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Expert Opinion? A Micro-Analysis of Eating Disorder Talk on Dr. Phil

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Abstract

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Keywords

Eating Disorders, Mental Illness, Conversation Analysis, Discursive Psychology, Mass Media, Talk Television

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Expert Opinion? A Micro-Analysis of Eating Disorder Talk on Dr. Phil

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In this study, we explored how eating and identities of individuals diagnosed with eating disorders are constructed on a popular television talk show, Dr. Phil. Informed by conversation analytic and discursive psychological research traditions, we show how Dr. Phil, jointly with guests, constitutes guests as mentally ill and accountable for their illness. Specifically, we highlight Dr. Phil's unilateral pursuit of a solution to the "puzzle" of the eating disorder, including its origins and meanings, as he enlists the guests' endorsement of his versions of their situations and experiences. We examine broader implications of such a framing for societal understandings of the subjectivity of individuals diagnosed with eating disorders. Keywords: Eating Disorders, Mental Illness, Conversation Analysis, Discursive Psychology, Mass Media, Talk Television

In this article, we offer a critical analysis of representations of mental illness, specifically eating disorders, in popular media. Mental illness is rarely portrayed on a media screen and existing depictions tend to be stereotypical and negative (Merskin, 2012). Alarming, media sources are a primary source of information about mental illness (Coverdale, Naim, & Claasen, 2002) and influence not only broader cultural perceptions of mental illness but also the experiences of individuals depicted as "mentally ill" (Bryant & Oliver, 2009; Wykes & Gunter, 2005). A number of studies have examined the construction of eating disorders in various media contexts, including newspapers, magazines, radio, and Internet (e.g., Brooks, 2009; Burke, 2006; Hardin, 2003; Hepworth, 1999; Malson, 1998; Malson, Finn, Treasure, Clarke, & Anderson, 2004; O'Hara & Clegg-Smith, 2007; Shepherd & Seale, 2010). Most prior work on the construction of eating disorders has been oriented to the broader socio-cultural forces and discourses. Bordo (1993), for example, explored how the culture of consumerism informs that construction of self as "thin" or "fat," highlighting the cultural requirement to enjoy and consume goods, on the one hand, and discipline the body through exercise or dieting, on the other.

Despite important deconstructive efforts from critical feminist scholars (Bordo, 1993; Leavy, Gnonng & Ross, 2009; Moulding, 2003; Rich, 2006; Schneider & Davis, 2010), less is known about *how* constructions of eating disorders are (re)produced and contested through language. In notable exceptions, discursive psychologists Brooks (2009) and Wiggins, Potter, and Wildsmith (2001) approached eating and eating disorders from a micro perspective. Wiggins et al. studied social negotiation, disputation, and argumentation of eating practices at dinnertime, illuminating the ways in which eating practices in general are normalized or abnormalized in interaction. However, these practices were discussed as they relate to eating in general, rather than in the context of eating disorders in particular. Focusing on eating disorders, Brooks (2009) identified discursive practices used in radio phone-ins to construct an "eating disordered" individual as more or less agentic and responsible for the disorder.

Joining these micro-oriented discursive initiatives, we sought to contribute a better understanding of the *process* of how "eating disordered" identities and experiences are constructed using language. Our objective was to generate a detailed description of discursive or communicative practices used by Dr. Phil and his guests to construct the show's guests'

actions and identities. Our broader, critical concern was with how eating disordered subjectivity is construed or presented in the context of the popular media and what kind of agency individuals distinguished as “eating disordered” are allowed when confined by these representations. The latter concern is rooted in the premise that it is important for critical analyses of discourse to not only identify practices of domination, but to also explore agency and resistance to these practices. This analysis contributes to an understanding of how language is used, often by individuals in positions of power, to produce and advance particular descriptions of subjectivity. Enhanced understanding in this area could be a critical step in disrupting the dominant cultural constructions of eating disorders.

We approached the study from the perspective of discursive psychology (DP) (e.g., Edwards & Potter, 1992; Potter, 2011), informed by conversation analysis (CA) (e.g., Sidnell & Stivers, 2012). The material analyzed in this study is drawn from a larger *YouTube* collection of episodes of *Dr. Phil* on the topic of eating disorders. *Dr. Phil* was chosen as a site of analysis based on its’ position as a long-running television talk show in the United States with a significant viewership (over 4 million). The daytime talk show debuted in 2002, prior to which time Dr. Phil was frequently featured on another popular television talk show, *Oprah Winfrey*. Dr. Phil has since become a contentious popular culture phenomenon in North America, having written many books, seven of which have become *New York Times* bestsellers, and has received notable accolades, including 25 Emmy nominations (Peteski Productions, Inc., 2013a). Dr. Phil, though he holds a PhD in clinical psychology, is not currently a licensed psychologist. Nevertheless, elements of his program draw strongly on a medical, recovery-based frame. A number of credentialed and licensed consultants work with the *Dr. Phil* show, including an “advisory board” of 18 professionals in the field of mental health (Peteski Productions, Inc., 2013b). Despite its use of staged therapy-style episodes (in front of a live audience), the show explicitly refers to its purpose as entertainment, not counseling, through the use of a disclaimer accompanying each episode. The show is broadcast in the USA and Canada, and is available online in a number of other countries.

The show is centered on the interaction between Dr. Phil and his guests. In print media it is text and image that “do” illness representation; however, on a popular television show like *Dr. Phil*, representational work is arguably accomplished via on-screen interaction (between the host, guests, and the studio audience). Representations, in this case, can be seen as interactionally formulated through on-screen actions and responses. Accordingly, to understand how mental illness is portrayed on *Dr. Phil*, it is important to examine social interaction and its role in the production of the subjectivities of individuals appearing on the show.

Theoretical Framework

Feminist and critical perspectives on eating disorders and mental illness more broadly informed our analysis (e.g., Hepworth, 1999; Malson, 1998; Malson & Burns, 2009). Using this lens, we are alerted to the ways in which biomedical discourses and practices may shape experiences of individuals with eating-related concerns. Many post-structuralist feminists have alleged that human (female) body and subjectivity have been controlled through medical and public surveillance (e.g., Gremillion, 2002; Harwood, 2009). This trend can be situated within a long history of surveillance of disability and difference, wherein mental health and illness are categorized along “normal” and “abnormal” lines in pursuit of the “correction” of bodily difference (Davis, 2013; Foucault, 1979; 1994). From this perspective, disciplines such as medicine or psychology are not mere collections of theories and techniques for curing ill, but are political and moral arbiters of health and normality (Foucault, 1994). Individuals whose bodies transcend the norm on either extreme (i.e., through pronounced corpulence or

thinness) are classified according to medical criteria, which render them objects of study and surveillance (Shildrick, 1997). Medical experts may inadvertently facilitate bodily (self) surveillance and regulation of “deviant” bodies (Foucault, 1979), including those of individuals diagnosed with eating disorders.

When health and the proper management of illness are constructed as personal moral responsibilities, individuals embroiled in the tensions inherent to occupying bodies coded as different may turn themselves into objects of self-policing (Foucault, 1994; Harwood, 2009) and act in ways consistent with normative client conduct (e.g., seek help from expert practitioners or “experts” like Dr. Phil). Practices of (self) surveillance and management (Juelskjær, Staunæs, & Ratner, 2013) are implicated in the identification and treatment of eating disorders and the disciplining of bodies through the use of weigh-ins and food diaries in the treatment context (Gremillion, 2002, 2003). The monitoring and surveillance of bodies is also underscored by larger societal discourses of power and control, including “cautionary tales” about the “contagion” of eating disorders via thin ideal internalization (Burke, 2006). These cultural practices may also take up an orientation toward a “recovery” model, suggesting that illness, mental illness, and bodily difference are things to be fixed in order to maintain social order (Foucault, 1979; Shildrick, 1997).

Individuals “with” eating disorders may certainly resist biomedical framings and labels attributed to them (Boughtwood & Halse, 2010). They may construct their subjectivities in ways that contest these dominant cultural constructions and assert that the eating disorder provides, for example, comfort or empowerment rather than distress (e.g., Malson, 1998; Warin, 2010). Arguably, there are multiple ways to frame a person’s embodied experiences. Despite these alternative possible framings of eating and embodiment, eating disorders are conventionally articulated in biomedical discourse according to specific diagnostic criteria and labels as outlined, for example, in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013). This pathologising construction of eating disorders can serve as the basis for seeing “eating disordered patients” as treatment-resistant, uncooperative, or even hostile (Kaplan & Garfinkel, 1999; King & Turner, 2000).

Furthermore, fitness and beauty discourses operate alongside biomedical discourses in shaping cultural ideals of “proper” embodiment and subjectivity. Female and disabled bodies are considered deviant, inferior, and in opposition to “normal” or “proper” embodiment (Shildrick, 1997). Moreover, women have to work hard to position themselves as successful through adhering to feminine, White, middle-class, able-bodied practices of embodiment, including exercise and dieting (Nash, 2011). As a result, women may become alienated from their bodies and struggle to explore and enact “preferred” alternative (to culturally dominant) ways of being. Media sources may rely on and reinforce these stereotypes or dominant constructions of the body and subjectivity (Gill, 2008). Notably, the meanings expressed in televised media come to be mobilized in cultural fora more broadly. Fiske and Hartley (1978) used the term “bardic television” to refer to the ways in which ideas expressed in the mass media come to bear on social relations. Viewers interact with media messages from their specific contexts to create meanings (Nelson, 1986), including around their bodily subjectivities. Dominant ideologies transmitted via media position viewers as cooperative (and at times resistant) members of capitalist systems, which may advance the interests of dominant social groups while marginalizing members of other groups (Fiske & Hartley, 1978).

Feminist, critical, and disability perspectives have been commonly used to unmask and critique social systems and practices that marginalize and stigmatize certain forms of embodiment and subjectivity. Examining the divide between normal and abnormal, as articulated in biomedical and beauty framings of embodiment, offers the opportunity to

problematize taken-for-granted categorizations, which may fail to capture a diversity of experiences (Malson & Burns, 2009). We situate these tensions within a broader framework of socio-historical developments and power differentials circulating in society (e.g., Gremillion, 2002, 2003; Hardin, 2003; Hepworth, 1999), including discourses reproduced through various forms of media.

Method

To analyze interaction on *Dr. Phil*, we used conversation analysis (CA; Hutchby & Wooffitt, 2008; Sidnell & Stivers, 2012; ten Have, 2007) in combination with discursive psychology (DP; Edwards & Potter, 1992; Potter, 2001). DP has become increasingly informed by CA, and thus this analysis reflects elements of both approaches to inquiry. While using the same analytical procedures as CA, DP is distinguishable by a focus on locating discourse in which participants' mental and emotional states become relevant (Potter, 2001). Discursive psychologists assume that people's descriptions of the world are not determined by the objective properties of the world itself (e.g., an expression "she is generous" does not correspond to some stable, inner trait; Potter, 2011; Wood & Kroger, 2000). Rather, faced with a variety of alternative ways to depict the world, people select and negotiate competing descriptions, with such descriptions serving specific social, rhetorical functions in situations of their production. An example of a function could be to bolster one's perspective of what happened or undermine an alternative view. In other words, discursive psychologists treat reports or descriptions (of events, people) as tools used to accomplish certain interactional ends. Similar to work in rhetorical psychology (Antaki, 1994; Billig, 1996), discursive psychologists view all interaction as rhetorical or argumentative and investigate how (i.e., with which discursive practices and devices) people invoke mental phenomena to produce persuasive, authoritative, or factual discourse (Edwards & Potter, 1992). Given that in this study we explore media discourse addressing the mental states and identities of guests on the show, DP is a natural choice.

A range of approaches and perspectives are present within the field of discursive research more broadly (Holstein & Gubrium, 2008). Two competing theoretical camps are commonly mentioned in the literature: CA, with its micro orientation to the details of discourse and critical (Foucault inspired) discourse analysis (CDA) with (often)¹ a macro orientation (Speer, 2001). Each approach is based on a distinct set of assumptions, is guided by different analytical concerns, and leads to a unique set of implications. Micro researchers are interested in *how* people locally orient to, evoke, interpret, and manage contextual factors (Schegloff, 1997). In contrast, macro- researchers argue that if the focus is solely on participants' local orientations to social injustices, such analyses do not help clarify why certain privileges are afforded to certain people, and not to others, in the first place (Wetherell, 1998). Marginalized individuals may also not orient to or recognize social injustices (Frith, 1998). We took a micro approach in this study, given that the vast majority of research in this area is macro oriented. We argue that there is a need for more studies on how culture is locally (re)produced and that clarify the link between situated action/meaning and social structure. Although CDA and CA positions may seem incompatible, offering a critical (macro) reading of the interaction *after* it has been micro-analyzed can supply further

¹ Some CDA scholars (e.g., Baker & Galsinski, 2001) adopt a more micro-oriented perspective, attending not only to the relations of power but also tying those relations to the socio-linguistic details of talk or text. The distinctiveness of a micro/linguistic approaches to CDA and CA/DP lies in the propensity of the former to import into analysis "external" categories (e.g., Halliday's classification of processes featuring in discourse, including mental, existential, behavioral, or material). CA/DP scholars attend to categories (e.g., emotion, cognition, attribution) constructed and used for various purposes *by participants* (Wood & Kroger, 2000).

insight into the studied phenomenon. Analytically, we only secondarily attended to discursive resources and the larger socio-cultural context, though theoretically these concerns profoundly shaped our research agenda.

The setting of the *Dr. Phil* show is unique, as Dr. Phil provides advice in a similar style to a therapy session, while also addressing a studio audience or special guests. Thus, the corpus of data assembled for analysis represents a scripted, stylized, and manufactured version of interaction, rather than “social interaction” per se. Unlike psychotherapy, the interactions between Dr. Phil and his guests are subject to the spectatorship of a live audience. Media programming is often presented as “overheard” by audiences, identified not as passive bystanders but as active contributors to discourse (Heritage, 1985; Tolson, 2006). Accordingly, we took the in-studio audiences’ observable (i.e., hearable, responded to, or prompted by Dr. Phil or guests) contributions into account in this study. The show’s explicit orientation toward the provision of entertainment also differentiates these interactions from more “naturally-occurring” professional encounters. We assumed that the focus on entertainment-provision (i.e., what makes the show appealing to the viewer in the context of modern Western consumerism) also shaped the nature of interactions on the show.

Furthermore, episodes are subject to editing and production prior to airing. Before appearing on the show, guests send a letter of intent or interest to the producers and are subject to pre-screening. Thus, Dr. Phil and the editing team are not encountering guests for the first time when they appear on stage, which likely influences Dr. Phil’s use of language and choice of how to portray guests and their situations. Editing processes may also change the flow of the show, including the use of commercial breaks. Awareness of this edited and produced context informed our analysis, and we acknowledged that these processes shaped the interaction that viewers observe. While acknowledging the potential significance of these background activities, we focused on observable (to us and to viewers) interactions, rather than commenting on unobservable, “behind the scenes” processes of production. There are undoubtedly special features of the material we are discussing; nonetheless, we would not want to overstate this case and suggest that none of the claims we make can be “generalized” to other professional interactional contexts.

We are both White, middle-class, educated women living in Canada. One of us is an immigrant. As middle-class women in a consumerist society, we have been subjected to cultural norms and ideals of femininity and the cycle of overindulgence and self-restraint, including around food. Our choice to examine eating disorder talk on a popular television talk show stemmed primarily from an interest in deconstructing the messages we receive around eating disorders through mainstream media. As a graduate student studying eating disorders and recovery, I (Andrea), encountered many instances in which participants in my research projects drew upon the cultural resources available to them (including, but not limited to, televised media). Participants explicitly mentioned shows like *Dr. Phil* and *Oprah* in their elaborations of seeking themselves in popular culture; often, they expressed that these shows oversimplify the journey of having and recovering from an eating disorder. This sparked a desire to learn more about how eating disorders are represented in popular culture. It is important to note that through conducting this analysis we were not seeking to “discredit” televised representations, including those on *Dr. Phil*. Instead, we were interested in developing a strong understanding of how these messages are conversationally assembled, as they likely come to bear on socially-relevant understandings of what it means to have and to recover from an eating disorder.

My (Olga’s) interest in examining social interaction on *Dr. Phil* fits my broader social justice research agenda wherein I focus on re-examining conventional understandings of psychological distress by considering the broader (and more immediate interactional) context of people’s lives. Although I do not have first-hand experience with eating disorders, as a

psychologist and family therapist I have worked with individuals presenting with eating-related concerns and witnessed how socially distributed biomedical perspectives shape and constrain identity stories by which these individuals live. Stories my clients share tend to be saturated with ideas that present concerns of living as personal shortcomings and overlook cultural pressures and socio-interactive origins of disorders (e.g., as realities co-constructed in the course of a psychological interview). My aim in various domains of my professional and personal life has been to diversify cultural and professional conceptions of subjectivity and distress and open space for new alternatives and possibilities for action and meaning.

Data Selection, Management, and Analysis

We selected the first five episodes, located by performing a *YouTube* search for the terms “Dr. Phil” and “eating disorder,” that focused particularly on eating disorders, rather than touching upon eating disorders peripherally or among other issues. The episodes span a 5-year period (2005-2010), with the most recent aired 3 years prior to analysis. We transcribed these episodes in their entirety, excluding commercial breaks and video segments recording “eating disordered guests” in their home environments interacting with their other family members. These sections were omitted in order to focus analysis on interaction between Dr. Phil and guests *during* the talk show. Though the data corpus was comprised of five episodes, extracts are drawn from two of these episodes, as these extracts most clearly illustrate trends that occurred across the data set. The second set of extracts (3-6) in particular illustrates an extended turn-taking sequence in which guests explore the origins of and “resolutions for” the eating disorder. The general construction of the five episodes was strikingly similar; including an in-depth analysis of extended extracts from two episodes in this article allowed us to provide evidence of the discursive strategies used on *Dr. Phil*.

Detailed transcription offered an opportunity to become more aware of the discursive practices used to construct eating disorders and identities of guests on the show. The first author transcribed all episodes, following orthographic transcription rather than relying on Jeffersonian (CA) transcription (Jefferson, 1984), attending to body language, subtleties of tone, and pauses involved in interactive talk. This choice was made as our interest lay primarily in the “design” and rhetorical effects of responses, and less in the sequential or overall organization of interaction. Following transcription, a broad look at the data allowed us to develop initial reactions to the data (ten Have, 2007) and to identify recurrent discursive practices and devices (e.g., extreme case formulations, metaphors, specific ways of posing questions). Both authors then engaged in a more in-depth analysis of transcripts. In analysis, we identified discursive practices from the discursive psychology literature and focused on how they were employed in this particular context. We used conventional concepts within CA as a guide, including turn-taking organization, overall structural organization, sequence organization, turn construction, focusing in particular on account construction and interactional asymmetries (Heritage, 2004; ten Have, 2007). By continuously identifying, analyzing, and comparing specific examples, we refined the list of discursive practices, which we then illustrated using specific extracts.

Results

In this section, we outline discursive practices used to construct guests’ identities and experiences, including formulating or describing actions as extreme (Pomerantz, 1986), metaphors (e.g., Antaki, 2007; Brooks, 2009), and quoting (e.g., Clark & Gerrig, 1990). In Extract 1, Dr. Phil sits on stage with a guest and her family sits in the audience. In this extract

and those to follow, DP refers to Dr. Phil, G to guest, M to mother, F to father and S to sister. Italics denote verbal emphasis.

Extract 1 (“Desperate Diets”; 13:54-14:47)

1. DP: Would it be even an approximation of what you were feeling that
2. night to say that you looked at that orange juice, for example the same
3. as any of us would if we knew somebody was bringing us a deadly
4. poison and were backing us up against a wall and saying drink this it
5. will eat away at your insides and destroy who you are but drink it
6. anyway, take it, take it take it.
7. G: Exactly. Exactly. And it used to be right at that point too that if
8. mom and dad were cooking in the kitchen and I knew that my food
9. was being prepared there I would just freak out I would be convinced
10. that they were poisoning with fat – and it was poisoning with fat was
11. the phrase I would use, so much the same.
12. DP: So it’s like a poison that would take away your life.
13. G: Yep.

Dr. Phil begins by positioning the guest as the expert on her own experience by presenting himself as uncertain about the accuracy of his understanding of how she may feel (line 1). He proceeds to offer metaphoric comparisons (comparing food to poison) to display his understanding of or alignment with her perspective and presents her resistance to eating as morally justifiable and reasonable, given her subjective perspective on food. The guest enthusiastically takes up his formulation of her experience in line 7, demonstrating strong agreement. She endorses his metaphoric depiction of her experience and contextualizes it with a personal example (line 11). It may appear that Dr. Phil privileges or centers the guest’s lived experience in this stretch of talk. However, it can also be noted that by comparing food to poison he implicitly proposes that the guest’s perspectives and experiences are too extreme or abnormal; the guest is constructed as seeing food as a “normal” person would see a poison. Thus, while validating the guest’s experience, Dr. Phil also pathologizes it. This is accomplished without the explicit use of psychiatric or medical terminology (ill or disorder) but through the use of “lay” vocabulary and imagery. Dr. Phil “finds” abnormality in the guest’s lived experience, which he narrates on her behalf using lay terms, rather than presenting it as coming from him and as based on his professional expertise and experience. It is possible that by rhetorically “removing” himself from the evaluation, Dr. Phil manages the issues of stake and interest. The eating disorder is constructed as a fact, an actual aspect of the guest’s experience, rather than as a product of his imagination or bias. Not actually naming the guest’s abnormality may also enhance the likelihood that the guest will endorse Dr. Phil’s potentially face-threatening proposal that she is “disordered.” The use of the “deadly poison” metaphor also helps to construct a compelling narrative for an audience, supported by its observable response (rapt attention). This is consistent with prior literature attesting to the importance of message construction for the overhearing audience; the primary audience of Dr. Phil’s message may be the show’s viewer rather than the guest (Crow, 1986). In the following excerpt, Dr. Phil responds to the guest’s assertion that nobody is able to understand her experiences around food.

Extract 2 (“Desperate Diets,” 15:02-15:32)

1. DP: Is it possible that, that there are people in the world who understand?

2. G: I think there's definitely, I should give people more credit there would
3. be some people who would understand –
4. DP: (Talking over her) and I'm not saying everybody, 'cause a lot of
5. people look at it and say, you know, (different voice used) you know shut
6. up and eat you know – get a life, you know.
7. G: Yeah, yeah and that's what I get a lot.
8. DP: You know, get a life, you self-consumed, superficial girl, get a life
9. (back to normal voice). Isn't there a part of your brain that logically says I
10. know this isn't right, I know this isn't healthy.
11. G: Yes.
12. DP: But I don't know how to get out of it.
13. G: Exactly right.

Dr. Phil's proposition (lines 8-10) concerning the guest's eating tendencies being morally questionable ("this isn't right") is preempted by an exchange topically dealing with how unspecified others view and respond to the guest's eating. We would argue that inserting (e.g., through verbal and para-verbal contrast and quoting) this piece allows Dr. Phil to bolster his point against undermining or dismissal from the guest. He presents himself as someone who understands and empathizes with the guest, unlike the unspecified others he and the guest have described. Arguably, the challenge is more likely to be entertained and accepted by the guest if it comes from someone who genuinely understands and respects her self-determination.

Focusing on the structure of Dr. Phil's conversational turn, we observe a polar (yes/no) question-response sequence of action (lines 1-4; Raymond, 2010). Polar questions can be a powerful tool to control interaction by imposing presuppositions (that have not been previously confirmed by recipients) and by eliciting particular types of answers (yes or no; see Hayano, 2013). Here, the use of a polar question ("isn't there a part," line 9) constrains the guest to a yes or no answer (preferably yes; Raymond, 2003), which she provides in line 11. Metaphors and reported speech (quoting) continue to form a key part of Dr. Phil's formulation of the guest's identity and actions. Here, we observe the construction of agency and moral accountability. The guest is depicted not as unwilling but as unable to stop eating abnormally and, therefore, not accountable for her prior failure to do so. She is first invited to recognize that her eating "isn't right" or is unreasonable (lines 8-10) and is then presented as lacking agency or capacity to change her problematic eating tendencies (lines 12-13). The discursive practices identified in this extract (specific ways of formulating questions, quoting, contrast) also feature in excerpts 3-6, taken from one episode. In the extract below, Dr. Phil is talking to a guest about her family interactions and relationships.

Extract 3 ("Dying to be Thin," 12:13-13:01)

1. DP: You manipulate these people, right?
2. G: Not purposefully.
3. DP: Alright well that wasn't the question. Do you manipulate these people?
4. G: I guess, yeah.
5. DP: Do you bully these people?
6. G: (Looking from side to side) No.
7. S: We know you don't mean to.
8. DP: (addressing sister) no, don't make excus- (addressing guest) listen,
9. we're going to start to – this is – here's the difference, you need to look at
10. me here 'cause if, if you want to stay with this disease, and I know there's

11. a part of you that wants to just be left alone, just you and your disease,
12. leave you alone to do what you want to do, true? That's what a big part of
13. you wants and we're going to have to call a spade a spade and if what you
14. want is to stay alone with your disease, I am your worst nightmare. You
15. bully these people, do you not?
16. G: N-

In line 1, Dr. Phil issues a yes/no declarative with a tag, eliciting confirmation from the guest (Raymond, 2010). The yes/no declarative presents the matter of the guest's manipulation of her family as an established fact and discourages sharing of her perspective on the issue. The guest offers a qualified confirmation accounting for her actions (line 2). Dr. Phil problematizes this "weak" uptake of his idea, modifying his prior yes/no declarative into a yes/no interrogative, attempting anew to elicit a more solid uptake from the guest, this time seeking an agreement with his claim. Whereas yes/no declaratives tend to seek confirmation and discourage elaboration, yes/no interrogatives elicit "yes" + elaboration responses, encouraging the guest to demonstrate her agreement by "unpacking" and exemplifying it (Raymond, 2010). Despite these conversational constraints, the guest manages to resist Dr. Phil's propositions. She produces a type-conforming (yes or no) response, yet fails to elaborate or solidly uptake his assertion that she manipulates and bullies her family (lines 5-7).

The guest's sister aligns with Dr. Phil's point (note her use of the pronoun *we*, marking collectivity; Lerner, 1993) implicitly proposing that the guest is manipulating her family (line 7). Dr. Phil briefly addresses the sister and then turns back to the guest, reasserting his claim. He uses a metaphoric expression (lines 10-14), constructing the eating disorder as external to the guest and the guest as in a relationship with the disorder. In so doing, Dr. Phil uses a compartmentalized description of the guest's experience (one part of her is described as having formed a coalition with the eating disorder). The guest is constructed as responsible for her eating disorder and for contributing to problematic family dynamics, yet Dr. Phil keeps accountable only the "part" of the guest that is colluding with the eating disorder. Again, the guest may be more inclined to endorse this partial, diversified, or complex construction of her selfhood and responsibility that preserves an aspect of her that is not eating disordered or accountable for her and her family's troubles. Absent but implicit in his talk is the proposition concerning the existence of the other, more reasonable part of the guest who is confronted to recognize and admit that the "disordered" part of her is at fault. By the end of the excerpt, Dr. Phil poses another interrogative with a tag, with which the guest begins to disagree before being interrupted by Dr. Phil who proposes a shift to another addressee (line 16). Overall, his attempt to get the guest on board with his argument has been unsuccessful, despite his persuasive efforts.

At this point, Dr. Phil turns his attention to the guest's mother (subsequent extracts denote the continued interaction between Dr. Phil and the family).

Extract 4 ("Dying to be Thin," 13:02-14:43)

17. DP: Does she bully you? Be honest here (mother gasps and sighs) and
18. listen you've got a problem with enabling this girl, right?
19. M: I ha- I feel I have a problem with it but I don't know if it's enabling or
20. if it's I don't love her enough or
21. DP: Well
22. M: I don't know where the boundaries are
23. DP: Well, we're going to, we're going to clear that up. You said, and I

24. quote: “I enable her because I let her eat knowing she will purge. I quit my
 25. job to take care of her full time. I try to accommodate her because I’m afraid
 26. I’m going to lose her. I don’t leave the house, she will call.” You’re held
 27. prisoner, right?
 28. M: I am held prisoner
 29. DP: You, y- you threaten to leave with her if your husband kicked her out,
 30. true?
 31. M: Very true.
 32. DP: Do you enable her?
 33. M: Yes, I enable her.
 34. DP: You can’t change what you don’t acknowledge.
 35. M: I know.
 36. DP: (addresses the father) It’s like here’s what it’s like [Dr. Phil], it’s like
 37. we’re all lost in the forest. We have no idea which way to go, what to do.
 38. And we say okay gather round who’s the most lost, disoriented, confused
 39. person here. And [the guest] raises her hand and you go okay, we’ll follow
 40. you. We’ll follow you. We’ll let you decide what the schedule’s gonna be,
 41. we’ll let you decide what we’re gonna eat, we’ll let you decide the
 42. emotional environment, we’ll let you decide what the logic is gonna be,
 43. we’ll let you decide who makes the decisions. Now. How does that make
 44. sense?
 45. F: (Laughing) perfect sense. I mean, not perfect sense, I mean, that’s our
 46. life.
 47. M: (Talking at the same time as F) You’ve reduced it down that’s our I –
 48. thank you
 49. F: Sorry that’s exactly.

Dr. Phil addresses the guest’s mother and attributes blame to her by suggesting that she is contributing to her daughter’s disordered eating. The mother’s “enabling” of the daughter is presented as problematic and as a current tendency rather than a singular occurrence (note the continuous verb tense; Edwards, 1995). Using a yes/no declarative with a tag, he elicits confirmation from the mother regarding the accuracy of his proposition (lines 17-18). Dr. Phil refers to the daughter as “this girl” (line 18), rather than “your daughter,” potentially making it easier for the mother to endorse arguments that present her daughter in a negative light. The mother accepts the blame, but expresses uncertainty regarding the precise nature of her unhelpful contributions. Dr. Phil proceeds to quote the mother (lines 24-26), finding examples or evidence of the mother’s enabling in her prior words. Listing of instances of enabling may allow him to present his argument as well-substantiated.

The momentum of agreement continues as Dr. Phil uses a series of questions and statements with which the mother agrees or which she confirms (lines 29-35) using strong imagery and figurative language to further strengthen his case. The metaphor “lost in the forest” may be a way to challenge the idea that organizing family life around the eating disorder is a reasonable choice. Metaphoric depictions of the family’s situation (at a more general level void of specifics) may be harder to take apart and refute (Antaki, 2007). The collective *we* pronoun constructs Dr. Phil as someone who is on the family’s side (Lerner, 1993). These practices may be used to build the case for the problematic nature of the family’s responses to the daughter and to attribute fault to them. Overall, Dr. Phil proposes that the eating disorder is rooted in systemic or family dynamics. Both the guest and the family are co-constructed as contributing to and responsible for the guest’s eating disorder. Although the father enthusiastically accepts this version of the problem (lines 45-49), the

mother's endorsements of Dr. Phil's assertions are brief and mirror his talk. We see no signs of her more solidly taking up his ideas (e.g., elaborating or exemplifying them).

Extract 5 begins with a question from the mother that indicates her uptake of the idea that the family is implicated in the guest's eating disorder (line 50).

Extract 5 ("Dying to be Thin," 14:44-15:09)

50. M: How did we do that? How did we let that happen?
 51. DP: How did you do that? I'll tell you exactly how you did it – you are
 52. loving, dedicated, devoted, well-intended parents who are in so far over
 53. your head that all you know how to do is nurture. You're not to blame for
 54. this; you didn't cause it. You – people say where does this come from.
 55. Some people think there's a genetic component, some people think it's
 56. associated with depression and low self-esteem, stress and trauma events at
 57. different points in their lives, there's all kinds of reasons that contribute to
 58. it. We're way past that –
 59. S: Right.

In this and next stretch of talk, Dr. Phil positions himself and is positioned as having superior knowledge and right to determine what to focus on when discussing the family's situation. The mother defers to his expertise in line 50. He also proposes that the task of identifying the origins of the problem, proposed by the mother in line 50, is irrelevant, thus marking his superior epistemic status. In lines 51-58, Dr. Phil's reinforces the construction of the problem as rooted in systemic dynamics while saving the parents' face by presenting them as caring individuals; it may be easier for the parents to accept that they are engaging in problematic behaviors if their identity as caring parents is preserved.

Having presented the family as accountable for the daughter's disorder, Dr. Phil returns to addressing the guest, attempting once again to solicit her agreement with his claim that she contributes to the problem; she manipulates her family and they submit to and enable her.

Extract 6 ("Dying to be Thin," 15:10-17:03)

60. DP: that's a theoretical discussion what we wanna know was what do you
 61. do now, as a family to help her. (Addressing the guest) What do you want to
 62. do? Do you want to get better?
 63. G: Yes, I – more than anything (pause) more than anything I just want to be
 64. happy again and I really don't try to manipulate – that's not my whole intent
 65. I don't.
 66. M: You do.
 67. G: I – I – I don't try to
 68. M: I know, I know, but you do.
 69. DP: (Talking over the mother) don't try to what
 70. G: Manipulate 'n bully
 71. M: But what well look at what John, I mean John and they can't even have
 72. friends over. I mean and you're aware of that too though.
 73. G: I don't live there though mom, I've only been home for about a month?
 74. M: (Sniffs and nods) you don't mean we know you don't mean to but it
 75. does, it consumes everything.
 76. DP: You throw chairs. You've been arrested for shoplifting. Do you hoard

77. food?
 78. G: (Sniff) yes
 79. DP: From the rest of the family?
 80. G: (Quietly) yes
 81. DP: (Talking over the guest) be honest, you've gotta be honest
 82. G: (Louder) yes
 83. M: Yeah
 84. DP: Were you hoarding food today in this building upstairs?
 85. G: No I just didn't eat my breakfast
 86. DP: You were gathering muffins up and down the hall
 87. M: (Laughing) you were
 88. S: It's not, it's not funny, we're laughing but it's not funny.
 89. DP: NO! I mean it, it, it, it is what it is, and you have to be willing to be
 90. honest here. You are a bully, you do manipulate, you do hoard food, you do
 91. practice emotional extortion, you do hold these people hostage. That can't
 92. go on. It can't go on with you guys. Alright, we've gotta take a break here.
 93. [The sister] once idolized her big sister but now she says they don't even
 94. have a relationship, uh, she says her family would be better off without her
 95. in the house. It hurts her to say that, but she says she doesn't even have a
 96. sister anymore; she just has an eating disorder in the room down the hall.
 97. We'll be right back.

Dr. Phil transforms his open-ended “what” question, eliciting the guest’s preference for how to proceed, into a yes/no question, seeking her agreement with his agenda, namely her improvement and recovery (lines 60-62). The guest’s unequivocal agreement is accompanied by an account that acknowledges manipulation while justifying it (lines 63-65). An extended accusation-defense sequence follows (lines 67-97). The guest is constructed as mentally unstable or ill through

- a) *scripting*, presenting her actions as recurrent or as instances of a repeated pattern and
- b) *listing* actions that the audience would likely find extreme, pervasive, and socially inappropriate (e.g., throwing chairs, shoplifting, hoarding food).

Dr. Phil concludes by formulating or summarizing the problem (lines 89-92). Using verbs in the present tense (e.g., “you *do* manipulate”) allows him to once again script the guest as routinely engaging in problematic actions. Placing emphasis on the word “do” may be seen as a way for him to present his observations as facts and to defend himself against the guest’s potential refusal to accept responsibility attributed to her. Dr. Phil then abruptly introduces the topic closure, which he explains as being due to the need for a commercial break, not giving the guest a chance to respond to his blame-attributing turn (line 92).

To summarize, we have identified and described the use of a range of discursive practices involved in the construction of eating disorders and subjectivities of those who “have” them. These include listing, quotations, metaphoric expressions, specific ways of formulating questions, unilateral decision to shift or determine a topic, and various scripting devices, to name a few. We showed how these practices were used to present certain perspectives as factual and to manage issues of moral accountability (i.e., attribute blame, defend against it). We found through our analysis that guests’ eating was constructed as abnormal, while they (and their families) were described as ultimately responsible for “their” pathology.

Discussion

In this study, we analyzed a popular television show, *Dr. Phil*, to explore the discursive construction of the show's guests' actions and dispositions ("selves"). We have shown how the guests' identities and eating were predominantly constituted in pathologising ways (as extreme, wrong, or abnormal). Dr. Phil recurrently directed the guests and their families to publicly admit to (i.e., accept blame for) thinking and acting in morally and logically questionable ways. The guests' attempts to justify or account for their choices and actions were repeatedly disrupted. We argue that pathologising constructions and attributions of moral accountability for the guests' problematic eating served to establish and reinforce Dr. Phil's superior institutional status of a mental health expert, enhancing the show's entertainment value. *Dr. Phil* provides a unique and interesting context wherein Dr. Phil routinely "solves the puzzle" of the issue that brought a guest to the show, in this case the eating disorder.

Unlike in everyday talk, where addressees are treated as "owners" of their own experience and as in a superior position to describe and assess such experience (Peryäkylä & Silverman, 1991; Raymond & Heritage, 2006), Dr. Phil recurrently positions himself (and is positioned as) an expert on his guests' subjectivity; he surveils and encourages self-surveillance of deviant bodies. Dr. Phil informs his guests about their emotions, thoughts, and motivations and treats them as unwilling or unable to recognize the "reality" of their experience as he presents it; his bias or stake is rhetorically removed in the process. Guests' impressions are managed not by themselves, but rather by an external "expert," who controls the degree to which they are able to pass in society as "mentally sound" or "normal" individuals. In a sense, through the communication of his "superior" knowledge of the guests' experiences, Dr. Phil is positioned as wise to their condition, and thus able to speak with some epistemic superiority (Goffman, 1963). Like Garfinkel's (1956) concept of the "degradation ceremony," Dr. Phil operates as "denouncer" for the eating disordered guest, bringing her stigmatized identity to the fore. Dr. Phil performs this action in a public setting, airing the "ceremony" to a social collective able to receive ("bear witness to") the transformation of the guest's identity into one that is total; the individual is wholly subsumed by her eating disorder (Ryan, Malson, Clarke, Anderson, & Kohn, 2006; Malson, Bailey, Clarke, Treasure, Anderson, & Kohn, 2011).

This witness denunciation and calling out of the guest's stigma is a major part of the premise of the show, and perhaps why it is so popular. The audience witnesses Dr. Phil's "masterful" pursuit of the solution to his guest's problem. He seeks to solve the puzzle of how to account for an eating disorder and what the family and the guest must do or change in order to escape what he constructs as an abnormal, extreme, and maladaptive pattern of thinking, behavior, and interaction. In the extracts we examined, he implicitly proposes that all parties are to blame for the problem and that the acknowledgement of blame is an important step in overcoming the problem. This denunciation is made successful by placing guests on the studio's stage, taking them out of the ordinary, making them accountable for their actions, and contrasting them to some dialectical counterpoint (Garfinkel, 1956), in this case, those who are "normal" around food. Dr. Phil, serving as denouncer, draws upon his "communally entertained and verified experience" (Garfinkel, 1956, p. 423) to call out the elements of the guest's (and family's) behaviors that do not fit within socially-prescribed norms for food and eating and enlists the agreement of the guests themselves.

Juulskjær et al. (2013) explored the concept of self-management in the context of education, suggesting that self-management concerns self-reflection and the desire to change. To promote management of the self, different methods can be used, including methods from psy-sciences, such as psychology and psychiatry (Foucault, 1994). Self-management can thus

be conducted “from the outside”: this control over self-management has an affective dimension, given that it deals with people’s intensions, wishes, and desires. As Juelskjær et al. (2013) argue, “managing self-management is a passionate affair; it is affectivized and when it includes methods from the psy-sciences, we speak of psy-management of self-management” (p. 1134). Our analysis illustrates how guests’ self-management was constructed in the context of the show, with the primary method being *attribution/acceptance of blame* for problematic actions and dispositions (expressed in psy-terms as “gaining insight into the self”). For example, in extracts 3-6, the guest admits to manipulating her family (extract 3, line 4) and hoarding food (extract 6, line 85/87) and the mother gains insight into having a problem with enabling her daughter (extract 4, lines 22 & 33). Although change of the self/family is expressed as relevant in the extracts we examined (e.g., extract 6, lines 60-63), no explicit and concrete directions for change are introduced, other than Dr. Phil asserting “that [i.e., problematic actions and dynamics] can’t go on” (lines 91-92).

The construction of eating disorders in particular agrees with prior research on media representations of disordered eating, which commonly reveal the tendency for media accounts to reinforce the differences between “normal” and “abnormal” eating and promote stigmatization and marginalization of individuals distinguished as “eating disordered” (e.g., Hardin, 2003; O’Hara & Clegg-Smith, 2007; Shepherd & Seale, 2010; Warin, 2010). Individuals with eating disorders may be constituted as entirely pathologized subjects whose efforts at resistance are challenged or interpreted as symptoms of disorder (e.g., Malson et al., 2004; Rich, 2006; Ryan, et al., 2009). While critical studies of media representations of mental illness are valuable, these approaches have primarily attended to larger socio-cultural dynamics, and have focused less on the micro-details of talk that are deployed in interaction to construct these dynamics. Some examples include the analysis of power relations between treatment teams and eating disorder patients (Malson et al., 2004) or between members of the general public on the topic of eating disorders (Bienveniste, Lecouteur, & Hepworth, 1999).

We similarly approached discourse using a critical/feminist lens, attending to the socio-historical construction of mental illness and the surveillance of bodies (e.g., Foucault, 1994). At the same time, we gave priority to the ways in which dominant and subjugated knowledges and practices are (re)produced through interaction. The construction of Dr. Phil as expert expands upon prior explorations of the surveillance and monitoring of bodies, particularly “disordered” and medicalized bodies (e.g., Ferreday, 2012; Foucault, 1994; Spitzack, 1993). The medical gaze on the “eating disordered” individual is replicated through this formulation, as Dr. Phil works up and responds to the “problem” of the eating disorder.

The show can be construed as a product to be consumed or purchased. Which aspects of the show would make it appealing or marketable to the viewer? It is possible that Dr. Phil’s overtly confrontational and argumentative style of responding, likely found inappropriate in many other conversational contexts, can help create an entertaining and compelling show. Moreover, efficient “finding” of the solution to the guests’ complicated situation by Dr. Phil may also be a way to enhance the show’s appeal to the audience, reaffirming Dr. Phil’s expert status. Dr. Phil as expert speaks to broader cultural ideas around the owning of expertise, positioning the “eating disordered guest” as deviant and no longer able to pass as “normal” (Goffman, 1963). The audience would then be able to respond to this reconstruction of a dominant cultural narrative around the owning of experience and interpret this portrayal as representative of the cultural abnormalizing of particular behaviors coded as eating disordered.

Implications

The primary consumers of this study are academics across various disciplines, specifically in applied (clinical and counseling) psychology. Discursive and social constructionist research has been only marginally conducted within psychology. Psychologists employing more conventional perspectives and forms of inquiry may benefit from the exposure to fine-grained analyses of discourse in order to expand their awareness of the constructive role of discourse/language. Such de-constructive, discursive efforts, we believe, are important in order to open up space for alternative framings of human subjectivity, both within and outside of academia. In particular, we challenged the realist notion that Dr. Phil's ideas comprise straightforward representations of the guests' behavioral and personality dispositions. Rather than locating eating "pathology" within people, we showed how it was produced as "real" or factual using language.

In the study, we problematize not only medicalized and individualistic understandings of people's eating and identity, but also representations that constitute and foster the spectatorship of illness and difference. Discussions of eating disorders are often placed in entertainment sections of news media (O'Hara & Clegg-Smith, 2007; Shepherd & Seale, 2010), and individuals "with" eating disorders might be offered up as "carnavalesque" or "contagious" spectacles for the gaze (e.g., Bray, 1996; Burke, 2006; Warin, 2010). Our study helps to enrich understanding of the potentially problematic "entertainment" framing of eating disorders by highlighting the details involved in the construction of eating disorders *for the audience*. This might be particularly problematic on a show like *Dr. Phil*. Although the entertainment orientation is acknowledged in the show's marketing materials, it tends to be concealed through interaction between Dr. Phil and his guests, which resemble a professional therapeutic encounter, making Dr. Phil's advice seem like actual recommendations from a mental health expert.

Unlike other sources of media, here there is a paradoxical therapy/entertainment (real/fictional) bifurcation that makes this media context unique and particularly interesting to study as a site of power dynamics. Dr. Phil is presented as diagnosing and treating the guests, without formally carrying out these activities. Psy-technology is used to construct expertise and subjugation of alternative, non-psy perspectives, with these processes being obscured (arguably even more than in actual therapy) by the entertainment orientation of the show and presence of the audience. This could lead viewers to believe that Dr. Phil is knowledgeable about eating disorders and so "trust" this simplistic, pathologising version of eating disorders. Future researchers might look at the impacts of such a framing of eating disorders on how audience members come to understand eating disorders and perceive individuals who "have" them. There is also an opportunity to examine how Dr. Phil or other popular shows' hosts interact with individuals with various concerns of living (e.g., depression, addictions, anxiety) and identify practices that are context-specific and shared across various contexts.

The study helps build connections between micro-discursive practices we have identified and macro-discursive initiatives. For example, extreme case formulations are commonly used to highlight the abnormality and severity of eating disorders. This, in turn, can be mapped onto macro-discourse analyses highlighting the abnormalizing of disordered eating behaviours (e.g., Bray, 1996; Burke, 2006; Ferreday, 2012; Warin, 2010). Micro studies like this could be linked to scholarly outcomes of macro studies and vice versa to strengthen and corroborate claims about the construction of eating disordered subjectivity and to broaden the applicability of conclusions across diverse settings.

Although we cannot directly extrapolate the results to the therapeutic setting, given the highly stylized nature of the show, these are still important considerations. This analysis may help mental health practitioners expand their awareness of how to converse with clients.

For example, they may become more mindful of the potentially constraining nature of polar questions. In a therapeutic setting, such questions may close off resistance initiatives on the part of clients and obscure more complex or differing understandings of eating disorders that clients may express. Taking a more collaborative approach to work with clients that places them in a more “expert” role could potentially help foster diversity of perspectives and ways of being in and outside of therapy. Therapists may further take into account that clients might watch Dr. Phil and this could influence their orientation toward therapists and seeking therapy. Moreover, practitioners need to be ready to address ideas clients adopt from viewing the show (e.g., regarding their own subjectivity). Studies like these help identify these ideas and how they are advanced in the context of a television show.

Limitations

Despite its potential usefulness, the study is limited in a number of ways. Firstly, the analysis hinges on five episodes of Dr. Phil dealing specifically with eating disorders, spanning the course of 5 years; extracts from two of these episodes have been presented to illustrate our analysis. It is possible that changing social and historical contexts may have impacted the way in which eating disorders are presented on the show. Secondly, due to the uniqueness of the television talk show context discussed above, it is possible that results may not “generalize” to other media contexts; however, we are able to draw links between our results and prior examinations of the discursive production of eating disorders. Future researchers might investigate the formulations of individuals with eating disorders and their family members in other social and institutional contexts, for example, in the context of family therapy.

Given that health and eating disorders are historically situated, raced, sexed, and classed (e.g., Hepworth, 1999; Malson, 1998), it would also be important to examine social constructs and their intersections, other than the institutional roles examined in this study. In our analysis, we attended mainly to Dr. Phil’s and guests’ institutional positions (as “expert” and “patients”) and did not comment on gender, race, class, and other aspects of social location. In the future, researchers could explore these various intersecting elements of the participants’ positioning. Finally, our analysis reflects an interpretation of the “finished product” seen by audiences, an assembled text, and thus carries significance in terms of conclusions television viewers may draw. It may be useful to analyze and compare edited versions with live versions.

Conclusion

The dominant discourses of embodiment (e.g., as thin, fit) and health (e.g., as a personal responsibility, within one’s control, normal/abnormal) may negatively impact individuals and families as they struggle to reconcile such discourses with their unique embodied experiences and external factors (e.g., growing up in a culture that objectifies). We have presented one example of a mediatized representation of eating disorders where a cultural figure is positioned as “expert” in a way that suggests he “owns” participants’ experiences. Representations playing out on the screen come to hold currency in social fora as they are interpreted and negotiated by audiences (Fiske & Hartley, 1978). The imperative to “fix” the abnormality of the eating disorder, to repair the stigma of an abnormal mind (Goffman, 1963) is carried out through calls for accountability for the irrational actions of the guests onscreen.

It is important to continue exploring how individuals and others in their lives *socially* construct selfhood and experience. While such constructions may emphasize personal

responsibility and control over health/body, they may also contradict, challenge, and modify such dominant understandings and their cultural significance. Further research considering the micro-details of talk and how these articulations come to assemble cultural imperatives for health and embodiment will help to flesh out understandings of how personal responsibility is socially attributed. It is from these positions, as they are embodied and played out socially, that disruption of dominant discourses become possible. Drawing again on Garfinkel, understanding the qualities of a successful “degradation ceremony” helps us to understand “how to render denunciation useless” (1956, p. 424). By acknowledging the discursive moves used on the Dr. Phil show to construct blame around the “eating disordered guest,” for example, we can come to entertain the idea of interacting differently, in ways that acknowledge the embodied, lived experiences of individuals with eating disorders rather than calling them out for their “abnormality.”

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