn't think **there's a problem** so that's immediately difficult
43. <A5F> And it was one of those really difficult
 <A6F> +Mm
 <A5F> +ones where she obviously didn't identify **there was a problem** at all
44. <A5F> +It's often the case with anorexia they don't admit **there's a problem** until well they never admit their problem sometimes.
45. <A6F> it's a parent that perceives **there is a problem** [...] and you've no admission from
 <A5F> +Mm.
 <A6F> +the young girl herself th= th= **that actually there's a problem** as in she sort of just wants to look good.
46. <A6F> I couldn't get anywhere. Absolutely nowhere. Until I think they'll admit **there's a problem** you= what do you do?

On a surface level, these extracts demonstrate a consistent discursive pattern around the clusters *there's a problem* and *there was a problem*, in which patients are presented as either unaware or in denial of 'a problem' (Reid *et al.*, 2010a; Warren *et al.*, 2009). This meaning is conveyed through a repeated pattern in the grammar of each speaker's turn. In each extract above, a mental or verbal process – 'think', 'identify' or 'admit' – or nominalised process 'admission' is attributed to a patient with the grammatical object represented by the existential clause 'there's a problem'. The categorical modality with which this object clause is expressed encodes the existence of 'a problem' as definitive, regardless of its perception by the patient. This meaning can be clarified by examining a possible contrasting clause:

Ex. 43*: 'she obviously didn't identify a problem'

Ex. 43: 'she obviously didn't identify [that] there was a problem'

Extracts 43* contains one clause expressing the proposition 'she obviously didn't identify a problem' in which 'a problem' is the direct grammatical object of the patient's personal perception. However, the additional relative clause in extract 43 creates a different propositional content, specifically: 'there was a problem and she obviously didn't identify it'. In this and each instance of 'there is a problem' or 'there was a problem' in extracts 42-46, 'a problem' is stated as existing objectively regardless of whether a parent or patient perceives it.

The difference in phrasing and grammar here is, admittedly, a subtle one but has appreciable implications for the way in which anorexia and the relationship between doctor and patient are portrayed. By constructing the patient's disordered eating as an objective problem ('there is a problem'), the GPs attribute clinical difficulty to the patient's inability to realise an objective fact, and preclude the possibility that the patient's eating may not actually be problematic. At the same time, the participants depict their understanding of the patient's condition as an unequivocal one; they are aware that 'there is a problem' whereas patients misconceive or deny this categorical reality. Slight changes at the level of clause grammar therefore construct the patient's pathology as objective and apportion responsibility to the patient for not acknowledging the reality of their situation.

In extract 46, speaker 6 categorically asserts that her management of a previous patient went '[a]bsolutely nowhere' because of the patient's denial. Her subsequent rhetorical question, 'what do you do?', implies that GPs are otherwise powerless to help patients who do not admit 'there's a problem'. A final instance of *there's a problem* similarly emphasises the importance of a patient's problem realisation:

47. <A2M> +so I think we're almost forced or our role seems to be recognising a problem weighing
measuring bloods
<A1F> Mm-hm.

<A2M> +weight. And then persuading that there's a problem and once they're once you know you've reached that point it's its referral really.

Here, speaker 2 formulates the role of the GP as 'persuading' the patient to admit to the 'problem' the GP has recognised. The notion that the patient is being made to see their condition as an objective problem is supported by the speaker's reference to 'weighing' and 'measuring bloods' as a precursor to persuading the patient. As discussed above, these medical assessments are claimed to offer objective evidence of physiological malfunction that can be used to overcome patients' subjective beliefs about their eating. Consequently, the role of the GP is depicted as a fundamentally medicalising one. Their task is to use clinical technologies to persuade the patient of the reality of a medical pathology so that they agree to clinical interventions. This process closely resembles Guilfoyle's (2001) account of bulimic psychotherapy in which therapists seek to disrupt their patients' self-identity as 'dieters' and encourage them to reconstruct their behaviour as pathological and amenable to professional treatment. However, whereas Guilfoyle describes the use of psychological concepts that help the patient reinterpret their behaviour as pathological, speaker 2 recommends the use of physical assessments that offer objective indications of pathology. Guilfoyle argues that undermining a patient's understanding of her/himself is only acceptable because it is a preliminary aspect of resolving the patient's condition (2001: 168). The GPs in the current study achieve a similar justification by linguistically constructing the patient's 'problem' as existing independently of the patient's beliefs. A patient's desire to lose weight or to look good is re-stated as an objective 'problem' that they refuse to identify, literally problematising the patient's beliefs and justifying medical intervention.

Further examination indicates that the co-occurrence of *problem* with verbs of cognition or speech such as 'recognising' and 'admit' is a pervasive trend throughout the corpus. These verbs are, however, differently attributed to clinicians and patients (see figures 6.3 and 6.4). Whereas professionals are described as able to recognise, think about, realise and potentially

feel a problem (figure 6.3), the participants describe eating disordered patients as denying, not seeing, not saying, not thinking and never admitting that they have a problem (including the nominalised verb ‘admission’ in figure 6.4, line 10).

N	Concordance
1	+Mm. +so I think we're almost forced or our role seems to be recognising a problem weighing measuring bloods Mm-hm. +weight. And then persuading
2	measuring bloods Mm-hm. +weight. And then persuading that there's a problem and once they'r= once you know you've reached that point it's it's
3	How she is just general. +Mm. +sounds like it's more of a personality problem than a + +real depression. Probably that's the reality of what I
4	about digestion problems I don't agree with you I don't think it's a digestion problem . You're not sleeping at night you're not going out you're crying all
5	+Mm. +So an ENT surgeon thinks a nasty cancerous neck lump is a problem that he needs to be thinking about and telling us about. Mm.
6	is the difficulty isn't it really just erm trying to persuade them it might be a problem +Mm. Mm. +before it becomes a real medical problem. +Mm.
7	they get to that point actually either cos they realise that this is an ongoing problem . Unless she eats it's gon= not going to get better. Mm. +And she
8	I saw= then I saw her a c= a few years later and I thought she had a thyroid problem . Erm which we corrected I= I referred out erm she wanted to see
9	make if I was concerned and I felt that there was a serious mental health problem I'd be arranging to see them relatively soon +Yeah. +maybe four or

Figure 6.3 –Mental and verbal processes associated with problem with clinicians as agent

N	Concordance
1	her BMI was eighteen. Erm. Erm when I chatted to her it wasn't a particular problem that she saw and she didn't have any She didn't come back for any
2	anorexia they don't admit there's a problem until well they never admit their problem sometimes. +No. Yeah. +Mm. And that is the difficulty isn't it
3	to get get ways of mak= making her acknowledge that there might be a problem +Mm. +that's going to get worse and that it is worth her going to
4	do you anticipate I mean course cos anorexics do not think they have a problem do they. +Yeah. +Absolutely and it's the disparity between the
5	is is worrying. Yeah. +Yeah. Erm but she obviously doesn't think there's a problem so that's immediately difficult cos she's not she's not coming But
6	+Mm. And I met a g= I had a girl yesterday who erm said she had a problem with digestion so she could only eat first thing in the morning and
7	herself and er she= she's just said that she's er not got an eating problem now that she's over it and she she said that she thought she had
8	+that's the lady I was talking about. +Oh yeah but she she denies having a problem now now she says she eats too much and she still feels hungry
9	really difficult +Mm +ones where she obviously didn't identify there was a problem at all +Mm-hm. +in fact her mother was quite keen on her doing
10	admission from +Mm. +the young girl herself th= th= that actually there's a problem as in she sort of just wants to look good. +Mm. +It's quite hard
11	Yes it's just +It's often the case with anorexia they don't admit there's a problem until well they never admit their problem sometimes. +No. Yeah.
12	get anywhere. Absolutely nowhere. Until I think they'll admit there's a problem you= what do you do? Yes it's just +It's often the case with

Figure 6.4 – Mental and verbal processes associated with problem with patients as agent

As the concordances demonstrate, over a number of instances in each focus group the participating GPs frame patients’ thinking as an inability or refusal to construe their own eating behaviour as problematic. The recurrence of this discursive pattern coheres with Jarman *et al.*’s (1997) and Malson *et al.*’s (2004) research, in which the notion that anorexics hold false beliefs about their health was found to be a primary feature of professionals’ understandings of anorexia. Similarly, these accounts correspond to Beumont’s description of anorexic patients as ‘divorce[d] from the reality that most of us recognise’ (2002: 169). These concordances also illustrate the depiction of *problem* as both existing objectively (‘there’s a problem’, ‘it’s a digestion problem’) and as a possession of the patient, realised through possessive pronouns (‘their problem’) and attributive processes (‘have a problem’). The latter of these representations coheres with the use of *eating disorder* and *anorexia* above, in which

the GPs present medical conditions as possessions of an individual. In the clinicians' talk, therefore, linguistic representations of both *anorexia* and the anorexic *problem* constitute mental illness as a discrete entity possessed by the individual patient (Malson, 1998).

6.5 Summary

Analysis of the anorexia focus group corpus reveals several emergent patterns in the discussion of anorexia and anorexic patients. The speakers consistently distinguish between *eating disorders* and *anorexia* during their responses to the hypothetical case scenarios and descriptions of their own patients. Across a number of the corpus extracts provided above, the participants also comment on the difficulty of distinguishing between an eating disorder and non-pathological eating behaviour. In one particular case (ex. 5), speaker 7 claims that practice of dieting to look good is 'common', resulting in a large number of young people who have issues around eating. This account suggests a belief in the connections between people's desire to achieve a culturally esteemed body shape, dieting and pathological eating behaviours that are repeatedly averred in sociological literature (Bordo, 2006; Orbach, 1986). Nevertheless, this speaker specifies diagnosis as a decision between 'when it's an eating disorder and when it's not', reducing eating disorders to exclusive categories that are distinct from a widespread concern with weight and eating.

Eating disorder(s) and *anorexia* are presented as countable entities that are attributed to patients using 'got', 'with' and forms of the verb 'to have'. Each of these grammatical relations constitutes mental pathologies as discrete possessions of individual patients, a grammatical relation also observable in the participants' use of the keyword *problem*. In contrast to the *anorexia.net* forum, *eating disorders* and *anorexia* are only infrequently used in grammatical constructions that depict them as existing beyond their sufferers and amenable to direct interaction. There is only one instance in the corpus in which a GP clearly represents

anorexia as agentive, claiming that it ‘gives’ sufferers ‘positive feedback’. The participants present *anorexics* negatively, using both explicit descriptions and implicit associations to portray them as dishonest and ill-informed about their condition.

Participants support diagnostic statements with reference to patients’ behaviours, emotions and body mass. The participants’ frequent use of *BMI* presents patients’ body mass as a central criterion in the bureaucratic aspects of diagnosis, referral and involuntary treatment procedures. The relationship between BMI and referral observed in the corpus data contradicts Currin *et al.* (2007) and Green *et al.* (2008), who both found that a hypothetical patient’s weight did not determine GPs’ attitudes towards referral. This suggests that GPs’ awareness that BMI is a recommended determinant of clinical care has increased since these studies were published. However, the participants also highlight that BMI can be a source of misinformation for patients and question the utility of using a BMI threshold to determine specialist referrals.

The foregoing analysis is consistent with previous professional-based studies in which patients with anorexia are described as challenging (Hepworth, 1999; King & Turner, 2000). While some areas identified as ‘difficult’ by the speakers relate to making clinical decisions based on the limited information in the hypothetical case scenarios (figure 6.2, line 31), others relate to the management of anorexic patients generally. The case scenarios were also designed as realistic presentations of anorexia in primary care, meaning that areas of difficulty identified in the hypothetical cases may well transfer to the participants’ real life practice. Indeed, these findings clearly supervene on results of previous research that identified professionals’ anxiety around the diagnosis (Reid *et al.*, 2010a) and treatment (Boulé & McSherry, 2002) of eating disordered patients.

The participants identify particular problems with referral and persuading patients to accept professional services. These two issues are related insofar as referral is presented as a desirable outcome for the doctor but also dependent on the patient realising that 'there is a problem'. The use of 'problem' in the focus group corpus is also remarkably similar to that of primary care doctors in Reid and colleagues' (2010a) study. The GPs they interviewed also used clause structures that construct the patient's 'problem' as existing objectively, claiming that patients 'don't see that they've got a problem' and need assistance to 'identify that there is a problem' (2010a: 5). In both Reid *et al.*'s research and the MHDC corpus, GPs construct the 'problem' of anorexia as a definite fact that the patient is unaware of. The construction of anorexia as unconditionally negative offers a justification for convincing the patient that they hold false beliefs about their eating behaviours.

Speaker 2 claims that, when trying to persuade Patient 1 to accept a referral, he would 'come up against a bit of a wall really. With my sort of communication in this area' (ex. 37).

Similarly, speaker 3 claims that admission would be 'really quite a difficult thing to talk about' and speaker 5 claims 'it's difficult [...] to know how to approach' discussions with anorexics (figure 6.2, lines 11, 24). In the absence of these communicative skills, speaker 2 suggests the use of blood tests and BMI scores to provide evidence that the patient is medically unwell. Additionally, separate clinicians in the two other focus groups advised discussing fertility risks and osteoporosis with the patient. These strategies suggest that the participants would frame the 'problem' of anorexia in terms of physiological symptoms and risks of which the clinicians have specialist knowledge. As demonstrated by the participants' criticism of BMI, however, this medical information may not carry the same significance for the patient as the doctor, nor relate to the aspects of their eating behaviour that they experience as problematic (Boughtwood & Halse, 2010).

Finally, although not explored in detail above, it is worth noting that there is little talk of successful patient recovery in the corpus (*recover*, *recovery*, *recovered* and *recovers* each occur once). Speaker 5's claim that anorexic patients can decide 'to get over their disorder' represents recovery using a simple spatial metaphor that clearly contrasts with the discourse of powerlessness identified in the pro-recovery *anorexia.net* forum. Other indications that recovery is regarded as dependent on the patient are discernible in speaker 6's rhetorical question 'Until I think they'll admit there's a problem you what do you do?' (ex. 45) and speaker 10's emphasis on patients 'engaging' in treatment. Previous research has suggested that clinicians strategically present recovery as dependent on patients in order to mitigate their own responsibility for curing difficult patients (Reid *et al.*, 2010b). For the current participants, however, patient motivation and specialist treatment are depicted as prerequisites for recovery.

7 Professional discourses of depression

7.1 Introduction

This final analysis chapter examines the discourses in three GP focus group discussions of depression and its management. The focus groups had five, four and three participants respectively with a mean recording duration of 37:04 minutes and an average of 6863 words per transcript. As with the previous chapter, the participants were provided with hypothetical patient vignettes to prompt discussion (see figure 7.1) and several participants in each group also referred to current or former patients during the recordings. The first hypothetical patient (Patient 1) presented a case in which a diagnosis of depression is uncertain or debateable, and was intended to situate the patient's unhappiness and potential suicidality in relation to difficult social circumstances and physical illness. The second hypothetical case (Patient 2) portrays a patient with long-term unhappiness for whom antidepressant therapy has been ineffective and whose consultations are tiring.

Depression Scenarios

The following scenarios are intended to trigger discussion about the problems raised. What else would you like to know? How would you feel about this situation? What would you think about doing?

Have you had patients similar to this in the past and what happened? Are there any issues arising in the management of depression which you would like to discuss?

Case Scenario 1

Harry Bryant is 58. He has long term 'asthma' that is due to smoking. He is overweight and can't walk far without getting out of breath. He hasn't worked for years (his last job was as a security guard for a supermarket). His medical treatment is about as good as it can be unless he quits smoking and loses weight.

As part of a regular review you ask him how he is feeling. He tells you that, for the past three months he has become fed up with feeling like this. Life isn't really worth living. He is smoking more. He has never slept well and this hasn't changed and he still enjoys his food. He doesn't go out much anymore but that is mainly because it is too much effort. He spends much of the day watching TV, but usually falls asleep in front of it. His wife looks after him.

Case Scenario 2

Juliet Fernley is 42. She is a frequent attender with various minor complaints. She has been seeing you fairly regularly for the past five years, but she also consults other GPs in the practice if she can't get in with you. She has chronic fatigue syndrome and some symptoms of fibromyalgia. She has had long term sleep problems and takes regular zopiclone (despite the fact that you have tried to persuade her to stop on numerous occasions!). She tried taking fluoxetine once, but she developed severe nausea and 'felt dreadful' so wouldn't ever try it again.

When you see Juliet it seems as though something is always going wrong: the boiler broke down; her son had an accident; her mother has had to have an operation; the car needs an extensive repair ... etc. etc. In some consultations you sit there for 10 minutes just listening to her tale of woes, and you feel exhausted!

Figure 7.1 – Depression discussion scenarios

The fictional patients were intended to provoke discussion around a number of issues prevalent in recent studies of depression in primary care, including the negotiation of borderline diagnoses and medicalisation (Maxwell, 2005; Russell & Potter, 2002; Thomas-MacLean *et al.*, 2005), patients with difficult social problems (Dew *et al.*, 2005), ineffective

medication, and the emotional drain of difficult patients (Chew-Graham *et al.*, 2004; McPherson & Armstrong, 2009).

Each group's discussion was broadly structured in relation to the two patient vignettes, with participants discussing Patient 1 before discussing Patient 2. Where participants referred to their own patients or patients in general, this was embedded within the wider discussion of the hypothetical patients and their management, rather than explicitly topicalised after the patient vignettes had been discussed.

As the ensuing analysis will suggest, the participating GPs are largely reluctant to diagnose either hypothetical patient with depression. A participant in the first focus group, for instance, stated during a post-recording debriefing that he 'didn't think the second one was depressed'. Instead, much of discussion analysed below is concerned with assessing patients and ascertaining the causes of their unhappiness, endorsing non-medical treatment options and identifying methods for managing consultations. These topics are broadly represented in the keywords for the GP depression corpus, presented in table 7.1.

Table 7.1 – Key lexical and semantic categories and associated keywords of the GP depression focus groups

Lexica/semantic category	Associated keywords
Medical conditions	<i>depression, chronic, fibromyalgia, fatigue, asthma, depressed, sleep apnoea, COPD, fibro, suicide, symptoms, syndrome, physical, polysymptomatic, respiratory, problems, pervasive, overweight, personality [disorder], disease</i>
Diagnosis and assessment	<i>PHQ, GAD, assessment, reveal, insight</i>
Treatment	<i>zopiclone, CBT, medication, fluoxetine, acupuncture, antidepressants, therapy, citalopram, Samaritans, Healthy Change</i>
Feelings and mental processes	<i>feeling, feel, exhausted, motivation, fed [up], woes, feels, esteem, insight, realise</i>
Patient management	<i>patient, heart sink, patients, GPs, NHS, consultation, GP, legitimacy, QOF, disentangle, wife, consultations, consults, follow [up], regularly, frequent [attender], secondary [gain], seeing</i>
Psychological terms	<i>CBT, psychiatric, therapy, transference, psychological, personality [disorder]</i>
Risks	<i>risk, smoking, lifestyle, alcohol</i>
Abbreviations	<i>PHQ [patient health questionnaire], CBT [cognitive behavioural therapy], GAD [generalised anxiety disorder assessment], COPD [chronic obstructive pulmonary disease], GPs, NHS, GP, QOF [quality and outcomes framework]</i>
Modality markers	<i>actually, probably, sometimes, really, would, maybe, actively, absolutely, regularly, certainly, needs</i>
Response tokens	<i>mmm, yeah, mm, hm, yes, erm, so, hmm</i>

Although decontextualised from their contexts of utterance, the keywords above provide an initial illustration of the clinicians’ responses to the patient vignettes and their experiences of managing depression more generally. For instance, the GPs mention psychotropic medications referred to in the vignettes (*zopiclone, fluoxetine*) and those which they topicalise themselves (*citalopram*), while also discussing ‘talking’ therapies such as *CBT* and

non-specific *therapy*. These keywords mirror those found in the depression support group sub-corpus, in which forum users frequently discuss antidepressants and professional psychotherapy. However, the GPs also mention the Samaritans helpline and Healthy Change, a local non-clinical service designed to facilitate access to sports centres, healthy cooking and dieting classes, and counselling for debt and housing problems. These two keywords indicate that non-clinical services are also salient to the GPs' discussions of depression and its management. The keywords relating to physical and mental health conditions include those used in the discussion scenarios (*depression, chronic, fatigue, fibromyalgia, asthma*) and those introduced by the participants (*sleep apnoea, COPD and personality disorder*). As well as addressing the pathologies explicit in the vignettes, therefore, the group participants also topicalise several other physical and mental health conditions and discuss their implications for patient management and mental well-being.

As in chapters 4-6, there is some overlap between the semantic categories and their constituent keywords. The keywords *motivation, insight, and esteem*, for example, could be placed in the 'psychological terms' category. However, examination of their respective concordance lines does not indicate that they are used by the participants in a specialised psychological sense. *Insight* also appears in the 'diagnosis and assessment' and 'feelings and mental processes' categories as it is twice used with reference to assessing a patient and also in reference to patients' comprehension of their own situation. The distinct 'feelings and mental processes' and 'psychological terms' categories thus indicate that the participants utilise both lay notions of motivation and self-esteem and more specialised psychodynamic concepts such as *transference*.

As in the preceding chapter, the following analysis examines extended concordances from the corpus and utilises systemic functional linguistics to consider the participants' grammatical

constructions of depression. I also use insights from spoken discourse analysis (for example, Edwards, 1991; Myers, 1999; Potter, 1996) to consider the discursive negotiation of diagnoses, treatment options and patients' identities. The following section focuses on the keywords *depression* and *depressed*. It first considers those instances of *depression* and *depressed* which cohere with a medical discourse of depression as a single entity or diagnostic category and examines the evidence with which participants credit the attribution of depression to a patient. An example of *the depression* from the focus group is considered as a point of comparison with the *depressiononline.net* data.

7.2 Medical discourses of *depression* and the *depressed*

Depression ($n = 36$, $\log\text{-likelihood} = 283.59$) is the most salient lexical keyword in the depression focus group corpus and the fourth highest keyword overall behind the backchannel tokens *mmm*, *yeah*, and *mm*. Frequency plots for occurrences of *depression* (figure 7.2) demonstrate that a clear majority cluster within the first half of each recording, occurring an average of 27% of the way through each transcript and hence when the participants tended to be discussing Patient 1.



Figure 7.2 – Frequency plots for depression in the depression focus groups transcripts

Given the relatively small number of occurrences, automated collocation analysis reveals few consistent collocates of *depression* with a frequency ≥ 5 . Of these, one is a lexical verb, *know* ($n = 6$, $\log\text{-likelihood} = 21.13$), of which five instances are used in the discourse marker *you know*. The remaining collocates are hesitation markers *er* and *erm* or high frequency function words with little consistent collocational patterns. Nevertheless, manual analysis of

concordance lines reveals a number of discursive trends in the GPs' uses of *depression*, most notably its distinction from other emotional states:

1. <D1M> +Yeah. Are there any any good questions that we would throw in that that we find useful to erm draw out erm if there's an underlying **depression** in this sort of situation.
2. <D5M> For me it's that pervasive nature {of **depression**} it's {looking} for is there are they is this is this consistent or erm [...] do they just get cheesed off from time to time.
3. <D8M> {Mmm insight into whether he's} really depressed with an **endogenous depression** or a <D6F> Mmm. Yes and wh=[...]
4. <D7M> [...] decide between er a more reactive social **depression** as opposed to a more {endogenous} one
5. <D10M> [...] probably he's not got enough motivation to really change his lifestyle er to help his asthma and as a result he's he's feeling mad rather than he's going through a clinical state of **depression**.

The above extracts suggest two related concepts of *depression* which are realised through different colligational patterns. The first is of a non-countable, abstract category that carries particular qualities. For example, extract 2 refers to the 'pervasive nature of depression', using an unmodified 'depression' with a zero article to specify a defining characteristic of depression as a whole. Similarly, in extract 5, speaker 10 uses 'depression' to qualify a particular 'clinical state'. As in extract 2, this speaker uses 'depression' to refer to a particular diagnostic category, although he also concretises depression using a spatial grammatical metaphor, presenting the condition as a bounded space that Patient 1 is 'going through' (Mintz, 1992; Semino, 2008). Both of these extracts also distinguish the diagnostic category of depression from non-clinical states that are categorised using the colloquial descriptions being 'cheesed off' and 'feeling mad'. In doing so, they differentiate the category of 'depression' from non-medical forms of unhappiness (McPherson & Armstrong, 2009; Dowrick, 2004). Despite this mutual distinction, each GP distinguishes depression from non-clinical experiences using different criteria: speaker 5 suggests depression is marked by a continual state of misery; it is 'consistent' rather than occurring 'from time to time'. Speaker 10, however, presents sub-clinical 'feeling mad' as a corollary of demotivation and chronic

physical illness. These differing explanations in turn suggest subtly different understandings of depression and its distinction from ordinary distress. Whilst speaker 5 implies that depression is the persistent experience of otherwise infrequent, non-clinical feelings, speaker 10 excludes a diagnosis of depression through reference to specific causes. Thus the corpus provides evidence that the participants' use of *depression* is heterogeneous, signifying a condition distinguished by either subjective experience or by a specific aetiology.

The second concept of depression discernible from extracts 1-5 constructs depression as a countable entity: 'an underlying depression', 'an endogenous depression', 'a more reactive social depression', and 'an endogenous one'. In contrast to the zero article used in extract 2 to refer to depression as a category, the consistent use of a singular grammatical article in extracts 1, 3 and 4 represents depression as an identifiable, countable object. Participants in extracts 3 and 4 indicate that these cases of depression can be differentiated in terms of their causation as either organic 'endogenous depression' or external, 'social' depression.

Speaker 8 (ex. 3) also states that it is only with a case of endogenous depression that a person is 'really depressed'. Although another participant begins talking before speaker 8 finishes his clause, the implication is that he regards cases of depression that stem from situational factors as somehow less authentic. Both this GP and speaker 10 (ex. 5) distinguish depression from non-clinical states in terms of particular causative factors; speaker 10 refers to frustrating physical illness to exclude a diagnosis of depression and speaker 8 attributes being 'really depressed' to organic 'endogenous' factors. Both expressions support Thomas-MacLean and Stoppard's (2004) finding that clinicians regard 'true' depression as biological in origin rather than engendered by social factors or physical illness (c.f. APA, 1994; Pilgrim & Dowrick, 2006). As well as presupposing a separation between organic and social aspects of the patient, this view also implies that diagnoses can be determined by the cause rather

than the intensity of the patient's distress. There is evidence, therefore, that some participants draw on an understanding of depression as ultimately a biomedical condition.

7.2.1 Uncertain diagnoses

While the first five extracts above indicate that the clinicians construct 'depression' as a diagnostic category and a tangible, countable condition, several concordance lines reveal varying degrees of confidence surrounding the application of the category 'depression'. The analysis here examines instances of *depression* and *depressed* ($n = 14$) in the corpus, considering first the grammar of these two terms and second the discursive features of the participants' diagnostic claims. Relevant extracts used below were identified during manual concordance analysis in which the prevalence of modal adverbs occurring within a -5 to +5 span of *depressed* and *depression* was noted. This in turn led to examination of other linguistic features through which the participants express varying degrees of confidence in diagnoses of depression. These include modal auxiliaries, reference to cognitive processes and modality expressed through premodification. Examples of these are reproduced below:

6. <D3F> [...]it may be that once he'd you know finished his last job that he for three or four years made every possible effort to get {another} job [...]And then couldn't and then in terms of what that's actually done to his self esteem and the way that he looks at himself and his his own value and [...] so you know he **might actually have depression**
7. <D12F> {Are you saying} that he **might have had erm er depression** for a long time which is why he cannot motivate himself [...]
8. <D12F> [...] So there're many other things we could ask him erm about his er **possible depression** erm and I think the big clue here is he says "life isn't really worth living".
9. <D10M> So we are dealing with I don't know whether we're dealing with depression here. Are we?
10. <D8M> [...] I see she was **really depressed** because her husband left he couldn't cope with the diagnosis and all the complications and all that.
11. <D11M> [...] All of those conditions fibromyalgia chronic fatigue et cetera they are associated with depression. <pause> Yeah? And it **could be** that this lady is **actually depressed**. And it **may** trigger from some event <inaudible> from when she was thirty seven.

12. <D9F> +Erm lots of people who maybe can't walk far and don't have a job and are overweight **not necessarily depressed**. [...] So you can't l= necessarily link the two but there may be a strong link

Extracts 6 and 7 both employ the modal auxiliary verb 'might' to tentatively attribute depression to Patient 1. Despite these expressions of uncertainty, each speaker nevertheless opts to present depression as an object that a patient may possess ('have') and which is either categorically present or absent in the patient. In extract 8, speaker 12 also questions a diagnosis of depression for Patient 1 by pre-modifying 'depression' with 'possible'. As in extracts 6 and 7, even though it is qualified as 'possible' rather than definite, depression is nominalised as a reified entity the patient possesses and which can be the subject of questioning and diagnostic investigation. Thus even when its diagnosis is under question, depression is verbally constructed as a possession or attribute of the patient and forms a focal point for organising clinical activities (Rogers *et al.*, 2001). Tellingly, this participant omits this pre-modification later in the same turn, saying 'we have to do a more detailed assessment of his depression'. In the space of a few clauses, Patient 1's 'possible depression' is upgraded to an unmitigated diagnosis that can be directly assessed.

In extract 9, speaker 10 offers an explicit statement of uncertainty over the attribution of depression to Patient 2, expressing his own doubt and using a tag question to seek confirmation from the other group participants. As well as representing the most open admittance of uncertainty in the *depression* concordance lines, this extract also involves a characteristically medical construction of illness (Johnson & Murray, 1985). Rather than presenting depression as a personal attribute or possession – as in the previous three extracts – this speaker presents *depression* as distinct from the hypothetical patient and as something that can be 'dealt with' directly. The grammatical elision of the patient represents a clear example of the reifying discourse of diseases identified in existing health communication research (Nijhof, 1998; Warner, 1976), in which diseases become metonymic substitutes for the individuals who experience them.

The turns involving *depressed* reproduced in excerpts 10-12 above feature modal adverbs with which the speakers express their commitment to a diagnosis of depression. For instance, the adverb ‘really’ modifying ‘depressed’ in extract 10 emphasises that the patient has a legitimate case of depression, while the use of ‘actually’ in extract 11 (and also ex. 6) emphasises that a diagnosis of depression is genuine even whilst it runs counter to appearances.

The use of hedging modality during diagnostic appraisals of patients as ‘depressed’ or ‘having depression’ appears in 12 separate instances in the corpus and represents a marginally dominant feature of the doctors’ talk. In comparison, diagnostic statements that present depression or evidence for diagnosis in categorical terms, such as ‘he is at risk for depression as well’, appear 11 times. Whether they are expressed with low affinity modality (extracts 6-8 and 12) or adverbs denoting their factuality (extracts 10-11; Hodge & Kress, 1988), the clinicians consistently express modalised diagnoses of depression in close proximity to evidence used to support their claims. This is the case both where the GPs are referring to the vignette patient (as in extracts 6 and 11) and their own real patients (ex. 10). In explicating the evidence with which they credit a diagnosis, the participants treat their diagnoses as accountable acts that must be supported rather than simply asserted (Peräkylä, 1998). Additionally, by offering evidence for potential or genuine cases of depression, the clinicians also convey their understanding of what constitutes a legitimate basis on which to infer that an individual has depression (Wetherell, 1998). For example, as mentioned in relation to extract 3 above, speaker 8 associates being ‘really depressed’ with having ‘an endogenous depression’, suggesting that cases of genuine depression are those with a biological basis. However, the other extracts indicate that participants utilise evidence from a wide range of domains to support a diagnosis of depression. These include lowered self-esteem due to unemployment (ex. 6 and ex. 12), lack of motivation (ex. 7), potential suicidal

ideation (ex. 8), marital separation (ex. 10), physical comorbidities (ex. 11-12), and previous traumatic events (ex. 11). Far from being presented as a solely biochemical condition, then, the participants more commonly frame a diagnosis of depression in relation to non-organic precipitates of unhappiness and situate diagnosed patients within a complex milieu of material, physical and psychosocial factors (Chew-Graham *et al.*, 2002; Dew *et al.*, 2005; McPherson & Armstrong, 2009).

There is, however, a seeming tension between the evidence with which the participants account for diagnoses of depression and their grammatical constructions of depression itself. While the participants relate cases of depression to situational factors external to the patient, depression is also grammatically constructed as an objective category or a distinct entity possessed by a patient and potentially separable from them. This creates in dissonant accounts of depression as both stemming from a patient's personal context and as an individualised, grammatically discrete object. A similar finding is noted by Thomas-MacLean and Stoppard, who observe that doctors' 'awareness of the relationship between social contextual influences and depression is juxtaposed with medicalised descriptions of depression' (2004: 284)

The foregoing extracts also indicate inconsistencies in the use of evidence for supporting diagnostic conclusions. Speaker 8, for example, attributes being 'really depressed' to both 'endogenous' factors (ex. 3) and marital separation (ex. 10). Additionally, in extract 5, a lack of personal motivation is used by speaker 10 as evidence to infer that Patient 1 is simply 'feeling mad' rather than clinically depressed. However, a few turns later in that discussion, this assessment is reformulated into a question by speaker 12 (ex. 7), who cites Patient 1's demotivation as an indicator of depression. Speaker 10 now assents to this formulation, responding with 'Yeah' and stating that 'there might be an underlying reason why he doesn't

really want to change'. Within a few lines of talk, the patient's motivation is used to support assessments that he both is and is not depressed, an inconsistency which is not noted by the participants themselves.

As the frequency of modal hedges in the foregoing corpus extracts attests, the participants often provide tentative diagnoses of the hypothetical patients. In discussing these uncertain diagnoses, the GPs also consider methods for classifying patients more definitively. Whilst specific diagnostic measures are examined substantively in section 7.3 below, one extract in which diagnostic uncertainty is overtly topicalised is reproduced for analysis here:

13. <D1M> +Yeah. Are there any any good questions that we would throw in that that we find useful to erm draw out erm if there's an underlying depression in this sort of situation.
<D5M> Mmm.
<D1M> I mean are there any erm <pause 2 seconds> are there any questions that that would then make th=th=th=th= that pick out the people who are depressed from most of the people who are I mean or are they the same? You know.
<D5M> For me it's that pervasive nature { of depression } > it's {looking} for is there are they is this is this consistent or erm

In the third turn of this extract, speaker 1 reformulates his question of whether there are 'good questions' to 'draw out erm if there's an underlying depression' (ex. 1). Speaker 1's first turn implies that depression is categorically present or absent even though it may be 'underlying' and hence difficult to ascertain from a patient's initial presentation. This categorical model of depression is initially upheld in his next as he suggests people who are depressed can be 'pick[ed] out' by particular questions. This question posits a clear distinction between individuals who do and do not have depression. However, speaker 1 then explicitly questions the distinction between 'the people who are depressed' and those who are not by asking 'or are they the same?'. In the concordances for *depressed* and *depression*, this utterance represents the only instance in which a participant overtly interrogates the label of *depressed*, querying whether it identifies an appreciably distinct class of people. However, this topic is not taken up by the other speakers in the subsequent turns and is not explicitly addressed

during the remainder of the group's discussion (c.f. Schegloff, 1996). Instead, the following speaker orients to the first question in speaker 1's turn by discussing criteria with which genuine cases of depression can be determined from those who are just 'cheesed off' (ex. 2), opting to consider practical methods of diagnosing depression rather than interrogate the diagnostic category itself.

Although the speakers in extracts 6-9 all convey at least some uncertainty over whether Patients 1 and 2 have 'depression', each speaker nevertheless maintains a categorical view of depression itself. That is, depression is presented as something that is either present or absent, or which a patient does or does not possess. With the exception of 'really depressed' in extract 10, the participants do not suggest that depression is something patients can partially possess, or show some signs of. Extract 13 provides the sole example of a speaker explicitly questioning the boundary between depression and non-pathology, though this issue is not discussed further in this group. The participants thus negotiate uncertain diagnoses of depression by hedging the attribution of the diagnostic category to particular patients rather than interrogating the utility of the diagnostic category itself. In doing so, they display a preference for preserving the integrity of depression as a diagnostic category even when it is of limited use for categorising patients. At the same time, they also reiterate a reified model of *depression* as an identifiable, assessable psychopathology rather than a 'vague term for a variety of states' (Leader, 2008: 4). By orienting to diagnostic categories even in uncertain cases, the GPs foreground the authority of diagnosis as a means of classifying patients and determining subsequent actions in the management of hypothetical and real patients (see ex. 17 below and Brown, 1995; Dowrick, 2009b; Rosenberg, 2002).

7.2.2 Comparisons with patient communication

The relatively low number of instances of *depression* and *depressed* in the depression focus group corpus means they do not have a semantic profile of statistically significant lexical collocates (Orpin, 2005). However, a medical semantic preference (Stubbs, 2001) is discernible from a number of lexical items infrequently occurring proximate to *depression*, including *chronic fatigue*, *endogenous*, *history*, *chronic disease*, *PHQ*, *GAD*, *clinical state*, *assessment*, and *diagnosis*, of which a number are also keywords. As is the case in the *depressiononline.net* patient corpus, these infrequent collocates signal that the participating GPs verbally situate *depression* in the co-text of diagnostic categories, clinical processes and assessment tools, indicating that a medical discourse of *depression* is shared by both patients and clinicians. However, in the *depressiononline.net* sub-corpus, statistically significant lexical collocates for *depressed* were all non-medical and pertained to processes of cognition and measurements of time. In the GP discussions, however, lexical items co-occurring adjacent or near to *depressed*, such as *chronic disease*, *trigger*, *patient*, *endogenous*, *antidepressants* and *anxiety*, clearly situate *depressed* in a medical discourse not evident in the patient forum.

Comparison of respective grammatical collocates for *depression* in the patient and professional corpora also reveal clear differences. Most obviously, while the messages sampled from the online forum are saturated by the collocation *the depression* ($n = 50$), this bigram appears only once in the GP focus groups. Even when the difference in corpus size and relative frequencies of *depression* in each corpus is normalised this is a substantial difference, with *the depression* accounting for 12% of instances of *depression* in the patient corpus but only 3% of the instances of *depression* in the clinicians' talk. The single instance

of *the depression* in the GP corpus does, however, reveal striking similarities with its use in the depression support forum:

14. <D12F> [...] we've raised the question of suicide then erm if he is erm a= appropriately erm aware then I would say to him that "Yes this depression is another illness like asthma but that's not you."
<D11M> Yep.
<D12F> "Okay so **the depression** is not you"
<D11M> "Yeah you're not this body."
<D12F> +"So you are not this body {and you're not even this mind}
<D11M> {And you're not this mind } yeah. [...]
<D12F> +Erm and I view that has been very very instrumental in several cases I have had. [...] Er where the patient then feels that "there isn't anything wrong with me. [...] But there is something wrong with my= or you know I have depression or I have asthma I have mental problems but that's not me." So that actually gives them a positivity

The use of *the depression* in the GP sub-corpus occurs within reported speech in which speaker 12 simulates a discussion that could be used to enable Patient 1 to regard himself as distinct from depression. Along with 'this depression' in her previous turn, the definite article (rather than possessive pronoun or zero article) is used as the determiner for *depression* as part of an explicit disconnection of depression from the patient: 'the depression is not you'. The participant's use of this construction to grammatically divorce the patient from depression supports my own analysis of the separating function of *the depression* in the forum interactions. Crucially, however, speaker 12 uses *the depression* as part of an explicit and deliberate attempt to dissociate the patient from depression, a separation which remains largely implicit throughout the extensive interaction in the *depressiononline.net* corpus. Speaker 12 also states that assisting the patient to feel they are separate from their physical and mental health problems is therapeutically beneficial and allows the patient to manage the subjective stigma of illness. This is also a function identified in my analysis of the depression forum discourse (see also Schreiber, 1996; Schreiber & Hartrick, 2002). Speaker 12 goes on to elaborate the benefits of this discourse-based 'logotherapy' (Halliday, 2002: 307) over her next few turns; regarding depression as detached from the individual is said to 'give hope' to the patient and relieve them of the 'burden [...] of the disease':

15. <D12F> [...] and I think that can give er a huge degree of hope to the person especially if they're suicidal because they're beginning to separate themselves already from this huge <pause>
<D10M> Burden.
<D12F> burden.
<D10M> +Yeah.
<D12F> +of the disease. [...]but it isn't appropriate in every consultation.

To some extent, speaker 12's suggestion that dissociation from depression is therapeutically beneficial for the patient runs counter to existing research. Schreiber (1996), for example, claims that patients recovering from depression are more likely to accept depression as a part of their identity. Similarly, analysis of the *depressiononline.net* corpus in chapter 5 suggests that those forum users who represent depression as a distinct entity are also more likely to regard it as beyond their own control (Bennett *et al.*, 2003; Schreiber & Hartrick, 2002). However, her qualification that this mode of therapy is useful 'especially if [patients]'re suicidal' but 'isn't appropriate in every consultation' signals that she regards it as suited to managing acutely distressed patients but not as a generic discourse of depression, as it is for the forum users.

The foregoing analysis indicates that the GPs use *depression* and *depressed* to refer to a range of related phenomena. The keyword *depression* is used to refer to a diagnostic category that it is differentiated from simple unhappiness and to signify an instance of that pathology that is possessed by an individual. The participants constitute *depression* as an entity that can be assessed and which is either categorically present or absent in patients while co-occurring lexical items situate *depressed* and *depression* in relation to medical processes and categories. The participants attribute depression to individuals on the basis of diverse biological, physical and social factors, suggesting a hybrid understanding of depression as both an organic pathology and a reaction to structural conditions (Lewis, 1995; Rogers & Pilgrim, 1997; Thomas-MacLean & Stoppard, 2004). A number of epistemic modality markers surrounding *depression* and *depressed* convey uncertainty around the diagnosis of depression, which is frequently attended by supporting evidence. The following section continues this topic of

diagnosis and considers the participants' discussions of assessing patients using screening tools.

7.3 A 'proper assessment' for depression

In extract 1, speaker 1 asks whether there are questions that can 'draw out' whether or not there is an 'underlying depression' in a patient. His pre-modifier 'underlying' constructs depression as potentially concealed and requiring identification through diagnostic investigation. Similarly, in the third focus group, speaker 12 proposes to carry out a 'more detailed assessment' of Patient 1 and a 'proper assessment' of Patient 2 to determine whether each patient is depressed. One aspect of such a 'proper assessment' mentioned by speaker 12 and in all three focus groups is the Patient Health Questionnaire, referred to in its abbreviated form as 'PHQ nine' or simply as the keyword *PHQ* ($n = 13$, log-likelihood = 161.13). The PHQ-9 is a self-report instrument that is widely used in UK primary care to identify cases and assess the severity of depression (Kroenke *et al.*, 2001; NICE, 2009). Patients respond to nine questions related to experiences of the *DSM-IV*'s (APA, 1994) diagnostic symptoms for depression with answers from zero ('not at all') to three ('nearly every day'). Total scores of five, ten, fifteen and twenty are taken to indicate mild, moderate, moderately severe and severe depression respectively (Kroenke *et al.*, 2001).

Frequency plot analysis of the 14 instances of *PHQ** in the depression focus group corpus indicated that 86% occur within the opening half of each group discussion, occurring at an average of 34% of the way through each transcription (see figure 7.3).

N	File	Words	Hits	Plot
1	Depression Discussion Group 1.txt	5,592	3	
2	Depression Discussion Group 2.txt	6,645	4	
3	Depression Discussion Group 3.txt	8,306	7	

Figure 7.3 – Frequency plots for PHQ* in the depression focus group transcripts

As with *depression* above, references to PHQ-9 are more common when participants are discussing Patient 1, which was designed to illustrate a borderline case of depression. Within these discussions, several clinicians recommended the use of a PHQ-9 for assessing the hypothetical patient:

16. <D12F> [...]we have to do a more detailed assessment of his depression. So I would want to ask him about erm any diurnal variation or er you know his er mood er whether he can concentrate whether he enjoys reading books. Erm really run a **PHQ** through him or even a GAD if there are features of anxiety. Er you know his libido his interests. Things like that.
17. <D6F> I mean would you be doing a **PHQ** nine would that add anything? <laughs> [...]
<D8M> {Mmm insight into whether he's} really depressed with an endogenous depression or a <D6F> Mmm. Yes and wh= {and how often} how often it's happening cos [...] it might reveal to him that actually actually it's not every day actually it's {more once a week or you know some=} sometimes can open up {lay out their ideas} about what

In extract 16, a PHQ-9 is introduced as part of a list of features which focus around diagnostic criteria such as concentration, interest levels, personal enjoyment and sex drive. The use of patient questionnaires is therefore introduced as an adjunct to a 'detailed assessment of his depression', that is, to assess a state of depression that has already been determined rather than to determine whether or not the patient is depressed in the first place.

In extract 17, speaker 6 introduces the possibility of using a PHQ-9, reformulating her initial question by asking whether it would 'add anything' to the assessment of Patient 1, which the group has jointly discussed in the preceding few turns. The PHQ-9 assessment is therefore formulated as a supplementary rather than substantive instrument for assessing the first hypothetical patient, and one which must be explicitly accounted for. Responding to this, speaker 8 claims that the questionnaire is able to offer 'insight' into Patient 1's condition, suggesting that the authenticity and cause of the patient's purported depression can be ascertained instrumentally. Participant 6 signals agreement with this in her subsequent turn using both a response token 'Mmm' and an explicit agreement 'Yes', before further specifying that a PHQ-9 would provide information on how frequently the patient is unhappy. She goes on to elaborate that this can be useful in demonstrating to the patient that they do

not feel unhappy all of the time, signalling that she perceives the PHQ-9 to have a potentially therapeutic function for the patient in addition to any utility as a screening tool. In one instance, the PHQ-9 was also invoked in an attempt to validate a topic shift from ascertaining diagnosis to the treatment of Patient 1:

18. <D11M> [...]let's assume that that is a depression situation and maybe he= we've done a GAD and a PHQ and they are you know significant er and what have you. S= so what what would we do then?

In order to move the discussion topic onto possible management options for Patient 1, speaker 11 attempts to establish a diagnosis of depression. Peräkylä (1998) notes that stating the basis for a diagnosis is common in clinical discourse but occurs most often when diagnosis is uncertain and needs to be warranted explicitly by reference to authoritative evidence. In keeping with Peräkylä's claim, speaker 11 uses the hypothetical results of a PHQ-9 and GAD-7 – an equivalent test for anxiety – as evidence to credit a diagnosis of depression. That is, it is the non-specific, 'significant' results of PHQ-9 and GAD-7 tests which are here invoked to warrant a diagnosis of depression and these results are cited in preference over the various aspects of the patient's subjective experience listed by speaker 12 in extract 16 above. The subsequent turns do not treat this evidence as problematic; one speaker agrees and offers further corroborating evidence in the form of a correlation between chronic disease and depression and the following turn accepts the topic shift into patient management. Neither of the other participants in this focus group question speaker 11's choice of evidence, suggesting that they regard the results of patient questionnaires as sufficient authority to credit diagnosis of depression in this instance.

Despite some participants advocating the complementary use of PHQ-9s and the conversational work which their invocation achieves in the focus groups, the usefulness of the test was questioned both by other participants and those GPs also espousing its benefits:

19. <D7M> But I think my my experience of PHQ nines is th= certainly it's not helpful to really erm dec= decide between er a more reactive social depression as opposed to a more

- {endogenous} one a=
 <D9F> {No. }
 <D8M> +Mm.
 [...]
 <D8M> {A snap shot isn't it.}
 <D7M> +And that and and er and actually it's very easy to to say "yeah that that's me all the time".
20. <D11M> +Well you know what happens when you give these people a **PHQ** nine.
 <D12F> +Mm.
 <D11M> They score twenty seven out of twenty {seven and they } score twenty one out of twenty one on GAD seven and there's naff all wrong with them because they're sitting there smiling at you and there's this
 <D12F> {Yeah yeah! Definitel=}
21. <D11M> {No but they're they're going to be twenty seven out of twenty seven.}
 <D10M> Mm.
 <D11M> +Because the= because that they don't they can't answer the question honestly. [...] They don't they don't have the the the the same insight as the rest of the public.
22. <D2M> {I wouldn't} I probably wouldn't be doing a **PHQ** at this stage cos I think it's I wo=
 <D1M> No I wouldn't either.
 <D2M> +N= not initially I would probably be seeing that you know going for lifestyle quite
 <D3F> +Yes.
 <D2M> +heavily.

In extract 19, which takes place shortly after extract 17, speaker 7 offers an explicit disagreement with speaker 8's suggestion that PHQs can be used to distinguish between types of depression. In contrast to speaker 8, speaker 7 states that PHQs are 'not helpful' for distinguishing types of depression, an assessment which is upgraded by the adverbials 'certainly' and 'really'. This disagreement indicates a clear disparity between the two GPs' understandings of a widely used screening tool, though speaker 8 tentatively aligns with this assessment with his response token 'Mm'. Speaker 7 also implicitly questions the accuracy of the assessment itself, using direct speech presentation to illustrate a response to a PHQ that would result in a high score, "‘yeah that that's me all the time’". The use of reported speech here detaches the negative assessment of the PHQ-9 from the speaker, presenting it as having a 'basis outside [his] own opinions' (Myers, 1999: 387). This is reinforced by the speaker's choice of an existential verb phrase in the reporting clause, 'it's very easy to say', in which a dummy subject 'it' is used in place of a more specific subject such as 'depressed patients'. This reporting clause is also expressed in the simple present tense, denoting repeated or

timeless events. Using this combination of a generic subject and tense, speaker 7 clearly constructs the reported speech as a universal response to a PHQ-9. The implication is that anyone – not only depressed individuals – can provide exaggerated answers to a PHQ, and that the assessment may therefore be inaccurate.

In a different group (ex. 20), speaker 11 suggests that a PHQ may be similarly ineffective for assessing ‘these people’ such as Patient 2, whom the participants are discussing. Whereas in extract 19 speaker 7 states that it is ‘easy’ to overestimate the frequency of depression’s symptoms, speaker 11 locates the source of a PHQ’s inaccuracy squarely with an unspecified group of patients who have ‘naff all wrong with them’ despite their maximal PHQ scores. The use of ‘you know what happens’ in speaker 11’s first turn presents his account of PHQs as knowledge shared by the other participants, providing a stake inoculation against his disparaging assessment of patients’ responses (Potter, 1996). Returning to the topic fifteen minutes later in the discussion (ex. 21), this participant again claims that particular patients undermine the purpose of the PHQ because they ‘can’t answer the question honestly’. The inaccuracy of the PHQ is clearly attributed to the patient here and the assertion that patients provide dishonest answers constructs a moral identity for problematic patients rather than a purely medical one (May, 2005; McPherson & Armstrong, 2009). Throughout both extracts, speaker 11 maintains a plural pronoun ‘they’ and hence characterises a wider, homogenised patient demographic associated with the second patient scenario. What emerges from the discussion in these two extracts is a consistent construction of a patient group that is distinguished by a pathological lack of ‘insight’ that dissociates them from the ‘rest of the public’ and is seen to enervate typical methods of clinical assessment (see section 7.5).

Finally, in extract 22, speaker 2 claims that he would not use a Patient Health Questionnaire in the Patient 1 scenario, a course of action with which speaker 1 agrees in his subsequent

turn. Speaker 2's use of a hedging adverb 'probably' and use of qualifying temporal adverbials 'at this stage' and 'initially' suggest that his proposal may be heard as a controversial decision and hence can be subject to change. In accounting for postponing the use of a PHQ-9, speaker 2 also offers an alternative proposal, claiming he would be 'going for lifestyle' instead. In addition to doubting the effectiveness of the test itself, then, the GPs also situate the PHQ-9 against other legitimate clinical activities, constructing an opposition between pursuing clinical assessments and managing a patient's unhappiness as a product of lifestyle factors.

In contrast to clinical guidelines (NICE, 2009), GPs in all three groups express at least some doubts over the use of PHQs for assessing depression and, in one case, disagree over what the test can measure. Whilst one GP claims she would include a PHQ within her comprehensive assessment of Patients 1 (ex. 16), two other GPs explicitly say that initially they would not (ex. 22). For one participant (ex. 17), the assessment is considered to have therapeutic potential, allowing the patient to reflect on their experiences and possibly realise that they are not permanently unhappy. Both across and within the focus groups, therefore, the GPs express several inconsistent attitudes towards PHQs and their suitability for particular patients, with several participants questioning their usefulness in real life consultations (Maxwell, 2005). In these cases, the apparent simplicity of PHQ-9s 'do[es] not reflect the realities of clinical practice' (Thomas-MacLean *et al.*, 2005: 1108) in which focusing on social circumstances may be clinically preferable and where patients' subjective responses undermine the apparent objectivity of the assessment (Dowrick *et al.*, 2009). This lack of faith in an established instrument for assessing depression is somewhat surprising given that depression is elsewhere verbally constructed as categorical (section 7.2.1). That is, the GPs present depression as categorically present or absent in patients yet doubt the efficacy of a diagnostic instrument designed to provide such a categorical assessment.

7.4 Medication, treatment and therapy

Treatment options were topicalised in all three focus groups, precipitating discussion of biomedical, psychosocial and non-medical interventions in relation to the hypothetical scenarios and patients more widely. Several of the keywords in this semantic category, such as *fluoxetine* and *zopiclone* occur when the participants initially recited or paraphrased the Patient 2 scenario. Manual reading of the transcripts also identified the repeated use of several other lexical items related to antidepressants and sedative medication. Corpus queries using these terms and keywords from the ‘medication’ category from the *depressiononline.net* data provided additional concordance lines for *medications*, *pill*, *tablet(s)*, *drug(s)* and *diazepam*, which were examined alongside the keywords. Frequencies of these and the keywords identified under the treatment category are presented in table 7.2.

Table 7.2 – Frequencies of ‘treatment’ keywords and associated lexical items

Key lexical items	Corpus frequency	No. of focus groups in which word arises
<i>medication</i>	8	3
<i>zopiclone</i>	8	2
<i>CBT</i>	7	3
<i>therapy</i>	7	2
<i>drugs</i>	6	2
<i>Healthy Change</i>	6	1
<i>fluoxetine</i>	5	1
<i>acupuncture</i>	5	1
<i>drug</i>	5	2
<i>antidepressants</i>	4	2
<i>Samaritans</i>	4	1
<i>citalopram</i>	3	1
Non-key ‘treatment’ lexis		
<i>pill</i>	3	2
<i>medications</i>	2	2
<i>antidepressant</i>	2	1
<i>tablets</i>	1	1
<i>tablet</i>	1	1
<i>diazepam</i>	1	1

Table 7.2 signals that a range of possible treatments are discussed in the corpus, though a number of these, such as *healthy change*, *acupuncture* and the *Samaritans*, are specific to individual groups (indeed, each of these terms arises in a separate discussion). Only the keywords *medication* and *CBT* occur in all of the focus groups, indicating that both psychotropic and psychotherapeutic interventions are considered in every discussion. Examination of concordances for *medication* reveals contrasting experiences of antidepressant prescription and patient expectations:

23. <D12F> And then ask him whether he actually wants to go on **medication** or do you decide whether you treat him with antidepressants today or in a few days' time or <pause> attempt to address those <pause> questions.
24. <D8M> Yeah but most of them say "No I don't want **medication** I want to go down the line of counselling and come back."
25. <D6F> Yes. Yes. Yes it's worth exploring both when sometimes when they come in you think that's they're wanting **medication**
 <D8M> +Yeah.
 <D9F> +Mm.
 <D6F> +but then the the minute you mention it they go "Oh no {no I don't want} that!" <laughs>
26. <D8M> +So most of them you know they come with and'll say "No I want **medication** today that is what I'm here
 <D6F> +Mm.
 <D8M> +for because I have suffered enough." So in that case I would have a little kind of negotiation

Extracts 23-26 are taken from discussions of the possible provision of antidepressants for Patient 1 and present a range of accounts of interactions with patients around the prescription of medication. Having previously recommended arranging a follow-up appointment for the patient, speaker 12 (ex. 23) introduces medication as an issue to be negotiated with the patient, and her use of 'actually' foregrounds the possibility that Patient 1 may not desire antidepressants. She then presents several possible options for prescription, including when to prescribe medication and when to discuss it with the patient. The use of several syntactically equal coordinate clauses presents these different options as equally feasible (Adolphs *et al.*, 2004; Hunt & Harvey, 2013) and indicates a need for careful consideration of several possible actions. Rather than a straightforward solution to patient management (Pilgrim & Bentall, 1999), antidepressant treatment is constructed here as only one possible treatment option that must be balanced with the patient's preference and other management options.

In discussing the possible prescription of antidepressants for Patient 1, speaker 8 begins to discuss patients more generally (ex. 24). His use of the plural pronoun 'them' and approximate quantification 'most' in his reporting clause signifies a characterisation of patients as a whole rather than specifically Patient 1. His subsequent use of reported speech can therefore be interpreted as providing evidence of a typical, repeated speech event in

which the interjection ‘No’ and spatial deixis of ‘come back’ are employed to simulate an authentic clinical dialogue (Myers, 1999: 396). Using these discursive features, speaker 8 presents encountering patients who refuse medication as a veridical – and indeed frequent – occurrence in his clinical experience. Speaker 6 continues this topic, offering a related account of medication refusal by a group of patients (ex. 25) and employing similar deictic and temporal shifts and an interjection, ‘Oh no’, to authenticate her reported speech. Speaker 6’s turn constitutes a narrated example of an ‘appearance-reality device’ (Edwards, 1991), in which patients’ apparent desire for medication is subverted and shown to be a professional assumption rather than underlying reality. Indeed, she claims that it is ‘worth exploring’ medication precisely because GPs’ can be wrong in believing that patients expect medication: ‘sometimes’ patients resist medication rather than pursuing it.

In contrast, participant 8 also offers an account of patients expressing an unmitigated desire for antidepressants (ex. 26). Somewhat inconsistently, he also uses ‘most of them’ to quantify his reported speech of patients demanding medication. This contradictory claim that ‘most’ patients do and do not want antidepressants can be interpreted as an indication that he is familiar with patients both resisting and seeking medication. In parallel with speaker 12, speaker 8 situates prescription in relation to having a ‘negotiation’ with patients and, in the talk following this excerpt, claims that he would ordinarily acquiesce to patients’ wishes and prescribe medication. In doing so, he presents the prescription of medication as at least partially dependent on the request of the patient, rather than any other measure of their pathology.

This account of patients seeking medication and GP-patient negotiations is mirrored by other participants in this and one other group. Corpus data on this topic was identified from examination of references to *pill* ($n = 3$), presented below:

27. <D7M> [...] {I just would} emphasise that the importance that that <pause> unlike a lot of other conditions that that sadly there isn't a tablet that will just make everything fine. It may help some g= always good to give em a bit of hope erm but but it certainly by no means erm the er
 <D8M> +Magic pill.
 <D7M> Yeah. {An= and I and I} think I would actually try and emphasise that the non-medical treatments [...] were more important.
28. <D5M> I'd be very careful to demedicalise it as well and and make it obvious that it was erm it was he that held all the solutions to this problem and that it was not something for which there was a pill or a you know an answer of that nature.
 <D1M> +Mmm.
 <D5M> Erm and that unless he changed it wasn't going to im= improve.

As in the above corpus data for *medication*, extracts 27 and 28 appear during the discussions of prescribing antidepressants for Patient 1. Having raised the possibility of prescription, speaker 7 states that he would also emphasise the limited efficacy of antidepressants by informing Patient 1 that there 'isn't a tablet' available to cure 'everything'. Speaker 7 employs a fronted adverbial phrase (Carter & McCarthy, 2006: 781), 'unlike a lot of other conditions', to foreground a contrast between 'other conditions' and Patient 1's unhappiness. In doing so, he emphasises that depression is not a condition that is amenable to cure through medication, thereby dissociating depression from other illnesses (c.f. section 5.5). Speaker 7 goes on to claim that antidepressants have a limited function for giving people 'a bit of hope'. This constitutes a distinctly non-technical description of the effects of medication and renders the label of antidepressants a misnomer. There is also a notable switch in reference here, with speaker 7 referring to patients using a plural pronoun '[th]em', indicating that this critical assessment of the function of antidepressants applies to patients generally and not simply to Patient 1. Following several hesitation markers at the end of this turn, speaker 8 completes speaker 7's clause, claiming that antidepressants are not a 'magic pill'. The co-production of the turn and subsequent agreement from speaker 7 signals 'understanding, affiliation, and agreement' between speakers (Lerner, 2002: 250; Coates, 1996) and a recognition that a 'magic pill' is a familiar concept.

In extract 28, speaker 5 presents a remarkably similar account of a negotiation with Patient 1, claiming that he would also state that there is not a 'pill or... an answer of that nature' to alleviate his experience of unhappiness. Both he and speaker 7 claim that they would foreground non-medical options for Patient 1, emphasizing activities requiring proactivity from the patient. Speaker 5's claim that he '[woul]d be very careful to demedicalise it' also constructs the diagnosis of patients as an explicitly volitional process. Grammatically, 'being very careful' is realized as the main process of the clause, with 'to demedicalise it' forming a non-finite adverbial clause indicating purpose (Halliday, 2004: 420). Compared with a possible variation 'I'd demedicalise it carefully', being 'careful' is clearly thematised and the process of demedicalising is expressed as grammatically dependent on careful action. In short, speaker 5 overtly constructs the decision of whether Patient 1 is medically ill as a deliberate, purposeful action rather than determined objectively from a test. In this instance, discursively demedicalising a patient prefaces speaker 5's claim that the patient, and not medical technologies, is responsible for their recovery. Consequently, speaker 5's turn foregrounds both the interactive nature of diagnosis and suggests it is closely connected with negotiating issues of patient-professional responsibility (Salmon & Hall, 2003 and see section 7.5).

The final instance of *pill* occurs later in this focus group when the participants are discussing patients' reasons for not reading recommended self-help literature:

29. <D3F> But they= people {they want other people to change you } {don't they? }
 <D5M> {Well they're seeking a quick fix aren't they.}
 <D2M> {I think that's the idea} I
 think the i= it's this {this quick fix. }
 <D5M> {Anything that involves } effort, yes or time or yes it's erm.
 <D3F> +Yeah.
 <D2M> "I'd like a happy pill". That's=
 <D3F> Yeah.
 <D5M> Or the blood test [...]

Speaker 3 offers a summary of patients' beliefs about treatment as 'they want other people to change you don't they', which is overlapped by speaker 5's 'Well they're seeking a quick fix aren't they'. Both of these turns involve negative interrogative tags that are responded to as assertions rather than questions to be answered (c.f. Heritage, 2002: 1441) and speaker 5's tag question is expressed with falling intonation rather than a rising tone that would indicate a question. Both speakers therefore opt for rhetorically strong turn designs that characterise patients as seeking unchallenging short-term treatments. In a further overlap, speaker 2 indicates strong agreement with speaker 5's description. He first expresses agreement and then repeats speaker 5's reference to 'a quick fix', replacing speaker 5's indefinite article with a definite determiner, 'this', which grammatically denotes familiarity with the concept. Speaker 5's subsequent turn constitutes a strongly negative assessment of patients, using an extreme case formulation (Edwards, 2000) to verbally construct patients as unwilling to engage in 'anything' involving 'effort... or time'. As in extract 27, speaker 5's turn ends in hesitation and his clause is completed by speaker 2, who uses direct speech to simulate a patient's request to their doctor for a 'happy pill'. As in several instances of reported speech in foregoing corpus extracts, Myers' (1999) observation that reported speech functions to exemplify recurrent interactions seems appropriate here. That is, speaker 2 is characterising patients generally as seeking 'a happy pill'. Over the course of several turns, the GPs verbally co-construct patients as holding a naïve and simplistic understanding of the function of antidepressants and as habitually seeking medication in preference to taking responsibility for their own well-being.

The use of the same lexical item, *pill*, to complete separate accounts of medication in extracts 27 and 29 demonstrates that the notion that antidepressants are 'magic' or 'happy pills' and a 'quick fix' is a readily available concept for the participating clinicians. However, it is a notion they consistently – and sometimes disparagingly – attribute to patients by simulating

their speech or simulating hypothetical advice used to regulate their expectations of antidepressants. Although one participant claims that ‘most’ patients do not want antidepressants, several other accounts indicate a perceived preference for medication amongst patients. Indeed, in the case of speaker 6 (ex. 25), it is encounters with those patients who subvert her expectations and refuse medication that merit narration and laughter. In a reversal of early medicalization research (Zola, 1972), the participating GPs construct their patients as the driving force behind the biomedical treatment of depression and frame this as a desire to avoid more pro-active avenues to recovery (Chew-Graham *et al.*, 2000). Further, two participants claim that antidepressants are unlikely to significantly help certain patients with depression (ex. 27-28). The prescription of medication is therefore presented as a complex clinical and moral issue in which GPs must balance the dilemma of prescribing antidepressants of questionable efficacy, meeting patients’ desire for a ‘quick fix’ and encouraging patients to take responsibility. In parallel with the analysis of PHQs above, therefore, the GPs’ discussions of infelicitous clinical options are juxtaposed against accounts of patients as problematic or irresponsible (Chew-Graham *et al.*, 2002; McPherson & Armstrong, 2009) and as lacking the clinicians’ more insightful perspective.

7.4.1 *Therapy*

In addition to speaker 7’s endorsement of ‘non-medical treatments’ for Patient 1 (ex. 27), positive evaluations of non-clinical treatments were also identified in the concordances of the keyword *therapy* ($n = 7$) and its lexemes *therapies* and *therapeutic* (both $n = 1$). These terms might be expected to relate to psychotherapeutic interventions or, when coupled with a premodifier such as ‘antidepressant’, to treatment with medication. However, this assumption is not validated by the corpus concordances. *Therapy* is once used as part of ‘cognitive behavioural therapy’ and twice to refer to non-specific treatments proposed by patients, ‘I’ve

had several come and ask me can they have this therapy or that therapy' (speaker 6). Other concordance lines show a different pattern however:

30. <D7M> {But the **therapy**} is the courses
 <D6F> +Yeah.
 <D7M> +she's not doing anything with em but <laughs>
 <D6F> No.
 <D9F> +It doesn't matter.
 <D7M> +It doesn't matter.
 <D6F> +I mean it does a lot of {you know she's meeting people and} yes and she's doing different things[...]
31. <D7M> [... acupuncture]'s certainly an option and and if only through the the **therapy** {of seeing someone} and its placebo value but if it's working fantastic
 <D9F> {Yeah whatever. } {If if se= } if no one gives you an hour of their time or an half an hour of their time and you're getting that then that can be quite quite **therapeutic** I should think.
32. <D7M> [...] T= to what extent do do you think it's appropriate that we that the doctor is the drug. You know I think I think that's true for for quite a few of our consultations at at the Practice that actually you know we we realise that there's there's no huge hopes of changing things but but actually you know we er to a certain extent w= we are the drug we are the bit of **therapy**

These four instances of *therapy* or *therapeutic* indicate a clear departure from orthodox medical models of the management of psychological distress. In extracts 30 and 31, copula and genitive constructions are used to equate *therapy* with participation in adult education courses and 'seeing someone' during acupuncture. In both instances, speaker 7 immediately qualifies the attribution of therapeutic value to these activities, stipulating that acupuncture may have only a placebo effect and a patient may not use educational courses to pursue employment. These alternative interventions are therefore presented as benefitting patients indirectly by combating social exclusion and isolation rather than addressing unemployment or somatic symptoms. Consequently, *therapy* or *therapeutic* value is attributed to activities on the basis that they benefit the specific patients, even when this benefit is derived from peripheral aspects of each non-medical care option.

Extract 32 provide an additional perspective on *therapy*. Referring initially to Patient 2 and then to 'quite a few' patient consultations at the group's surgery, speaker 7 offers two figurative copula constructions that equate GPs with a 'drug' and 'therapy'. These metaphors

construe GPs as themselves therapeutic tools deployed in consultations rather than professionals able to advise and facilitate access to treatments outside of the doctor's office. Speaker 7's comment that doctors may function as 'the drug' for patients with 'no huge hopes of changing things' signals a concern that consultations may simply function like antidepressants to manage patients' symptoms rather than address situational precipitates of their distress (Chew-Graham *et al.*, 2004). As such, speaker 7 both acknowledges the reality of such a patient-professional relationship and questions its propriety as an effective or desirable aspect of patient management. The therapeutic potential of ordinary consultations is also foregrounded in an extended narrative by a participant in another focus group, identified during manual reading:

33. <D11M> [...] I just sat and I said to her "If I'd met you twenty years ago what three things would have given your life value and meaning" and she said "Walking er painting and bird watching" and I just said to her two words I said "Well then?" and that was it. And she came back two weeks later and her PHQ Q score had gone from nineteen to two out of twenty seven she'd brought me a picture yeah? So {that's C=} that's CBT.

Foregoing the way that a PHQ score is invoked as an objective, quantified measure of the patient's improvement, speaker 11's concluding remark, 'that's CBT', similarly construes ordinary consultations as a form of professional therapy. The participant emphasises the negligible nature of his role in the consultation by using minimisers, 'I just sat there', 'I just said', foregrounding his minimal spoken contributions, 'two words', and remarking on the brevity of the overall interaction, 'and that was it'. His remark is nevertheless explicitly equated with cognitive behavioural therapy, suggesting that emphatically ordinary interactions and advice are considered equivalent to specialist psychosocial interventions (Dew *et al.*, 2005; Thomas-MacLean *et al.*, 2005). Encouraging the patient to pursue activities that would give her life 'value and meaning' also indicates an emphasis on treating depressed patients through pleasurable activities derived from their own individual narratives,

rather than symptom management and pre-defined, recommended treatment options (Pilgrim & Dowrick, 2006).

These excerpts demonstrate that the professionals conceive of *therapy* as a wide-ranging category which encompasses social and alternative care options as well as the GP-patient relationship. The participants present subjective benefit for the patient as the defining criteria of *therapy*, although speaker 7 also cautions against allowing consultations to become a patient's only form of therapeutic intervention. Comparable doubts about unhelpful client-professional relationships were also articulated across the other focus groups, for example as 'we're surrogate spouses or parents or whatever' (speaker 11) and 'she's coming every few days [...] and you're not getting anywhere' (speaker 1). Both quotes reiterate concerns over establishing personal relationships that ultimately do not improve patients' health. These focus groups also reveal equivalent advocacy of non-medical options and their therapeutic benefits. Speaker 1, for instance, offers conducive support for the local Healthy Change programme for Patient 1, presenting it as a remedy for social exclusion, disinterest and physical inactivity rather than mental pathology:

34. <D1M> I mean he's asking to be ch= asking to be referred to Healthy Change isn't he? If you could get somebody alongside him to get him to take some exercise and to stop smoking and to lose some weight and to find a hobby that might be interesting him and
<D3F> +Yeah.
<D1M> +and actually get out and engage in in the world he probably would feel a lot better wouldn't he.

Far from being constrained by typical biomedical or psychosocial treatments, extracts 30-34 demonstrate that the GPs explicitly advocate low intensity, socially-oriented care options. These interventions focus on tackling social exclusion or unemployment in an attempt to relocate 'value and meaning' (ex. 33) in the patient's life. By encouraging patients towards adult education, volunteering or complementary therapies, the GPs are recommending care options supported by a considerably smaller evidence base than orthodox pharmacological or

psychotherapeutic treatments. For example, Prins *et al.*'s (2008) systematic review of depressed patients' treatment preferences makes no mention of local volunteering courses, let alone walking, painting and bird watching, which fall outside of health and social care structures (though see Elley *et al.*, 2003). As noted in previous research (McPherson & Armstrong, 2009), the GPs in the present study testify to stepping beyond the boundaries of evidence-based medicine in order to deliver patient-specific care. In doing so, the GPs warrant these non-medical care options anecdotally, legitimising these atypical interventions by citing current or former patients for whom such 'therapy' has been beneficial. Rhetorically, these accounts closely mirror the depressed patients' descriptions of helpful activities (see section 5.5.1), which also detail positive personal experiences to endorse the use of non-traditional interventions. These alternative treatments are categorised as 'therapy' and considered effective regardless of how therapeutic value is gained from the proposed treatment. As speaker 6 says with regard to acupuncture, '[w]hether it's a placebo effect it doesn't matter [...] if it helps.'

Despite this inclusive concept of therapy, speaker 7 expresses reservation over patients using frequent consultations to express their unhappiness in a manner that ultimately does not bring about recovery. Similarly, suggestions that some patients want other people to change [them]' and are 'seeking a quick fix' (ex. 29) indicate that patients are also considered a source of exasperation if treatment suggestions are not taken up or if medication is used as a substitute for personal responsibility. The focus groups' discussions of treatment for depression therefore suggest that, however the category of therapy is defined, it is circumscribed by accounts of patients as responsible and potentially blameworthy (Chew-Graham *et al.*, 2002; McPherson & Armstrong, 2009).

7.5 (De)medicalization and *heart sink*

As the foregoing discussion of non-medical treatment options demonstrates, the participants endorse recuperative measures for hypothetical or real patients whose benefits are construed in largely non-medical terms. In suggesting these treatments, the GPs orient to patients' psychological distress within a milieu of social and emotional as well as organic factors. The final section in this chapter continues this topic. Using keywords categorised under the 'Patient Management' category (table 7.1), I identify several recurrent discursive features which function to situate certain patients outside of a medical domain and the remit of the GPs' professional responsibility.

Examination of the focus group conversations while transcribing highlighted the recurrence of initially non-clinical responses to the patient vignettes in every group. These opening reactions took the form of jokes about the patients that were responded to positively with laughter from other group members:

- 35. <D5M> He needs a slap.
<D4F> <Laughs>
- 36. <D5M> "What else would you like to know."
<D1M> When she's moving to a different area.
<All laughter>
- 37. <D7M> Fairly standard for this practice!
<D6F> <laughs> Yeah. So erm <laughing> anything else we'd like to know probably not no, too much already!
- 38. <D11M> That'll teach you not to ask the question.
- 39. <D12F> {Oh I'm feeling really exhausted <laughs>}

Following Sacks (1992), Wilkinson (2004) observes that focus group participants typically attempt to forestall venturing the first opinion on a topic. In keeping with this, the initial jokes and laughter serve to defer earnest responses to the scenarios' stimulus questions and the need for any participant to enact the role of *de facto* discussion moderator amongst their

peers. Rather than orienting to the discussion task, the jokes can be seen to perform a group identity function in which participants establish group unity through colloquial, non-goal oriented talk and affiliative laughter (Richards, 2006). In signalling group cohesion, these jokes are simultaneously made at the expense of the fictional patients who are construed as feckless ('He needs a slap'), unwelcome ('When's she moving to a different area') or bringing a large amount of unwanted problems ('too much already!', 'That'll teach you not to ask'). With these initial responses to the vignettes, the participants perform an explicit denial of their identities as healthcare providers who are obliged to respond sympathetically to patients while their ostentatiously unsympathetic reactions serve to create humour through their contrast to expected professional responses. These jokes also signal solidarity with group members who are party to such disparaging views while excluding patients from whom they are kept secret (Holmes, 2000). Indeed patients are doubly excluded by being both the butt of these jokes and excluded from the 'backstage' context in which they are made (Goffman, 1969 [1959]). While all participants subsequently offer more serious and more sympathetic accounts of patients, their first reactions, however humorously intended, clearly demonstrate the potential for emotive responses to replace medical understandings of patients (McPherson & Armstrong, 2009: 1141).

The adoption of an uncaring or even antagonistic stance towards patients foregrounds a tension between the participants' professional identities and their capacity to respond unsympathetically towards patients amongst one another. Although it is used in these initial responses as a source of humour, this tension is manifest throughout the focus groups' discussions, and particularly around the keywords *heart* and *sink*, which combine 18 times as the bigram *heart sink* ($\log\text{-likelihood} = 223.06$). *Heart sink* was originally transcribed as two words in the focus group discussions, though is commonly written as 'heartsink' in existing literature. I use two words here when reproducing the focus group data and one when

discussing the concept in relation to previous research). Originating in the work of O'Dowd, 'heartsink' has become common clinical parlance to denote professional reactions to patients who 'evoke an overwhelming mixture of exasperation, defeat, and sometimes plain dislike' (1988: 528). Subsequent research has found that GPs' feelings of heartsink are commonly associated with patients with chronic health problems and where intractable social factors leave clinicians feeling powerless to resolve patients' suffering (Chew-Graham *et al.*, 2004). However, Mathers and colleagues (1995) aver that heartsink cannot be explained by characteristics of patients alone. Rather, they found it reflects characteristics of the categorising professional, with lower-qualified, over-worked GPs and those without counselling training reporting significantly higher numbers of 'heartsink patients'. For these highly stressed doctors, the heartsink label provided a coping mechanism, permitting certain patients to be categorised as incurable and hence removing expectations for their improvement. The recent history of heartsink thus suggests it is closely entwined with negotiating professional responsibility for patients (Salmon & Hall, 2003), an association also evident in its deployment in the focus groups:

40. <D3F> [...] it's very easy reading this scenario to feel quite it's a bit of a **heart sink** one isn't it really. And that we can assume lots of things but it may be that once he'd you know finished his last job that he for three or four years made every possible effort to get {another} job [...] And then couldn't and then in terms of what that's actually done to his self esteem and the way that he looks at himself and his his own value [...] Erm so you know he might actually have depression
41. <D11M> And in fact when you acknowledge n= the to the patient that they in fact are a **heart sink** [...] they get a sort of sudden realisation because they don't realise what they're doing to other {people.}
42. <D12F> I don't like the use of the word the {**heart sink** patient I wouldn't use it.}
 <D11M> {No.}
 <D10M> {Alright as in like **heart sink** } to me.
 <D11M> No we're using that is our jargon. We might not necessarily use that language to the patient but what language would you use because th= **heart sink** is a well known phraseology?
 <D12F> What= what I said I= well with the patient I= <stutters>
 <D10M> A problem
 <D12F> What I use in my writing is multiple symptoms.
 <D11M> {Polysymptomatic.}
 [...]
 <D11M> {that's where the terminology} comes from because doctors felt like their **hearts sink** they saw the name on the {list and their **heart sinks**.}

<D12F> But if you resign } yourself to being sunken hearted
 <D11M> +So let's u=
 <D12F> +it just doesn't get us anywhere.

Extract 40 follows from this group's discussion of social welfare systems that financially support the unemployed or disabled, in which speaker 1 has suggested that these may provide a motivation for Patient 1's continued unemployment. In response to this, speaker 3's subsequent turns construct an appearance-reality account (Edwards, 1991) of Patient 1 that contrasts his apparent 'heart sink' scenario with a declaration that he 'might actually have depression'. This discursive opposition between 'heart sink' and 'actually hav[ing] depression' implicitly excludes heart-sinking patients from genuine cases of depression and hence the GPs' professional duty. In this respect, speaker 3's turn supports previous research arguing that clinicians seek to retract responsibility for patients associated with heartsink (Salmon & Hall, 2003). However, speaker 3's account offers a stronger position than those identified in previous research by implying that heartsinking patients are not medically ill at all. In this instance, heartsink patients are implicitly demedicalised and heartsink itself associated with a patient's dependence on social welfare rather than a professional response to feelings of powerlessness.

Speaker 11 (ex. 41) similarly detaches the label *heart sink* from the attributing clinician, stating that it is possible to acknowledge to patients that they 'are a heart sink'. Whereas early research stated that heartsink 'clearly refers to the doctor's emotions' (O'Dowd, 1988: 528), speaker 11 specifies heartsink as an identity of the patient themselves, thereby eliding the subjective role of the clinician in the categorisation process. In keeping with his account of patients using PHQs, this participant further identifies such patients as lacking some form of insight, in this case into their effect on other people. However, his use of 'heart sink' to categorise patients is also explicitly challenged in this focus group by speaker 12 (ex. 42). Speaker 12's meta-discursive comment 'I don't like the use of the word the heart sink

patient' strongly disaffiliates from the category 'heart sink patient'. In response, speaker 10 attempts to repair 'heart sink' as a personal reaction, 'heart sink to me', indicating that constituting heartsink as a subjective feeling is perceived to be more acceptable. Speaker 12 proposes 'multiple symptoms' as an alternative label to 'heart sink'. In parallel with extract 40, this alternative category explicates the patients' pathology and hence emphasises the clinicians' responsibility for their care, rather than the feelings of hopelessness they might engender. This participant's further comment that 'if you resign yourself to being sunken hearted [...] it just doesn't get us anywhere' also signals an explicit awareness of the role of medical jargon in shaping specific relationships with patients (Salmon & Hall, 2003). Therefore, although some GPs readily use the label 'heart sink' to identify patients, others express concern over its negative effect on patient relationships and use alternative descriptions of patients to emphasise their responsibility of care towards patients.

The issue of patient-professional responsibility is also identifiable in the contextual use of the keyword *disentangle* ($n = 3$, $\log\text{-likelihood} = 37.17$):

43. <D5M> [...] I suppose I'm I'm probably jaded slightly by meeting people who're stuck and
 <D3F> +Yes.
 <D5M> +seem incapable of getting out of this alone. I'm very careful to **disentangle** myself from from them at that point
 <D1M> +Mm.
 <D5M> +when you realise actually that you're beating your head against a brick wall and and that's why that's why the secondary gain thing came up at the beginning for me cos sometimes you I don't know you you realise there's some reason why this is perpetuated [...] And then I'm quick to **disentangle** myself from a fruitless situation. <laughs>
44. <D2M> Don't= don't worry ne= new patients until you **disentangle** yourself <laughter>[..]

In all three instances in the corpus, *disentangle* is used to denote participants' extricating themselves from their patients. In extract 43, speaker 5 initially situates *disentangle* in relation to 'people who're stuck' and 'seem incapable of getting out of this alone'. The post-modifying use of 'stuck' specifies a lack of clinical improvement as a characteristic of patients rather than the result of any clinical management. As with 'heart sink patient', then,

the motivation for withdrawing from a patient is attributed to the patient and their situation and distanced from the success or failure of clinical practice. The identification of these patients as also 'incapable' of helping themselves reiterates the underlying theme of responsibility found in previous research (Dew *et al.*, 2005; McPherson & Armstrong, 2009) and the discussion of *heart sink* above. That is, clinicians appear to retract responsibility from those patients unwilling or unable to address aspects of their own lives. Speaker 5's third turn in ex. 43 qualifies this rather unsympathetic position, recalling his previous reference to 'secondary gain' (indirect benefits from diagnosis such as legitimising unemployment) as a reason for patients' illness being 'perpetuated'. This participant therefore warrants his reported distancing on the grounds of patients' own helplessness and systems of social welfare that support those with diagnosed illness but which enervate clinical management. Whilst complex socio-economic processes such as secondary gain appear to be blamed as much as patients themselves, the speaker's use of 'careful' and 'quick' indicate that the process of 'disentangling' from patients is performed both deliberately and as a priority. Finally, regardless of its cause, the description of such clinical practice as 'beating your head against a brick wall' and 'fruitless' makes vividly clear that managing such patients is considered an unrewarding aspect of practice (Chew-Graham *et al.*, 2002) and offers a justification for extricating personal investment in a patient.

7.5.1 Consultations and challenging patients

Discussion of how to manage patients with depression is a common feature in all three focus groups and typically involves use of the keywords *consultation* ($n = 15$, $\log\text{-likelihood} = 48.31$) and *consultations* ($n = 6$, $\log\text{-likelihood} = 25.79$). Along with the contracted copula *consultation's*, these terms are distributed evenly between the groups (figure 7.4), with two instances of *consultations* occurring during participants' reading of the Patient 2 scenario.

N	Concordance
1	this. I want to give them a kick. I don't allow that to come across I hope in my consultations but I think internally that is what I exactly what I feel. It is
2	to be very very useful to be aware of that isn't it +Mmm. How you feel after a consultation is very ha very revealing to of what to do next. Mm-hm. Yeah. If
3	Er but again it's this question of in terms of actually what they in terms of each consultation as you said once you've realised what's going on in terms of
4	"Ah was it is it?" That positive I got told there's there's a phrase for that erm consultation style isn't it there's the new +Confrontational consultation. No Nol
5	a phrase for that erm consultation style isn't it there's the new +Confrontational consultation. No Nol there's erm What's that c=u= there's You can do erm
6	erm What's that c=u= there's You can do erm courses in it in the erm in new consultation styles and I can't remember what it's +Ooh. +Something to do
7	as I would be on another day then +Mm. +the whole day just slows down and consultations take twice as long if you +Mm. if you bounce a bit and sort of s=
8	yes. What does it mean. +Yeah. Would you need more time spending with the consultation wise he might need a longer consultation to explore more issues
9	need more time spending with the consultation wise he might need a longer consultation to explore more issues +Mmm. +from a social point of view and
10	their PHQ's quite high erm I certainly don't go for the medication in the first consultation +Mm-hm. +I would tell them "why don't you come back look this
11	an operation the car needs an extensive repair et cetera et cetera in some consultations you sit there for ten minutes just listening to her tale of woes
12	doctor is the drug. You know I think I think that's true for for quite a few of our consultations at at the Practice that actually you know we we realise that
13	probably a sign for us to change somehow the way that we're managing the consultation with her. Mm. Do you think? Yes. +Yeah. Well I'm feeding back
14	you think? Yes. +Yeah. Well I'm feeding back that it's obviously you know the consultation's making us feel exhausted +Mm. +so it must +Mm. +be even
15	negotiate that with him. Mm And also whether his wife wants to be part of the consultation. To seek more information and also be part of his management.
16	leaves. Whether he's. That's a very good idea. If you've gone back to the first consultation then it'd probably be clear. To make sure he I think that's a really
17	support mechanisms and if they were relevant then I would bring those into the consultation. I think that's that's exactly right. Yeah I think that might help his
18	that could work +Mm. it's very useful to bring in but it isn't appropriate in every consultation. +No that's the thing I was going to say it's er yeah so you have
19	this week or next week" and then do this you know really good appoi= good consultation and then split it into shorter times so give them a long
20	really exhausted It's a heart sink patient +Oh. +et cetera et cetera in some consultations you sit there for then minutes just listening to her tale of woes
21	you said when best given if she's= if she's going to present be better as a last consultation then Yeah these people And I'd want to I'd want to support her a

Figure 7.4 – Concordances for consultation* in the depression focus groups

Again, while neither *consultation* nor *consultations* have recurrent lexical collocates, there are identifiable semantic and discursive preferences in their co-occurring lexical items.

Firstly, there are three uses of the pre-modifiers *first* and *last* relating to the temporal organisation of consultations. In these cases, 'first consultation' is used metonymically to signify the records from the first appointment with a patient that can be used to understand their present state (figure 7.4, line 16) and to specify the initial meeting with a patient with depression (line 10). Consultations with patients are therefore situated in relation to both previous recorded meetings and within a series of appointments in which possible treatment options are utilised at different times. Conversely, in the final concordance line, 'last consultation' specifies the final appointment in any particular surgery. Here, discussion of *consultation* focuses around managing the appointment-making process for particular patients, ensuring that they attend at particular times to avoid a backlog with subsequent patients. Similarly, co-occurring references to *time*, *longer* and *shorter* indicate a cross-group emphasis on arranging consultations of specific lengths for patients (figure 7.4, lines 8, 9 and 19). In line 9, for instance, a 'longer consultation' is proposed as means to explore Patient 1's case 'from a social point of view', suggesting that social context is not automatically adopted

or prioritised in an ordinary appointment. The shared semantic preference of these co-occurring lexemes indicate that one recurrent theme of talk around *consultation(s)*, therefore, is the administrative management of depressed patients. More specifically, the participants discuss offering patients appointments at specific times or of particular duration in order to meet individual care needs within the bureaucratic processes of their surgeries (Chew-Graham *et al.*, 2006; Thomas-MacLean *et al.*, 2005).

Secondly, in relation to Patient 2, participants in the first focus group refer to *consultation styles* (figure 7.4, line 6) and the need to present themselves as energetic and cheerful to counteract the patient's unhappiness. Similarly, a participant in the second focus group states that the feeling of 'being exhausted' is a sign to change the way 'we're managing the consultation with [Patient 2]' (line 13). Interactions in consultations themselves are therefore construed as a site to be professionally managed, with the GPs considering changing or adopting their behaviour in order to respond to the emotional burden of certain patients' consultations. In response to the Patient 2 scenario in particular, each group discussed ways of interacting with patients whose consultations are draining. Common to such discussion across each focus group was a suggestion to confront patients about the feelings they engender:

45. <D7M> sometimes do we need to challenge that an= and er you know I I've tried different things with different people sometimes I've s= I've said you know erm how do you erm d= do y= just exploring whether they have any insight into how they come across.
 <D9F> Mm.
 <D6F> +Mm.
 <D7M> You know and sometimes I've said "I= I've do you know I've I've felt exhausted listening to to to what you're saying."
46. <D12F> And if we had the time we could challenge her to say "Look this is what's happening it's making me feel really drained even every time you walk into this surgery" If you have that relationship with her. And say "What do you think about it you know all of us doctors have had a chat about you
 <D11M> Mm.
 <D12F> +do you mind if we speak to you openly"

47. <D1M> [...] I mean I think it's quite useful to sit down with people and erm say "Well okay what's going on [...] why why are we in this situation what are you gaining from coming to the doctor er and what are what are we what service are we offering you. Er an= and you know what what are we going to do and what are we not going to do". And come to some actual open agreement about what's happening.

<D3F> +Mm.

<D1M> +Erm and I think that that really can shake things up a bit and and and move things forwards.

In parallel with their discussions of antidepressants, the participants make extensive use of reported speech to address how they might confront patients during consultations. Whilst all these extracts appear during the respective groups' discussion of the Patient 2 scenario, speakers 7 and 1 introduce their simulated discourse as occurring with plural 'people', indicating that their subsequent reported speech can be considered typical of multiple interactions and relevant beyond the patient vignettes. In extracts 45 and 46, 'challenge' is used as a reporting verb along with 'say' to explicitly characterise the recommended interactions as confrontational. While speaker 7 (ex. 45) downgrades the immediacy of 'challenge' to 'exploring' after several false starts and hesitations, the content of both speaker 7's and speaker 12's reported speech signals a clear departure from an identity as a passive, sympathetic listener. Instead, they simulate a direct confrontation with a patient over the negative emotional effects they have. Speaker 12's simulated question 'do you mind if we speak to you openly?' suggests that altering the professional-patient relationship is an explicit feature of this interaction, and functions to permit more candid discussion with the patient. Similarly, speaker 1 recommends explicitly asking the patient what they gain from attending the surgery (ex. 47), shifting the focus of the consultation away from the patient's health concerns and obliging them to account for their attendance. Speaker 1's proposed interaction also involves managing the patient's expectations for subsequent care, establishing 'what are we going to do and what are we not going to do'. Speaker 1's use of 'we' here is somewhat ambiguous: at the start of his reported speech, 'why are we in this situation', 'we' ostensibly refers to doctor and patient. However, the subsequent 'we' in 'what services are we offering

you' signifies the GP practice, a reference which appears to be maintained in 'what are we not going to do' (see Skelton *et al.*, 2002b). As a result, although the initial use of 'we' indicates affiliation with the patient, speaker 1's recommended interaction also involves a unilateral decision on the limits of service provision for the patient. Nevertheless, speaker 1's coda, 'that can really shake things up a bit and and and move things forwards', indicates that this confrontation is seen as a means of helping the patient.

Across the focus groups, therefore, GPs recommend or recount previous occurrences of informing certain patients of their demoralising effects, making them justify their use of primary care services and explicitly requesting to step outside the conventional doctor-patient relationship. These practices bear little resemblance to doctors' roles as medical specialists and, tellingly, these data extracts contain no mention of medical pathology. Rather, the GPs present the management of patients with chronic psychological distress as necessitating a movement beyond the institutional identity of a clinician in order to relate to patients on a footing unsupported by medical authority (Maxwell, 2005; McPherson & Armstrong, 2009). Chew-Graham *et al.* (2004) argue that such confrontations provide GPs with a means to regain authority during consultations with patients whom they are medically powerless to assist. This contention is supported in the present data, in which strategies for confronting patients are proposed as part of a response to patients such as Patient 2, who are resistant to standard medical management. However, as with the discussion of *heart sink* above, demedicalising patients and adopting non-medical approaches to their management also coincides with attempts to emphasise patients' own responsibility by making them accountable for their attendance and behaviours. Speaker 1 nevertheless presents this confrontation as being in patients' interests, indicating a perceived benefit of managing patients' treatment-seeking behaviour as well as their substantive medical problems.

7.6 Summary

The foregoing analysis of the depression focus groups highlights a number of distinctive trends in the participating GPs' discussions of depression and the management of patients presenting with depressive symptoms. Depression is used as a diagnostic category distinguished from non-pathological states and also as a countable entity that can be specified according to particular aetiological factors. With one undeveloped exception (ex. 13), the participants treat depression as a largely unproblematic category, questioning whether or not the hypothetical patients meet its criteria, rather than the boundaries of the diagnosis itself.

While one participant claims that 'most' patients refuse medication, other participants construct patients as actively seeking or expecting antidepressants. The participants indicate a need to address patients' expectations of medication and claim patients see antidepressants as a 'magic' or 'happy pill' and a 'quick fix'. The participants' discussions of the suitability of antidepressant medication may have been occasioned by the patient vignettes, which describe individuals experiencing psychological distress in relation to situational factors and following unsuccessful antidepressant therapy. Nevertheless, the GPs' discussions of medication frequently refer beyond the vignette patients. Patients are nominalised using plural pronouns 'them' and 'they' and the participants' uses of reported speech repeatedly attempt to illustrate prototypical professional-patient interactions. Contrary to Rogers *et al.* (2001), the GPs do not simply propose biomedical solutions for depression, nor indicate that medication is their only perceived means of assisting patients (Maxwell, 2005). Rather, they articulate a broad view of what constitutes *therapy*, advocating patient-specific, non-medical activities intended to provide enjoyment or alleviate aspects of social and economic deprivation. One participant also questions whether consultations should become the sole source of therapy for some

patients, offering them some emotional relief but ultimately deterring them from addressing the causes of their problems.

The discussions in each focus group frequently run to non-medical aspects of patient management. Such discussions address the emotional difficulties some patients engender, and specifically the feeling of 'heart sink'. The term 'heart sink' functions in the groups to implicitly demedicalise particular patients and thereby place them outside of the remit of medical intervention. Classifying patients as 'heart sink' is also contrasted with overtly medicalising alternatives such as 'actually hav[ing] depression' and 'polysymptomatic'. One participant also explicitly states that he 'disentangles' from patients deemed to be beyond help or where secondary gains encourage patients to remain medically unwell. Finally, participants in each group address generic ways of managing patients within the administrative and interactional context of clinical consultations and address strategies for confronting patients. The pervasive discussion of *consultation* management, *heart sink* and recommendations of non-medical *therapy* signal that a significant aspect of these professionals' discourse centres around performing largely non-medical roles. Specifically, the GPs consistently discuss how to manage their own affective responses to patients and how to address socio-economic antecedents of patients' unhappiness. Nevertheless, in discussing these issues, the clinicians maintain a largely reifying discourse of depression as a definite pathology which, at least in some cases, can be measured and assessed through diagnostic instruments (Rogers *et al.*, 2001).

The participants' discussion of patient management and treatment options confirms that the management of 'depression' in primary care is a more complicated endeavour than a purely medical understanding of depression would suggest (Maxwell, 2005; Thomas-MacLean & Stoppard, 2004). For example, speaker 5's claim that he would 'be very careful to

demedicalise' the case of Patient 1' clearly demonstrates that medical diagnosis is the result of a volitional interactive process and cannot be simply determined from the results of clinical instruments such as a PHQ-9. Consequently, previous research identifying 'missed' or 'under' diagnosis of depression in the general population may result from GPs' deliberate attempts to formulate patients' problems in non-medical terms rather than a lack of diagnostic acumen (Dew *et al.*, 2005; Thomas-MacLean *et al.*, 2005). Similarly, managing appointment schedules, confronting difficult patients and advocating painting and volunteering as 'therapy' for psychological distress all require GPs to work outside of biomedical, evidence-based practice in order to respond holistically to the needs of individual patients (O'Riordan *et al.*, 2008). The recurrent recommendation of confronting patients over their emotional burden also demonstrates that interpersonal communication skills are considered a salient aspect of the managing depression and responding to patients' sustained distress (Pilgrim & Dowrick, 2006). However, for these participants, managing the emotional costs of treating depression appears to be closely imbricated with shifting the boundaries of doctor-patient responsibility, making patients accountable for their situation and making personal and moral judgements over patients and their attendance (May, 2005; Salmon & Hall, 2003). Given the documented evasion of responsibility for depression observed in the interactions of the *depressiononline.net* forum, the negotiation of responsibility would appear to be an area ripe for dispute in doctor-patient interaction. I discuss this further in the following chapter.

8 Concluding discussion

8.1 Introduction

The foregoing chapters have examined a unique specialised corpus of patient and professional interactions using a distinctive corpus-based discourse analytic approach. In doing so, they have offered original insights into the language used by patients and general practitioners in discussing anorexia nervosa and depression. This final chapter synthesises the findings from the four MHDC sub-corpora and identifies points of commonality and divergence between the different patient and professional datasets. I first compare findings from the two online fora, then the two sets of focus groups before comparing the professional and patient discussions directly. Based on these comparisons, I highlight some practical implications of the findings for proprietors of electronic support groups and working healthcare professionals. Finally, I provide an evaluation of the study's methodology, integrating this with proposals for further research.

8.2 *Anorexia.net* and *depressiononline.net*

Although anorexia and depression are distinctive conditions with different core symptoms, the respective users of *anorexia.net* and *depressiononline.net* display a number of consistent linguistic practices. Chief amongst these is a tendency to present anorexia and depression nominally (as 'ED' or 'depression') rather than as personal attributes ('I'm anorexic') or affective states ('feeling depressed'). In both fora, collocation analyses indicated that the forum members' dominant practice for representing their conditions was using a definite article, as *the depression* or *the ED*. This determiner choice avoids encoding a relationship of possession that would be denoted by a possessive pronoun. In the *anorexia.net* data, there was also evidence that some forum members used *the ED* to represent anorexia as a single

entity shared by all anorexics. In each support group, these collocations correlate with instances of illness personification, in which verbal and material processes characteristic of human agents are attributed to anorexia and depression. For example, *the ED* is presented as persuading, speaking and ‘getting scared’ (section 4.3, ex.1-4) and also as an *ED voice* that speaks to the sufferer. Similarly, *the depression* is described as ‘talking’ and ‘hitting’ (section 5.2.1, ex. 13 and 18). However, whereas the anorexia forum members frequently present themselves as the recipient of *the ED*’s actions, *depressiononline.net*’s members tended to distance themselves from depression’s actions. This was typically achieved by avoiding explicitly presenting themselves as the grammatical objects of actions they attributed to depression, or by using intransitive verbs to depict depression as ‘starting’ or ‘lifting’ independently of the sufferer.

I argue that, in both fora, the grammatical objectification and personification of psychological difficulty serves two principal functions. Firstly, these tropes construct a separation between the identity of sufferer and their condition. Secondly, they constitute mental health problems as beyond the control of individual sufferers, who present themselves as passive in the onset and continuation of their conditions (Fleischman, 1999; Galasiński, 2008). As a consequence, these two functions also serve to nullify two forms of illness stigma: firstly the ‘negative evaluation’ of a mentally ill identity and, secondly, the volitional stigma which attends the belief that illness is self-inflicted or endured voluntarily (Easter, 2012: 1411; Goffman, 1963). In contrast to Galasiński (2008), who regards the discursive separation of self and illness as characteristic of men managing the stigma of depression, these linguistic choices are repeatedly adopted in the patient corpora by men and women, anorexics and depressives. When deployed in illness narratives and supportive messages in each forum, these linguistic strategies may enable sufferers to affirm an acceptable identity as a patient and ‘patch up the moral rupture’ of an illness diagnosed on the basis of an individual’s conduct (Kangas, 2001:

77). As such, the discursive naturalisation and personification of mental illness may constitute cross-condition linguistic signatures of stigma management. Further research into the presence of these leitmotifs in accounts of other mental health conditions could usefully substantiate this further.

Collocation analysis of each online corpus indicated additional recurrent phrasal structures around *ED* and *depression*. For instance, newer users of *depressiononline.net* tended to use *suffered with depression*, while more established forum members use *suffering from depression*. Users also referred to *my depression* and *my ED*. Although it does not account for every instance, there is a shared tendency for *my ED/depression* to be used in each group by individuals claiming to be recovering or to have recovered from their illness. This grammatical parallel between the separate fora suggests that those who claim to be experiencing relief from mental illness are also willing to represent it as a personal possession rather than distinct entity, perhaps indicating that these individuals are coming to terms with their condition (Schreiber, 1996). More generally, the variation in grammatical representations of anorexia and depression demonstrates that verbal constructions of mental illnesses are not static, but correlate with forum users' duration of forum participation and stage of recovery.

Frequency data indicates the relative dominance of these different representations of anorexia and depression in the two corpora. For example, in the *anorexia.net* sub-corpus, *ED* occurs 623 times and *anorexic* occurs 29 times, while *depression* features 442 times and *depressed* occurs 126 times in the *depressiononline.net* data, indicating a clear preference for nominal representations of each condition. Similarly, *the ED* and *my ED* account for 32% and 11% of L1 collocates of *ED*, while the frequencies of *the depression* and *my depression* are more equal, making up 32% and 21% of L1 collocates of *depression* in the depression corpus. In

each case, the statistical data point towards a preference for objectifying constructions of anorexia and depression in the forum users' discourse, with this preference being consistently stronger amongst the *anorexia.net* users. This stronger preference for objectifying anorexia is also exemplified by its consistent representation as *the ED voice* on *anorexia.net*, a more specific personification than is apparent in the depression forum.

Qualitative analysis supports the numerical evidence that these objectifying constructions represent dominant discourses in their respective fora. In particular, sections 4.7 and 5.5 illustrated forum members' use of personified representations of anorexia and depression to construct mental illness as beyond individual control and to attribute unfavourable actions to theirs and others' respective conditions. The numerically dominant concepts of anorexia and depression therefore also serve contextually relevant functions in facilitating peer support, accounting for non-recovery and resolving conflicting points of view between members. In short, objectifying and personifying depression and anorexia provides a powerful discursive resource with which to fulfil local interactional goals, making it a contextually potent discursive practice (Blommaert, 2005).

On the basis of the forum data, I have argued that verbally separating depression and anorexia from the self serves to alleviate the stigma of mental illness for patients. This contention is corroborated by triangulating data in the GP focus groups. In the depression focus group corpus, speaker D12 uses the objectifying, non-possessive representations 'this depression' and 'the depression' when simulating a discussion with a patient (section 7.2.2, ex. 14-15). Telling the patient that 'the depression is not you', she claims, can give patients 'a positivity' and enable them to 'separate themselves already from this huge [...] burden [...] of the disease'. In both my own analysis and this practitioner's account, objectifying constructions

of mental health conditions are said to enable sufferers to distinguish their identity from their condition for therapeutic ends.

Interactions in the two online fora also demonstrate a number of consistent rhetorical features. In particular, the foregoing analysis identified the use of extreme case formulations (Edwards, 2000; Pomerantz, 1986) in accounts of anorexic ‘behaviours’, unilateral medication management and suicidal ideation. In each case, forum members used these formulations to situate their actions within extreme scenarios and thereby legitimise their contentious practices as responses to acute psychological distress. The presence of these rhetorical features in forum members’ posts serves as a reminder that accounts of mental illness cannot simply be regarded as reflections of an individual’s psychology, but rather should be understood as designed to achieve particular interaction effects (Guise *et al.*, 2007). The ‘defensive detailing’ (Drew, 1998) discernible in forum members’ accounts of ‘behaviours’, suicidal ideation and medication non-adherence indicates that one such effect is to negate possible accusations that they desire these actions or are irrational for performing them. That is, members’ messages appear, at least in part, designed to respond to the possibility that these are sanctionable acts by constructing an internal logic to their actions (Harris, 2000) and demonstrating an awareness of their implications (Drew, 2006). Alongside their grammatical constructions of anorexia and depression, the rhetorical strategies used by the online group members further respond to the potential stigma of their actions and offer rationalisations for seemingly irrational situations.

8.2.1 Online medicalisation

Sections 4.7 and 5.5 both argued that contributors to *anorexia.net* and *depressiononline.net* promote a medicalised understanding of their illnesses. The respective participants’ interactions consistently fulfil Conrad’s defining criteria for medicalisation, introduced in

chapter 2 as 'defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to "treat" it' (1992: 211). Firstly, as discussed above, group members verbally depict their conditions as distinct entities, aligning with the ontology of diseases discernible in medical discourse (Cassell, 1976; Fleischman, 1999; Nijhof, 1998). Secondly, at times anorexia and depression are defined in accordance with key concepts of biomedicine: anorexia is described in terms of 'genes' and 'brain chemistry' (section 4.7, ex. 90) while depression is specified as 'an imbalance of chemicals in our brain' (section 5.5, figure 5.1). Although these are not the only definitions of depression and anorexia provided in the corpora, biomedical descriptions appear at interactively delicate points such as disagreements and are used to facilitate contextually-relevant supportive goals.

Thirdly, users of each forum advocate contact with healthcare professionals and professional forms of treatment for mental health problems. This is most evident in the recurrent discussion of antidepressant medication in *depressiononline.net*, and its members' repeated recommendation to find the 'right medication'. One user in particular is advised to leave a GP who is unwilling to prescribe in order to find another doctor who is willing to help her find the 'right meds' (section 5.3, ex. 54). In this instance, depicting one member's psychological distress as amenable to medical treatment simultaneously (and paradoxically) overrules the opinion of a medical professional. In keeping with this preference for professional forms of treatment, there is little explicit discussion of treating depression and anorexia through non-professional means (Johnston *et al.*, 2007; though see section 5.5.1). It is, however, important to regard the forum members' participation in their respective electronic support groups as a proactive effort to manage their emotional difficulties outside of clinical interventions.

Fourthly, the forum members frequently present themselves as passive sufferers who are unable to control their conditions. This is exemplified in clause transitivity choices throughout the forum messages (see sections 4.4 and 5.2.1) and arguments over whether anorexia may be a 'choice' (section 4.7). Although a passive patient position need not be regarded as an inherent aspect of a medical model of illness, it is a subject position cued by framing anorexia and depression in medical terms (Hardin, 2003; Karp, 1996). That is, presenting anorexia and depression as the result of factors beyond lay individuals' control corresponds with a position of limited power for the sufferer and a dependence upon professional intervention.

8.3 Anorexia and depression focus groups

A comparison between the two sets of practitioner focus groups indicates several areas of difference and convergence. The comparative frequency of *difficult* in the anorexia focus group corpus suggests that challenges of patient management are a more salient aspect of treating patients with anorexia than treating individuals with depression. In contrast, the depression focus group discussions contained repeated references to *heartsink*, a lack of morale arising from patients whom doctors feel incapable of helping. *Heart sink* was used in the depression discussions to categorise patients whose problems are believed to be social and moral rather than medical in nature. This use feasibly explains the relative absence of *heart sink* in the anorexia discussions since, in these groups, discussion emphasised the biomedical indicators of eating disorders and their need for psychiatric rather than socially-oriented interventions.

Participants in both the anorexia and depression groups highlight the importance of communication for achieving desired outcomes during consultations (Gask *et al.*, 2003). This is exemplified through the anorexia discussants' reference to ECG and blood tests as 'tools'

to convince a patient that they have ‘a problem’ (section 6.4.1), and discussions of how to effectively ‘challenge’ patients in the depression groups (section 7.5.1). These discussions also illustrate that the participants adopt diverse strategies for communicating with patients, such as using diagnostic tests as rhetorical resources or attempting to re-frame the client-professional relationship in order to ‘speak to [them] openly’. One participant in each set of focus groups also foregrounded the importance of language and the effect this can have on their care. In the depression groups, speaker D12 states ‘I don’t like the use of the word the heart sink patient I wouldn’t use it’, going on to claim that being sunken hearted ‘just doesn’t get us anywhere’ (section 7.5, ex. 44). In the anorexia discussions, speaker A6’s pre-repair comment ‘that sounds awful’ demonstrates that she perceives labelling patients as ‘very hardened anorexics’ to be problematic (section 6.2.1, ex. 23). Albeit briefly, then, language itself is a topic of the GPs’ discussions, with participants orienting to different verbal descriptions of patients and the implications these different categories can have for their care.

Across all the focus groups, participants referred to different aspects of patients’ physical and social lives when discussing diagnosis. GPs in the depression groups referred to unemployment, marital trouble, physical illness, possible suicidal ideation, PHQ-9 scores and ‘endogenous’ causation when discussing depression’s diagnosis and causes (section 7.2.1). In the anorexia groups, BMI, family dynamics, personality traits and individual behaviours were all tentatively cited as characteristics or possible diagnostic indicators of anorexia (section 6.2).

Throughout the focus groups, diagnoses of patients were frequently offered hesitantly and, more often than not, were replete with vague language and hedging modality. The participants’ linguistic efforts to distance themselves from descriptions of anorexia provides tentative support for Currin *et al.* (2009), who found low levels of knowledge about eating

disorders amongst healthcare professionals. However, it is necessary to situate these examples of low affinity modality within a context of group communication in which participants may seek to avoid committing themselves too strongly to a diagnosis that will be evaluated by their peers. Strongly asserted diagnoses might also be avoided in order to encourage others to offer a contrasting perspective. Within one anorexia focus group, such an unmarked contradiction between two participants did arise, with anorexia described as both disassociated from 'external stuff' (A12) and as often 'triggered by something' (A11). There were also clear differences in the diagnoses of the patient scenarios offered by GPs in different groups. For example, whereas speaker A8 suggested that the second anorexia scenario 'sounds more like anorexia', speaker A12 stated that she 'hasn't got anorexia by any sort of definition'.

Differences between the GPs may well reflect the variety of perspectives on depression and anorexia nervosa available in professional literature. Interpreted critically, variation in the GPs' accounts could signal inconsistencies in how different professionals diagnose and treat the same case presentations. That is, the differences between GPs demonstrated here may indicate that 'supposedly "professional" reactions' to patients with depression and anorexia are in fact 'based on differing personal understandings and preferences' (Jarman *et al.*, 1997: 150). More positively, however, these differences could also indicate that the participants are able to accept that anorexia and depression are heterogeneous conditions whose symptoms and aetiology vary between patients. This in turn entails that they are able to appreciate and respond to patients and their particular circumstances.

In both sets of focus groups, participants expressed doubt towards the screening tools and clinical measures used to assess patients. In the depression groups, speaker D11 (section 7.3, ex. 20-21) stated that a PHQ-9 could not always provide an accurate indicator of depression

because some patients overstate the intensity of their symptoms. Elsewhere, speaker D2 (section 7.3, ex. 22) suggested that, for the first patient scenario, he would initially be 'going for lifestyle' and 'be quite positive and upbeat about things' rather than attempting to assess the patient's mood using a PHQ-9. In the anorexia groups, speaker 2 (6.3, ex. 35) claimed that BMI scores are unhelpful in convincing patients that their low weight is dangerous if patients do not share GPs' understanding of different BMI values. Speaker A7 (section 6.3 ex. 34) also claimed that it is 'helpful' that GPs can refer patients to local eating disorder services on the basis that they appear to be 'falling into problems' rather than when they reach a specific BMI. Therefore, while PHQ-9 results and BMI are cited as possible aspects of diagnoses or referral, the GPs also identify the limits of using such standardised measures with particular patients or patient groups. Additionally, they indicate a preference for using diagnostic questions and subjective assessments of whether patients 'look as though' they are having difficulty and attempt to contextualise a patient's condition within their social and environmental milieu. The participants also identify alternative functions for diagnostic measurements. Specifically, different GPs suggest using blood tests and ECGs as rhetorical resources, using a BMI score to assess a patient's subjective account of their eating behaviour and using PHQ-9s to help patients reflect on their situation. These alternative functions suggest that the GPs are able to work creatively and marshal standardised clinical technologies to fulfil tasks specific to individual patients.

In both sets of focus groups, the GPs represent 'depression' and 'eating disorder' as definitive diagnostic categories. In the anorexia discussions, speaker A7 claims that issues around body image and weight loss are 'so common' amongst young people, suggesting an overlap between anorexia and adolescent experiences of dieting (section 6.2, ex. 5). Nevertheless, she claims the professional must decide 'when it's an eating disorder and when it's not', constructing the label of 'eating disorder' as an exclusive category which patients either do or

do not match. In the depression groups, speaker D1 asks whether ‘the people who are depressed’ might be ‘the same’ as those who are not (section 7.2.1, ex. 13). However, the next speaker does not orient to this question directly and instead suggests ways of distinguishing between depression and those who ‘just get cheesed off’. In doing so, he avoids interrogating the diagnostic category of depression, and instead stipulates his criteria for its application. In both cases, participants initially raise the possibility that a label of anorexia or depression may not clearly distinguish a medical pathology before the categorical status of these diagnoses is then reinforced. Thus despite expressing doubt over the use of the purportedly objective assessments discussed above, the participating GPs nevertheless opt to maintain the integrity of ‘anorexia’ and ‘depression’ as exclusive diagnoses (Rogers *et al.*, 2001; Thomas-MacLean & Stoppard, 2004).

Finally, the foregoing analysis illustrated that the topic of patient responsibility arises in both the anorexia and depression groups. Although no participant explicitly claimed that patients are responsible for the onset of mental health problems, some GPs clearly expressed the view that patients were at least partly responsible for their own improvement. For example, speaker A6’s rhetorical question ‘Until I think they’ll admit there’s a problem you what do you do?’ (section 6.4.2, ex. 46) suggests that recovery from anorexia is dependent on patient cooperation. Patients’ non-improvements can therefore be accounted for by their reluctance to ‘admit there’s a problem’, rather than a professional’s lack of expertise.

In the depression groups, patient responsibility was a recurrent topic in each transcript. With regard to the first hypothetical patient, for instance, speaker D5 recommends making it ‘obvious’ to the patient that ‘he held all the solutions’ (section 7.4, ex. 28), while speaker 3 claims that patients ‘want other people to change [them]’ (ex. 29). Further, the participants’ discussions of how to ‘challenge’ patients involve simulated consultations in which patients

are asked to account for their frequent appointments and the effects that their consultations have on the professional (see section 7.5).

Confronting ‘heartsink’ patients and asking them to state what they are ‘gaining from coming to the doctor’ may constitute an attempt to involve patients in their own care and encourage them to identify personally significant health-related outcomes (Byng, 2012). In this respect, what appear as unsympathetic challenges to patients experiencing long-term difficulties may signify efforts to transcend a paternalistic client-professional relationship and establish a therapeutic partnership that will ‘move things forwards’ (section 7.5, ex. 47).

However, past research suggests that clinicians’ attempts to emphasise patients’ responsibility for their own healthcare behaviours typically arise in the absence of viable medical solutions (Chew-Graham *et al.*, 2004; Reid *et al.*, 2010b; Roberts, 2004). McPherson and Armstrong (2009), in particular, illustrate GPs’ tendency to apportion culpability to patients who are unresponsive to antidepressant therapy. In this respect, the GPs’ palpable frustration and deprecation of so-called ‘heartsink patients’ may arise as much from a lack of effective clinical options and systems of care as from characteristics of the patients themselves. Emphasising patient responsibility may therefore aid clinicians in managing the threat posed to their sense of expertise by patients who display little long-term improvement (Mathers *et al.*, 1995).

Presenting recovery from mental illness as dependent on patients’ behaviours and encouraging them to be responsible for their own healthcare therefore appears to serve several simultaneous functions in the GPs’ practice. Firstly, these actions may stimulate patients to be more active in their own self-care and address social and environmental aspects of their lives over which doctors have little control. At the same time, representing recovery as at least partially dependent on patients’ own actions provides GPs with an explanation for

chronic patients' non-improvement. Such patients are also described unsympathetically in the focus group transcripts. These descriptions emphasise social and political identities for patients, presenting them as morally impaired 'heart sinks' who make unfair demands on services rather than legitimate sufferers in need of medical help. In the present data, demedicalising patients and emphasising their responsibility appears to go hand-in-hand with making negative judgements about their characters.

8.4 'Patient' and 'professional' discourse?

The content of the MHDC illustrates a significant blurring of the boundaries between supposedly 'lay' and 'professional' responses to depression and anorexia nervosa. Analysis of the discussions of anorexia and depression authored by 'lay' sufferers indicates a blending of discourses, with forum users presenting anorexia and depression as issues of personal and moral significance while also drawing on scientific and medical concepts. For example, the narratives of the forum members illustrate a tendency towards objectifying representations of anorexia and depression characteristic of professional medical discourse. Users also simulate professional discourses to resolve disagreements or when diagnosing new forum members (sections 4.7 and 5.5). Such interactions provide clear instances of lay-driven medicalisation. In the depression forum, a narrative in which a new member recounts having an 'ache in [her] head and heart' and claims 'there's only me that can help myself' is categorised by a forum moderator as indicating 'most of the classic symptoms of depression'. Similarly, *anorexia.net* members' expressions of uncertainty about recovery or claims that anorexia may be a choice are categorised by other users as symptoms of 'the ED' itself. In both instances, a disease label ('symptoms of depression', 'ED') is used to classify an account of behaviour which did not involve – or actively resisted – description using medical terminology. In these threads, states such as heartache and expressions of doubt about recovery are used as candidate

reasons for inferring the presence of a medical pathology, suggesting the participants exercise liberal criteria for diagnosing anorexia and depression. These diagnoses are supported through comparisons between anorexia and depression and other conditions; anorexia is not a choice just as cancer and 'brain chemistry' are not a choice and depression is like a 'broken bone' or 'fever' even if it has no 'outward signs'. These comparisons emphasise an organic or physiological basis for anorexia and depression and exclude socially contextualised explanations of their development. Therefore, although the two fora's interactions are concerned with personal narratives and emotional difficulties, these accounts of distress are juxtaposed against 'proto-professional' descriptions of anorexia and depression that draw on medical and scientific concepts (de Swaan, 1990).

An exception to this trend appears on *anorexia.net*, in which eating in accordance with a professional meal plan is represented as a moral issue that warrants guilt, pride or feelings of 'fidelity'. This suggests that the dominance of medical discourses over lay understandings of eating disorders is not a one-way process on the fora. Instead, clinical technologies can equally be imbued with normative and emotional connotations.

A similar discursive hybridity (Chouliaraki & Fairclough, 1999) is illustrated in the GP focus groups. The participants discuss professional tasks such as diagnosis, referral and prescription and refer to the use of medical technologies. The participants also construct anorexia and depression as grammatical possessions of individual patients and present diagnoses as exclusive categories. However, the GPs also question the use of standardised instruments such as BMI scores and the use of professional therapies such as antidepressants. In the depression focus groups in particular, the participants provide explanations of patients' suffering that foreground social and environmental rather than organic factors. In proposing diagnoses and treatment options, the GPs also refer to their own clinical experiences and

utilise 'ordinary' accounting strategies such as speech representation rather than evidence from clinical research to account for their decisions in talk (Myers, 1999).

The GPs also construct a range of non-clinical identities for patients. This was most apparent when the GPs were discussing patients who had been unaffected by previous interventions, who were variously described as 'heart sink', 'time wasters', 'stubborn', those with 'naff all wrong with them', needing 'a kick' and 'hardened' anorexics. In lieu of successful clinical options, the participants' talk emphasised the moral identities of chronically ill clients by constructing them as an emotional burden, as reluctant to change their behaviour and as making unwarranted use of healthcare services (May, 2005). Constituting such identities clearly foregrounds patients' personal failings over their possible medical needs.

Both pairs of patient and professional sub-corpora therefore demonstrate a number of heterogeneous discourses of depression and anorexia, with participants drawing on medical and sociocultural explanations of mental illness (Chew-Graham *et al.*, 2009; Swartz, 1987) and constructing the use of healthcare services as an act of both clinical significance and moral accountability. In each dataset, different constructions of anorexia and depression are adopted strategically by discourse participants to fulfil interactional goals such as providing supportive advice, mitigating responsibility for sustained illness and accounting for frustration towards patients. Perhaps surprisingly, the data suggest a stronger tendency towards medicalised models of anorexia and depression within the patient support groups than amongst the participating health professionals (Barker, 2008; Conrad, 2005). This is most clearly demonstrated in the two depression sub-corpora, in which support forum members advocate pharmaceutical treatments while the GPs endorse non-clinical, socially-oriented interventions over 'quick fix' medication. Similarly, while the GPs remain

ambivalent over whether the scenario patients have depression, the forum users will categorically tell new users that they ‘have most of the classic symptoms of depression’.

Accordingly, the foregoing analysis provides contrasting evidence to studies indicating a preference for situational explanations of depression and its treatment amongst patients (Dowrick, 2004; Lewis, 1995; Rogers & Pilgrim, 1997) and a medicalising tendency amongst healthcare professionals (Pilgrim & Bentall, 1999). Rather, both the claims of the GPs and the analysis of the forum interactions suggest that it is patients who encourage the medical diagnosis and treatment of depression. Maxwell’s (2005) finding that GPs believe medication is their only available means of assisting patients with depression is also unsupported by the corpus data. Rather, the participating GPs propose a raft of non-clinical interventions for addressing patients’ unhappiness. In parallel with Maxwell’s research, however, the GPs emphasised situational explanations of patients’ distress and were sceptical of patients becoming dependent on professional help.

8.5 Implications for users and moderators of online health fora

The number of users registered to each forum, the frequency with which they post messages and their sustained participation over the time periods sampled in each sub-corpus indicate that *depressiononline.net* and *anorexia.net* provide a valued facility for their users. In both sub-corpora, there are instances in which forum participants report having difficulty discussing their condition with immediate friends and family members, suggesting that online communication enables disclosure of concerns that would otherwise be left unsaid. These disclosures frequently engender supportive responses and further discussion that sufferers may not receive during their offline interactions. Both fora also constitute venues for the presentation of illness narratives (see section 5.2.2), allowing users to reflect upon the effects of anorexia and depression on their lives and discursively construct a positive self-identity

(Bamberg, 2012; Galasiński, 2008; Kleinman, 1988). These findings corroborate existing research that emphasises the function of online support groups in managing perceived stigma for illness (Bell, 2007) and satisfying emotional needs that are not met elsewhere (Joinson, 2003).

Given that both the corpus interactions and existing literature present self-injurious behaviour as a form of maladaptive expression (Boynton & Auerbach, 2004; Harris, 2000), it is also worth highlighting the value of *depressiononline.net* a venue for expressing challenging emotions. The orthodox understanding of suicide as an irrational behaviour problematises individuals' ability to seek help for fear of being labelled as mentally ill (Bennett *et al.*, 2003), leading to limited disclosure to clinicians (Coggan *et al.*, 1997; Michel, 2000).

Negative experiences with healthcare providers can be both a direct precursor of additional self-harm (Harris, 2000) and potentiate suicidal behaviour by increasing an individual's sense of isolation and hopelessness of receiving help (Williams & Pollock, 2000). Whilst never encouraging suicide, the interactions on *depressiononline.net* largely avoid this stigma and there are no identified instances of forum members explicitly describing others' suicidal ideation as irrational or pathological.

Non-critical discussions of suicide and the public nature of the medium also provide users with accessible, continuous and non-judgemental emotional support that has previously been identified as a factor protecting against suicide (Michel, 2000). Indeed, given that users associate suicide with thwarted self-expression and loneliness (sections 5.4, ex. 75), the availability of an accessible venue in which to communicate with others and express emotions is likely to be beneficial. Furthermore, the ethos of mutual peer-support on *depressiononline.net* and *anorexia.net* provides users with the opportunity to adopt positive roles as listeners, advice-givers and helpers that may otherwise be unavailable for those

deemed mentally ill. Therefore, whilst the public reaction to websites permitting discussion of self-injurious behaviours has been largely condemnatory, expressing distress and stigmatised beliefs in a non-injurious manner may offer some users an alternative to suicidal ideation, rather than promote it (Baker & Fortune, 2008). Similarly, users expressing difficult emotions through *anorexia.net* may find immediate relief from psychological distress that may otherwise lead them to restrict their diets or exercise excessively.

The analysis indicates that participation in the support groups' discussions will encourage new users to make contact with healthcare professionals and adhere to professional interventions such as meal plans (sections 4.6.3) and antidepressant medication (sections 5.3). Eivors *et al.* (2003) note that regarding anorexic practices as an index of lost control is a common precursor to anorexics seeking professional help. This view of 'behaviours' and 'restricting' is expressed by several high-posting users of *anorexia.net*. As a result, individuals who are initially reluctant to seek treatment for anorexia may be motivated to reinterpret their own 'behaviours' as pathological through encountering this discourse in the forum.

There is also some evidence that forum interactions affect users' healthcare behaviours. For example, a member of *depressiononline.net* who describes ceasing antidepressants later acknowledges that he was wrong to do so (section 5.3.1, ex. 63). Similarly, a new member who is told she has 'most of the classic symptoms of depression' (section 5.5, ex. 83) subsequently posts a message describing an appointment with her GP which resulted in a prescription of Citalopram and claims 'i probably would not have bothered going if i hadn't had such encouraging replies'. Participation on *depressiononline.net* is also likely to increase users' exposure to psychologising explanations of difficult experiences. If reiterated in

consultations, these explanations increase the likelihood of undiagnosed users receiving a diagnosis of depression (Kessler *et al.*, 1999).

Healthcare professionals may look favourably on such online interactions as a means of encouraging contact with services and adherence to professional treatments. However, the promotion of medical diagnosis and treatment online may also be a source of tension between internet users and healthcare providers. Most obviously, individuals who are encouraged by their online activities to begin a 'moral career' as a person suffering from a treatable illness increase the demands on finite healthcare services (Rose, 2006). Individuals convinced by the sophisticated proto-professional diagnoses of their internet peers might also experience a sense of conflict if medical professionals do not validate the advice they receive online. Similarly, users of *depressiononline.net* who are urged to find the 'right meds' may pursue a prescription of antidepressants even when, as the focus groups suggest, doctors are reluctant to prescribe. This may lead forum users into confusion over the appropriate way to manage their distress and perhaps to their discontinuing consultations with GPs who do not prescribe medication.

The preference for medical models of psychological distress amongst the online communities mirrors Stoppard's (2000) account of women's consciousness raising support groups.

Stoppard argues that patients' group discussions provide an opportunity to foreground the pervasive cultural and structural inequalities that give rise to their mutual psychological distress. However, Stoppard claims, contemporary groups typically fail to integrate this contextualising perspective and instead represent mental illness as an individualised pathology. *Anorexia.net*, for example, contains extensive discussions of individual therapies and personal meal plans but little discussion of gendered discourses of female body shape and physical regulation that might situate anorexia in relation to oppressive cultural norms.

Consequently, rather than fostering explanations of mental illness that critically examine cultural and emotional causes of psychological distress, anorexia, depression and their respective aetiologies are depoliticised in the forum interactions (Barker, 2008; Conrad, 1992). On *anorexia.net* in particular, forum members strongly disaffiliate from accounts that constitute anorexia as a choice, even if they posit a more empowered role for the individual in managing their anorexia (Giordano, 2005). Similarly, persistent emphasis on individualised treatment options means that online support groups may be ineffective in establishing collective resistance to cultural practices that produce and oppress sufferers of mental health problems (Gorman, 2008; Stoppard, 2000). Therefore, although mutual peer support is the *raison d'être* of *depressiononline.net* and *anorexia.net*, in practice this support involves the elision of politicised explanations of personal distress. This argument does not undermine the positive effects *anorexia.net* and *depressiononline.net* may have for the lives of sufferers. However, online group users and moderators should be aware that their electronic communities may emphasise professional diagnosis and clinical interventions at the expense of identifying wider material and cultural factors that may contribute to members' distress (Pilgrim & Dowrick, 2006; Schreiber & Hartrick, 2002).

8.6 Implications for healthcare practice

The findings from chapters 4-7 carry a number of implications which are relevant to the work of healthcare professionals, and particularly those in primary care. Chapter 4 demonstrated that externalisation and personification of anorexia was a prevalent feature of messages on *anorexia.net*. As noted in section 4.7, externalising anorexia is advocated in both popular and CBT-based self-help literature as well as the leading Maudsley Methods for treating anorexia (see Rhodes, 2003). However, objectifying anorexia as 'the ED' or 'the ED voice' does not appear to signal recovery for the users of *anorexia.net*, but rather correlates with an expressed

powerlessness over anorexia. It also contrasts with forum users in recovery, who are more willing to represent anorexia as something they possess. The findings thus signal a need to thoroughly investigate the therapeutic implications of encouraging patients to externalise and personify anorexia (Higbed & Fox, 2010).

In chapter 5, the analysis of patients' discussions of antidepressants, side effects and self-control offer a means of reassessing patients' antidepressant non-compliance. Where non-adherence to professional treatments could be regarded as irrational (Conrad, 1985), the forum users' discussion of side effects and explicit comparisons between expected and actual benefits illustrate that their non-adherence is part of a considered attempt to manage their overall illness experience. This finding suggests that doctors prescribing antidepressant medication should foster adherence by being open to discussions of side effects and discursively constituting antidepressants as a means of increasing personal control, rather than an index of diminished personal agency.

Chapters 6 and 7 signal that GPs identify a need to exceed traditional clinical responsibilities when working with patients with depression or anorexia (Byng, 2012; McPherson & Armstrong, 2009). This can involve actively managing patients' appointments, helping patients with income support forms, bespoke 'therapy' such as painting, or using diagnostic tests as interactive resources to overcome patients' repudiation. The 'therapeutic flexibility' these GPs endorse should be considered a valued aspect of their work in this area and for responding to the needs of individual patients more widely (Pilgrim & Bentall, 1999).

In simulating confrontational meetings with chronically unhappy patients and interactive difficulties with anorexics, the GPs also topicalise issues of doctor-patient communication. The participants' repeated orientation to interactional problems suggests that professional training should be directed towards the interpersonal communication skills needed to cope

with encountering patients' distress and persuading them to accept medical interventions (Pilgrim & Dowrick, 2006). This is particularly the case in the anorexia groups, where GPs identified a need for enhanced communication skills when encouraging patients to accept specialist referrals. Enhancing clinicians' communicative repertoires may be more beneficial than increasing GPs' knowledge of screening tools, antidepressants and BMI-based referral criteria, to which they express at least some reservations. Different models of care may also assist in managing the patients exemplified in the focus group case scenarios. Using primary care mental health workers, for instance, may alleviate some of the workload of frequently attending patients with low level psychological problems. For anorexic patients who are unwilling to attend an eating disorders clinic, primary care mental health workers may also enable referral to a mental health specialist within primary care. Patients may still need some persuading for this step, however.

In the anorexia focus groups, speaker A1 suggests that diagnosis can require doctors to 'grasp the nettle' while in the depression groups, speaker D5 claims he would 'demedicalise' the first patient scenario and emphasise the patient's control over recovery. Both GPs indicate that classifying a patient's condition within the boundaries of medical pathology is a volitional process determined by the professional's choice. GPs should be aware of the personal and emotional motivations that influence such decisions and the implications that they can have. For instance, although the process of demedicalising and 'disentangling' may alleviate GPs' anxieties towards patients whom they feel unable to assist, it would seem unlikely to reduce the patients' own sense of suffering or desire for care. Similarly, as speaker A1 intimates, patients may experience prolonged distress and delayed treatment if GPs are unwilling to 'grasp the nettle' of diagnosing anorexia. Practitioners could beneficially identify whether a reluctance to diagnose anorexia arises from inadequate knowledge of the condition, anticipated difficulties with the patient or the lack of available

treatment services (or a combination of all three). Doing so would provide a clear pathway for improving care for eating disordered individuals.

Patients with anorexia present infrequently in primary care and participants in the anorexia focus groups claimed to have little clinical experience with anorexic patients. One way in which clinicians could be exposed to the discourse of those suffering from anorexia is through examination of electronic support groups such as *anorexia.net*. Medical education that included exposure to online support communities would facilitate understanding of the interactions of anorexics, their experience of healthcare services and their manner of articulating concerns. The study of online depression support groups may be similarly beneficial, particularly in light of patients' attested difficulties in discussing suicidality with clinicians (Michel, 2000). As with anorexia, medical education could sensitise clinicians to the language used by patients when discussing depression and the concepts that patients co-develop online that may influence their beliefs about treatment. Corpus linguistic methods would also permit the study of large volumes of naturally-occurring patient data and provide a strong evidence base on which to base such training. In particular, corpus methods could demonstrate salient areas of patients' communication as well as the consistent linguistic choices through which they encode their understandings of illness and express beliefs about clinical interventions (Crawford & Brown, 2010).

These proposals were discussed with the participants during feedback seminars delivered in late 2012. Participants could also receive a booklet summarising the findings of their respective set of focus groups and the corresponding examination of *anorexia.net* or *depressiononline.net*. The presentation of findings from the relevant online forum enabled the GPs to make direct comparisons between their own discourses and those of individuals suffering from depression or anorexia, and served to expose them to the potential for studying

online support groups. The seminar participants provided positive feedback and were particularly interested in the way in which they and patients verbally negotiate responsibility for mental illness. Several participants also claimed they would attend more closely to their patients' linguistic choices and particularly those utterances which denote that patients are not taking 'ownership of their illness'. The seminars thus enabled a connection between 'the research and the researched', constituting the GPs as both active participants and potential research users and delivering findings that are relevant to their own clinical practice (Roberts & Sarangi, 2003; Sarangi, 2002).

8.7 Methodological evaluation, further research and concluding remarks

Having discussed the main findings of this research and their practical implications, I now offer an evaluation of the design and analytical approach of the study. I first consider the use of online health fora as a means of illuminating sufferers' accounts of mental illness before appraising the focus group design adopted in the professional arms of the study. Finally, I evaluate the corpus-based critical discourse analysis methodology used to examine the data. Where shortcomings are identified in the research methodology, I outline opportunities for their development during future research, as well as significant areas for further study suggested by this project.

8.7.1 Online fora

Online health fora constitute popular, accessible sources of support and, for patients in sparing contact with healthcare professionals, can represent a principal source of healthcare information. As well as proving expedient to the compilation of two large corpora, the collection of data from two such groups has therefore enabled analysis of a major form of contemporary health communication. The use of web fora has also allowed for the study of non-elicited patient interactions that occur without the input of a researcher or healthcare

professional. As such, the collection of messages posted on *anorexia.net* and *depressiononline.net* has permitted access to an otherwise unobtainable context of patient health communication. To this end, the study has contributed to knowledge of the linguistic choices made by sufferers when articulating experiences of depression and anorexia, the salient aspects of sufferers' experiences of psychological distress and the function of medicalised models of mental illness in the dynamics of support group discourse. Analysis of two different illness communities has also enabled identification of consistent linguistic signatures and rhetorical strategies – illness objectification, personification and extreme case formulations – as well as accounts of group-specific concerns such as 'behaviours' and antidepressants.

These are novel findings in this area and, as novel findings should do, inevitably encourage further questions. For example, the 'causal indeterminacy' inherent in the study of online behaviour (Herring, 2004: 350) raises the question of whether the objectification and medicalisation of illness illustrated in chapters 4 and 5 is specifically encouraged by features of computer-mediated communication. Similarly, the present data does not conclusively indicate whether the 'ED voice' concept originates from users' own experience or their exposure to professional and self-help therapies. The unobtrusive nature of the study's data collection prevented such questions being posed directly to the discourse participants. However, they could be fruitfully investigated through active online research projects or comparisons between the online fora and interactions in face-to-face support groups. The latter suggestion would provide contrasting sufferer-led supportive talk that could be examined for verbal indications of illness reification and its function in the groups' interactions. The study of face-to-face support groups would also allow future research to account for sociolinguistic variables such as age, gender and ethnicity that are difficult to ascertain from online profiles but which may correlate with particular linguistic styles.

Investigation of face-to-face groups would also help to capture the discourses of individuals with mental health difficulties who are unwilling or unable to participate in online support groups because they do not have regular internet access. In this respect, it should be noted that the views of those experiencing mental health problems who are not computer literate or who also experience material poverty will be omitted from internet-based health studies. Similarly, those sufferers who do not perceive a need for on-going peer support or for whom psychological distress is short-lived are less likely to be represented in this study and in future research into online communities (Houston *et al.*, 2002). This should not, however, detract from the valuable insights that are gained from online research, and the large number of individuals whose talk can be examined. Also, while the present research has investigated only two online communities, a preliminary analysis highlights the presence of similarly objectifying and medicalising constructions in several other pro-recovery anorexia and depression fora. Detailed examination of additional web communities – including those with non-Western users – would reveal the wider prevalence of the discursive features identified here.

8.7.2 Focus groups design

As discussed in chapter 3, the decision to use focus groups to investigate the experiences of general practitioners was made in consultation with two established healthcare professionals who specialise in eating disorder psychiatry and primary care respectively. As the product of this cross-disciplinary collaboration, the GP sub-corpora cohere with my own research concerns whilst also responding to the experience and research lacunas identified by leading professionals. The aims, methodology and outcomes of the current applied linguistics research are thus negotiated ones; I have involved end users from an early stage and sought to illuminate issues salient to these end users through linguistic analysis.

As my clinical colleagues identified, studying general practitioners provides an apposite response to the lack of published qualitative studies of GPs' experiences of treating eating disorders. Primary care is also the principle venue for the management of depression. The perspectives of GPs are therefore integral to the provision of care for the majority of patients with depression and merit sustained investigation.

Although the focus group participants were drawn from practices across socio-economically diverse areas of Nottingham, they nevertheless represent only a small geographical area under one primary care trust. As a result, the GPs' experiences may partly reflect aspects of local healthcare organisation – such as the availability of specialist eating disorder services – which may not extrapolate to other regions of the UK (Reid *et al.*, 2010b). Although the use of corpus methods usefully identified key areas of consistency between groups and their constituent speakers, the relatively small number of focus-groups also made the degree of data saturation uncertain. Data from supplementary focus groups may have resulted in the identification of additional keywords or categories and hence afforded insights into other salient aspects of GPs' discourses. Participant recruitment was constrained by two factors: the number of GP surgeries in the approved research area that had three or more GPs and the response rate (35%) from invitees. I hypothesise that the latter factor was limited by the logistics of securing several GPs at one time for group discussion, the lack of available funding to reimburse participants and the comparatively low incidence of anorexia in the general population affecting GPs' research interests. Although participants were self-selecting, there is little indication that they held a special interest in mental health – indeed several participants in the anorexia discussion claimed they had little experience of eating disorders. Alongside the resource demands of participant recruitment, my inexperience of the bureaucratic obstacles posed by the NHS ethics review discouraged the use of pilot studies to test different focus group designs. Further focus groups could evaluate alternative formats

such as using moderators or participants who did not already know each other. Additional groups could also substantiate whether the findings of the present study are consistent among a larger proportion of general practitioners.

Using patient scenarios to stimulate participant talk means that the research design has shaped the content of the resulting data. This is, however, an inevitability for all non-observational qualitative studies rather than a drawback of the current study in particular. Further, although the GP interactions were catalysed using case scenarios, the absence of a moderator allowed the duration and trajectory of the discussions to be largely determined by the participants themselves. As well as offering a parallel with the patient data, using non-moderated focus groups meant that the on-going production of talk (i.e. *data*) was less influenced by the researcher than during the interviews traditionally adopted in qualitative healthcare research.

The collaborative research design and joint authorship of the patient scenarios ensured that the focus groups could respond to the concerns of the professional community under scrutiny. Accordingly, during debriefing sessions, several participants commented that the scenarios were 'well written' and 'familiar', suggesting they provided appropriate representations of actual patients. Green *et al.* (2008) note that patient vignettes are particularly useful for assessing attitudes towards eating disorders, which present infrequently in primary care and so may be difficult to discuss if GPs are asked to recall their own patients. In the first anorexia discussion group in particular, three participants stated that they had seen few patients with anorexia in primary care, and so would have been unable to talk extensively about their own experiences. The perspectives of these inexperienced doctors are relevant nevertheless, and the provision of patient scenarios provided an effective means of eliciting them. Green and colleagues (2008) also caution that the use of patient vignettes can limit

participant responses to the content of the scenarios. However, this did not appear to be a reality in the present study. Participants in every group referred to their own patients and situations that differed from those in the patient vignettes. The discussions in each set of focus groups also addressed topics that were not obviously anticipated by the case scenarios. These include the negotiation of patients' 'heartsink' label, discussion of confronting patients, doubts over the use of PHQ-9s, the use of diagnostic tests as interactional 'tools' and the difficulty of referring patients with anorexia. The open-ended focus group design therefore clearly permitted sufficient lee-way for participants to establish topics that were, at most, implicit in the stimulus materials but salient to their own practice.

8.7.3 Corpus Linguistics

The foregoing chapters have drawn extensively on the methods of corpus linguistics in the compilation and analysis of four distinct sets of naturally-occurring health communication. Corpus techniques have been integral in identifying recurrent lexical items and multiword collocations throughout the four sub-corpora. In doing so, they have contributed to illuminating discursive signatures used to express experiences of psychological distress and its management and exposed linguistic patterns that might otherwise be overlooked. Corpus-driven methods have delivered summary information for large amounts of language and provided quantitative data that enabled insights into the relative dominance of different constructions of anorexia and depression at a corpus level. This degree of quantitative precision remains largely elusive in non-corpus discourse studies. *WordSmith Tools'* concordancer also facilitated focused qualitative analysis of specific stretches of text – forum messages, turns at talk – spread throughout each corpus. In these respects, computer-assisted corpus tools constituted the most expedient methods for interrogating the MHDC. Corpus linguistics has therefore proven an apt and successful methodology for the current research

and supported a number of its key findings. This provides a strong indication that corpus linguistic methodologies could also be brought to bear on future health communication research and education.

The use of corpus methods throughout the study has also brought to light several limitations inherent in the principles of the discipline which I feel have particular relevance to the study of mental health communication. The discussion of these limitations does not belie the preceding findings. Instead it offers guidance for the analysis of health communication corpora and adds my own voice to more established calls for methodological plurality (Baker *et al.*, 2008; Mautner, 2009b).

The quantitative and qualitative analysis of large amounts of language supports corpus linguistics' claim to be a 'data driven' enterprise (Johns, 1991). Adolphs *et al.* (2004) argue that this gives corpus linguistics an 'evidence based' philosophy that resonates with contemporary healthcare and delivers findings in a format that is relevant to research users in healthcare contexts. Myriad corpus-based studies illustrate that this data driven approach is primarily operationalised through the presentation of frequency data and keyword and collocation analyses based on lexical frequencies. The provision of frequency information has been a core aspect of corpus linguistics and contributed to the discipline's self-definition as offering a rationalised approach to data. Starcke, for instance, claims that 'analysis of the frequency of linguistic items is the only available objective evidence for the significance of this item [*sic*] in the text' (2006: 88). The analysis of frequent items in critically-oriented corpus studies has also helped counter accusations that critical discourse analyses are compromised by researchers' pre-analytical priorities (Widdowson, 2002a).

It should be obvious, however, that frequency information offers only one way to prioritise what is closely examined in a corpus. Accordingly, it should be noted that, by focusing

primarily on linguistic features that are quantitatively dominant, corpus analyses may overlook statistical outliers, that is, the accounts of those speakers who express themselves idiosyncratically. For example, section 5.4 examines the keywords *suicidal* and *suicide*, which both appear with statistically significant frequencies in the *depressiononline.net* corpus. Close consideration of these keywords provided insights into the discourse of those forum members who use these lexical items. What, then, of the forum users who express themselves differently and claim that they wish to ‘go to sleep and never wake up’ or ‘drive somewhere remote and never come home’? While couched in more euphemistic terms (itself an interesting linguistic finding), these expressions are significant disclosures for their authors and signal the possibility of examining additional accounts of suicidal ideation. However, these variable and oblique references to suicide are individually infrequent in the corpus and so will not be identified using keyword analyses. Furthermore, their idiomatic form means that even sophisticated, semantically aware corpus platforms such as *WMatrix* would not identify them as references to suicide. As a result, they are unlikely to feature in any analysis driven primarily by computer-derived frequency analyses; the views of these mental health sufferers would be discounted from further study because their expressions are lexically *atypical* rather than empirically irrelevant. Researchers should remember that prioritising corpus frequency in the name of ‘evidence-based’ research therefore not only shapes analysis but inadvertently warrants the exclusion of potentially relevant data. Further, this exclusion occurs not because of the validity of the data, but because corpus analysis programmes have limited facilities for identifying complex discursive phenomena.

It is tempting to draw parallels between corpus linguistics and quantitative healthcare research more generally here. Bensing (2000) notes that randomised control trials are largely based on homogenous patient groups who meet strict recruitment criteria and bear little resemblance to the individuals with diverse symptoms, comorbidities and coping strategies

that physicians meet in practice. Similarly, we might claim that corpus frequency and keyword analyses narrow the population who are reflected in subsequent qualitative findings to those who choose contextually common lexical items. Additionally, corpus tools tend to efface individual speakers by presenting their language use as a numbered concordance line and foregrounding consistent, repeated verbal phenomena over idiosyncratic utterances. Bensing (2000) goes on to argue that evidence-based practice derived from meta-analyses of randomised clinical trials need not result in optimal patient-centred care for individual patients, and particularly those who would not fulfil the inclusion criteria of the clinical studies. What is needed, he argues, is care that integrates external scientific evidence into the specific context, needs and capacities of the individual patient (2000; Byng, 2012). Similarly, frequency-based corpus studies of health communication may not be ‘patient-centred’ insofar as individual speakers’ discourse tends to be either homogenised into statistical representations or omitted from further analysis. Just as RCT evidence requires interpretation against particular patients, quantitative corpus-driven findings must therefore be viewed as only a partial heuristic of the data that must be interpreted to be meaningful in individual cases (Skelton & Hobbs, 1999a). To this extent, this study has integrated the interrogation of frequent keywords with examination of infrequent lexical items and strings identified through intuition and manual reading of the corpora (see sections 5.4 and 7.4 in particular). In doing so, I have examined instances of patient and professional discourse that are relevant to the study’s overriding research aims but which would have been overlooked by a more stringent corpus-driven methodology.

The pluralistic approach of the study’s analysis can also be regarded as a methodological strength (Baker *et al.*, 2008; Mautner, 2009b; Skelton & Hobbs, 1999a). Keyword and collocation analyses have pinpointed dominant linguistic practices in the respective corpora and supported granular analysis of single words, bi- and trigrams and their contribution to the

wider meaning of the texts. Close analyses of these keywords assimilated concepts from systemic functional linguistics, discourse analysis and discursive psychology to offer analytical triangulation. For example, collocation data initially highlighted the frequent use of *the ED* and *the depression*, which suggest objectifying representations of anorexia and depression. Subsequent analysis of the clause representations of these bigrams supported this contention, demonstrating that online forum members represent their conditions as active clause participants that are distinct from their identities. Both findings demonstrate speakers' efforts to verbally distance themselves from their respective conditions, while the use of systemic functional grammar also illuminated the role of transitivity and agency in forum members' constructions of identity and responsibility (Bamberg, 2012). Arriving at complementary results using different methodologies suggests that these are robust findings derived from effective methods of linguistic analysis. Elsewhere, analysis of clause representations and agency in the focus group data have been referenced against the British National Corpus (see section 6.2.1) to support interpretations, further demonstrating the possibility of integrating systemic functional and corpus linguistic approaches to discourse analysis (O'Halloran & Coffin, 2004). While corpus methods tend to foreground lexical aspects of texts, my own analysis has also considered discourse-level features such as the use of reported speech in the GP focus groups, which was central to their discussion of patient management.

The penultimate sections of chapters 4 and 5 have also contextualised corpus-derived findings from the patient corpora within the dynamics of the forum communities. Section 4.7, for example, considered the function of *the ED voice* as part of a core 'shared repertoire' used to facilitate the *anorexia.net* community's mutually supportive discursive enterprise (Wenger, 1998). This interactional repertoire contributes to the production of new meanings of

anorexia and depression by the forum members, and new identities for those who define themselves as suffering from anorexia and depression.

By illustrating the context-specific interactive functions of verbal constructions of anorexia and depression, these sections demonstrate the potential for combining corpus linguistics' 'top down' perspective with a 'bottom up' approach to the study of social groups. As the foregoing use of Wenger's (1998) terminology suggests, I believe Communities of Practice would be a fruitful theoretical framework to adopt for such a venture and have argued so elsewhere (Hunt, 2011). Unfortunately, space constraints have not permitted substantive exploration of *anorexia.net* and *depressiononline.net* as communities of practice in the present study. Further analysis adopting this body of theory more fully would be particularly useful in illuminating the dynamics of the two forum groups.

8.7.4 Future research and conclusion

Although my own manual reading has covered all of the four corpora, inevitably only a small proportion of the keywords and content of each corpus have been subject to closer analysis. In particular, analysis of keywords related to self-harm in the *depressiononline.net* sub-corpora have not been presented here. A useful starting point for further investigation of the MHDC would be to examine the healthcare roles which constitute keywords in both online corpora. Analysis of these roles would supply further insights into patient-professional relations and patients' experiences of clinical interventions. Forum users also consistently refer to the titles of family members and close social relations who occupy significant roles in their lives, whether as informal carers or possible antagonists. Given the substantial role of family and friends in providing support for those experiencing mental health problems (DoH, 2012), analyses of these keywords would shed light on an central facet of contemporary mental health care. From a more discourse analytic perspective, chapters 6-7 demonstrate that

speech and thought representation are important discursive strategies in the GPs' discussions of patients (Myers, 1999 and see Hall *et al.*, 1999). Further investigation could analyse their functions in this context more fully and contribute productively to research on clinicians' accounting and reasoning practices.

These proposals gesture towards a range of additional research avenues that could be pursued using the health communication corpus compiled during this study. These projects would contribute to valuable developments in the fields of corpus linguistics, discourse analysis and health sociology. In addition to the findings presented here, therefore, the value of the MHDC resides in its potential to sustain on-going research projects and further enhance knowledge of contemporary experiences of mental health.

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