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If you can't eat what you like, like what you can: how children with coeliac disease and their families construct dietary restrictions as a matter of choice

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Abstract Although it is recognised that a gluten-free diet has many social implications for coeliac disease patients, not much is known about how such patients actually manage these implications in their everyday interactions. This article examines how dietary restrictions are treated by patients and their families. Data from recorded mealtime conversations of seven Dutch families with children suffering from coeliac disease were analysed using discursive psychology. We found two main discursive strategies by which patients and their families manage the diet during mealtime interactions. A reference to pleasure is used to manage the tension between the child's agency and parental responsibility in the face of health requirements and, by softening the denial of food, the diet is normalised and treated as a shared family practice. The analysis shows that the gluten-free diet is demedicalised and treated as a matter of choice rather than prescription. We conclude with the practical implications of these findings.

Keywords: discursive psychology, coeliac disease, family mealtime, discourse analysis, experience of illness

Introduction

Coeliac disease (CD), an autoimmune disorder of the small intestine, is estimated to affect about one per cent of all Indo-European populations. Currently, a lifelong gluten-free diet is the only way to avoid the occurrence of symptoms, which include chronic diarrhoea, failure to thrive, fatigue and mal-absorption of nutrients. Studies show that CD affects adult patients not only physically, but also socially and psychologically (Ciacci *et al.* 2002, Hallert *et al.* 2002) and affects children with CD in the same way (Nijholt 2006). Even the CD medical diagnosis may be highly charged with conflict (Copelton and Valle 2009). CD also has an impact on patients' social environment. In the case of children with CD, it is mostly the parents who are responsible for preparing food in a safe way and avoiding gluten contamination in setting the table and washing up (Svenker *et al.* 2007).

Currently, research on CD is beginning to produce new prevention, treatment and diagnostic tools that could have an impact on the quality of life of CD patients. For these innovative efforts to be successful, they will need to take into account the context into which they will be introduced, that is, the everyday life of patients (Veen *et al.* 2010a, 2010b). For example, a lack of sensitivity to the practices CD patients have already established to deal with their condition can lead to miscommunication about innovations (Veen *et al.* 2010a, 2010b).

To understand the needs and wants of patients who are restricted to a medically imposed diet, it is crucial to use the terms that they are using rather than categories conjured up by researchers. This allows research findings to better reflect the actual practices of patients. Earlier studies show that relaxing dietary restrictions is sometimes beneficial for patients (see for instance Maclean 1991), although it may cause identity troubles. Patients are faced with the difficulties of resisting a 'spoiled identity' (Broom and Whittaker 2004) and tend to attribute lapses to external circumstances so as to maintain the identity of a faithful diet follower. They also negotiate the tension between being normal and being ill and try to preserve a sense of normality despite disruptions in their routine due to their dietary requirements (Gregory 2005). Overall, these studies show the challenge of living with dietary restrictions and the diversity of practices invented to cope with this challenge.

Little attention has been paid, however, to dietary routine as a profound social practice. There are studies that show that factors such as moral conflicts (Balfe 2005), family context and professional support (Maclean 1991) have an influence on health-related dietary practice but they still treat the diet as an essentially individual accomplishment. Other research recognises the significance of the discursive and interactional dimensions of disease-related dieting (Gregory 2005, Lawton *et al.* 2008, Peel *et al.* 2005) but these studies do not ground their analyses in actual interactions between patients and others in everyday life. This study aims to fill this gap by looking at how dietary talk performs discursive work of various kinds in the real-life context of its production.

Gregory (2005) found that practices relating to dietary management were seen by all family members as a shared family practice rather than an individual responsibility. She identifies family as important not only as the location where much of everyday life takes place but also for its constitutive role in constructing how one deals with disruptive events such as being diagnosed with a chronic illness. This is not a once-off event but an ongoing 'process of normalising family practices which are construed as predictable and stable, whilst encompassing change and uncertainty' (Gregory 2005: 389, see also Hall *et al.* 2005).

By analysing dinner conversations between CD patients and their close relatives, we hope to gain more insight into how people deal with dietary restrictions on an ongoing basis in their everyday life. In addition, our aim is to add to the body of research on mealtime interactions, first of all, by showing how medically imposed restrictions affect these interactions and, secondly, showing additional ways in which food assessments can be an integral part of other social practices.

A discursive psychological approach to family mealtimes

Focusing on families dealing with chronic illnesses, Gregory (2005: 376) highlights the privileged role of language at mealtimes: 'Within families the language of food and eating derives its strength through the repetition of the routine and the expected'. Previous studies of family mealtimes, not related to disease and diet, have already provided valuable insight into the pivotal role of talk in the organisation of eating practices. Mealtime conversations were also found to be ways of socialising children into culturally specific ways of talking (Aukrust and Snow, 1998). Other studies have used discursive psychology as an analytic

perspective to study mealtime conversations (Hepburn and Wiggins 2005, Wiggins 2002, 2004a, 2004b, Wiggins *et al.* 2001, Wiggins and Hepburn 2007, Wiggins and Potter 2003). Food assessments, for instance, were found to perform social practices besides evaluating food, such as bringing disagreements to a close (Mondada 2009). Discursive psychology, an approach developed in the 1990s by Derek Edwards and Jonathan Potter (1992, see also Edwards 1997, Potter 1996, Edwards and Potter 2005), examines how talk is used to perform actions, such as constructing one's identity, negotiating the rights to assess situations and claiming or denying responsibility for (descriptions of) actions and events.

Discursive studies on mealtime talk reveal that families often negotiate categories that are usually regarded as individual bodily experiences (Wiggins *et al.* 2001). Wiggins and Hepburn (2007) have shown how parents continuously manage the tension between the child's primary rights to make assessments about their own physiological condition, such as being full and being hungry, or whether the food tastes good or not, and their responsibility for the wellbeing of the child. Parents construct these internal states as observable through external sources, thus allowing them to make assessments about it. Seemingly private issues such as the food's tastiness and appropriate quantity appear part of a web of interactional concerns.

In analysing family mealtime conversations including child CD patients, we examine whether and how parents manage the tension between the child's primary rights to assess the food and their concern for the child's wellbeing, in relation to offering gluten-free food and withholding food that contains gluten. In a situation where food choice is limited and eating food (just) because one likes it is more unlikely, this tension seems even more acute. Although a comparison between 'healthy' families and families dealing with CD is not the first aim of this article, we will point out noticeable differences where this improves our understanding of the interactional patterns distinguished.

As mentioned before, this research takes place in the context of emerging medical innovations in the field of CD research, such as, for instance, diagnostic tools and gluten-safe wheat species. By using discursive psychology to analyse families' mealtime conversations, we hope to give CD researchers a better insight into the way patients and their families currently cope with their condition, so that these innovations can be better integrated into the current practices of CD patients¹ and researchers can communicate about them more effectively.

Data

To account for dietary management in children, the role of parental concern for the child's health and the impact of the diet on family stress need to be taken into account (Dunn-Galvin *et al.* 2008). We have chosen to focus on parent-child interaction for several reasons. First of all, and especially when the child has been recently diagnosed, we assume that there is an environment of teaching the child to deal with CD, making dilemmas explicit that might otherwise be dealt with more indirectly. This allows us to see how particular descriptions are preferred over others and how participants deal with breakdowns and disruptions in routine as they are learning about them. Secondly, the case when a child has CD and the parents do not offers the interesting situation where the child is the one suffering physically from the condition but the parents are the ones who are responsible for the child's wellbeing and have authority over the child. Thirdly, and relating to this latter point, we were able to gather data from families with children ranging from a very young age to adults, thus allowing us to see – in an explorative manner – whether particular interaction patterns change or remain the same when children grow up.

Selection and analytic procedure

Families were recruited through a call for participation on the website of the Dutch CD association (NCV). In this announcement, families were asked to self-record their family supper on an audio recording device that we supplied. Out of the 17 families that we interviewed, we selected seven with children on the basis of our criteria: their age and the family practice of regularly eating together. The children in these families were CD patients aged between two and twenty years old, and had been diagnosed between eight years and three months previously (see Appendix A).

Once they fully agreed with the conditions for participation in the research, the families were given an audio recording device that they were instructed to switch on before every supper and switch off afterwards. This resulted in approximately 63 hours of recording. After a month, the recording device was collected, and we listened to all the audio recordings and made a word-level transcription of potentially relevant data. These data were analysed using the procedure outlined, for instance, in Potter and Hepburn (2005). We first looked for data sections in which gluten played a role. These were sequences in which food was being offered, accepted or denied. The emphasis on turns and sequences rather than isolated spates of talk is both a theoretical and a methodological starting point. People use the turn-by-turn development of a conversation as a resource to make sense of the social activities that are being accomplished. These publicly displayed and continuously updated understandings of what is being said and done are an important proof procedure for the analyst. Close sequential analysis suggested, for example, that food-offering sequences in families with young children were completed with repeated yes/no taste queries (e.g. 'Do you like it?'). We became interested in what exactly was being achieved in doing so. Comparison with other mealtime conversations (such as Wiggins 2004a) indicated that this finding was different from the situation in families without a child with CD.

The data set resulting from this procedure was transcribed in detail using Jeffersonian transcription (Jefferson 2004, see Appendix B). Fragments discussed in this article were translated into English with the help of a native speaker, trying to capture the literal meaning as closely as possible (see Supporting Information online). All the data used were anonymised by changing the participants' names.

Analysis

Out of the seven participating families, four were found to touch upon issues related to CD during supper. In two of the other three families, CD sometimes came up as a topic of conversation but it did not seem to concern or affect the meal itself, at least not in an observable way. In some cases this could perhaps be explained by the fact that the entire family was eating the same gluten-free food as the patient but this was not always the case. In the third family (Family 6 in Appendix A), it was not discussed at all, perhaps due to the young age (two years old) of the child.

In the four families found to deal frequently with CD issues during supper, it turned out that this was only the case in situations where gluten-free food was being offered or food containing gluten was being denied, and in situations where the gluten content of the food was in question. These were all situations in which the child was eating food that was different from all the other family members. By exploring the sequential relationships in these situations, we found that in situations where food was being offered, tastiness queries were persistent and were always used as a topic closer. In cases where food was being denied, this

denial was softened by constructing it as a practice previously agreed upon. Finally, even in situations where the gluten content of food was initially treated as uncertain, the exchanges were followed by evaluations of taste. In the following sections these findings are elaborated upon.

Taste queries as a way to secure ultimate acceptance of (safe) food in terms of its tastiness
Offering gluten-free food was systematically followed by often repetitive queries about, and confirmations of, the tastiness of the food, as in Extract 1:

Extract 1

Family 1

- 1 Mother: Say I also have eh^h
2 bought those
3 ↑crackers (.) that
4 grandma always has for
5 you (.) If it's
6 [goo↓]
7 Pascal: [Yea:h↑]
8 Mother: Would you like a
9 gluten-free cracker?
10 Pascal: Yea:hhh
11 (1.2)
12 Which gra:ndma
13 (0.3)
14 Mother: Grandma Barbara
15 ((30 seconds omitted. Speaking about
16 grandparent coming to visit))
17 Mother: Look at ↓this one
18 (1.4)
19 Do = you find that ↑tasty?
20 Pascal: Yes I want [↓one of]
21 [((Sound of
22 opening crackers))]
23 Mother: Yes of those °you can
24 have ↓one.°

In line 7 Pascal displays excitement when his mother mentions that she has bought the crackers that his grandmother always has for him. Despite this positive reaction, the mother goes on to ask for confirmation of its tastiness (lines 8–9). In Dutch, the mother uses the words '*Lust jij?*', which simultaneously mean 'Would you like?' and 'Do you find it tasty?' so that a positive answer to this question signifies both wanting and liking the food offered. In this way, acceptance of the food is established on the basis of its tastiness. Pascal produces a type-conforming response in line 10. Yet in line 19, the mother again requests confirmation of the tastiness of the food. Notice the negotiation going on in lines 19–24. After his first 'Yes', the child renegotiates the field of constraint set by the question by not remaining indexically tied to it. He reformulates 'Do = you find that ↑tasty?' into 'Yes I want ↓one,' thereby explicitly establishing his own right to decide on the matter. The mother subsequently responds with: 'Yes of those °you can have ↓one.°,' re-taking the initiative. Both the child and the mother claim to be in charge of the food: the child by evaluating its taste (his territory) and entitling himself to have the food on that very basis, and the mother makes

this claim in terms of the child being allowed, or not, to have it (her territory as a parent). This shows that there is more to these repeated requests than just evaluating the food (see also Mondada 2009 about food assessments managing social relationships). They are also used to negotiate the epistemic privileges of the child and the mother.

In this sequence the ‘allowability’ of the food is constructed as a result of the food being tasty, and Pascal wanting it. The formulation of the question (*‘Vind=je die ↑ lekker?’*, translated as: ‘Do = you find that ↑tasty?’) again implies both liking the food and wanting it, but foregrounds the tastiness aspect even more than in the formulation used in lines 8–9 (*‘Lust jij?’* translated as ‘Would you like?’). Note how the food is offered to Pascal only after his mother has requested confirmation of its tastiness on multiple occasions, even after Pascal has already stated that he likes the food (line 7). This makes the mother’s actions different from pursuing a response since her queries do get answers, even enthusiastic ones. Where she repeats her query, she produces them as separate actions, of which the outcomes are treated as somehow unsatisfactory. This reflexively marks the way food choice is dealt here with as highly uncertain and delicate.

The elaborate offering of food on account of its tastiness occurred frequently in our data. In Extract 2, in which Pascal and his mother are discussing the gluten-free cereal that she has bought, we can observe a similar pattern. This extract starts when the mother shows him different gluten-free products that she has bought (crackers and muesli). ‘That’ in line 1 refers to the muesli, and ‘all of those’ refers to all the gluten-free products (including the muesli) that are on display. Notice also how the food is actually offered by the mother only after re-requesting a positive evaluation of the food from the child (lines 11–12):

Extract 2

Family 1

- | | | |
|----|---------|--|
| 1 | Mother: | That is also ↓tasty. |
| 2 | | ((<i>She means the muesli they</i> |
| 3 | | <i>bought</i>)) |
| 4 | Pascal: | Huhh↓ |
| 5 | | (0.3) |
| 6 | | all of tho:se |
| 7 | | (1.5) |
| 8 | Mother: | O↑kay? |
| 9 | | ((<i>sound of opening crackers</i>)) |
| 10 | | (2.4) |
| 11 | Mother: | °Do you find those |
| 12 | | tasty, honey?° |
| 13 | Pascal: | °= yeah =° |
| 14 | Mother: | °Well take that one |
| 15 | | out° |
| 16 | | (1.7) |
| 17 | | H↑mm? |

In line 1, the mother makes an assessment of the food, after which the child confirms and upgrades it, that is, extends the assessment to all other products (‘all of tho:se’ in line 6), thereby claiming independent (and broader) access to the food’s taste (cf. Heritage and Raymond 2005).

Even though both the mother and son have already confirmed that the food is tasty in lines 1–6, the mother seeks renewed confirmation of its tastiness in lines 11–12 before actually

offering the food. The question is constructed in such a way that liking the food is the preferred option. In almost all cases, tastiness queries take the form of questions requiring a yes or no answer. Yes/no type interrogatives (YNIs, Raymond 2003) are a way to allow recipients to formulate their own response, while simultaneously exerting agency in terms of the kind of response that is required. YNIs maximally exploit agenda setting by setting the terms within which recipients' responses are to be constructed, and designing the question for a confirmatory response. The yes/no tastiness query in lines 11–12 is not a neutral question soliciting information, but elicits a yes/no response, in which the preferred option is yes. In this case, the preferred option has already been established by the mother by having evaluated the food as tasty earlier on in the conversation (line 1).

Food evaluations during mealtime conversations, such as with gustatory 'mmms', are often thought of as a spontaneous reaction to a physical sensation of the food and are also interactionally built as such (Wiggins 2002). Surprisingly, in all the mealtime conversations that we analysed, we found almost no spontaneous tastiness confirmations in relation to gluten-free food. What stands out are the repeated requests for confirmation of tastiness and its interactional effect: (i) the mother in the previous fragments formulates questions so as to anticipate a yes, thereby constructing 'tasty' as the preferred option over others, (ii) the mother seeks an affirmative response *before* the food is actually offered (see also Mondada 2009), (iii) tastiness (and not the allowability) of the food works as an account for offering it and (iv) the child's repeated and clear confirmations often do not seem to satisfy the mother.

In another family, the mother asks for confirmation of tastiness after having first established that the child is allowed to have the food by looking at the label. In this extract the mother and daughter are eating dessert:

Extract 3

Family 2

- | | | |
|---|----------|--------------------------------|
| 1 | Mother: | ↑Tasty? |
| 2 | | (1.5) |
| 3 | Zuzanna: | That ↑ <u>pi:nk</u> one is the |
| 4 | | ↓tastiest |
| 5 | Mother: | That one is ↑sweet uh |
| 6 | | (.) the other one is |
| 7 | | yoghurt |
| 8 | | (0.7) |
| 9 | Zuzanna: | Yes↓ |

After the tastiness query in line 1, there is a long pause without a response from the child. In lines 3–4 the child, instead of simply confirming the food's tastiness, points out what item of food is the tastiest, thereby comparing the food items' relative tastiness. The mother responds by relating tastiness to sweetness (of the food that the child likes best), and naming the other option: yoghurt (lines 6–7). She does not challenge the child's food evaluation directly but through the more or less objective qualities of the food that can be established without having tried it (sweet versus yoghurt; implying the non-sweet character of the latter). Her upward intonation on '↑sweet' can be taken as another indirect challenge. The mother thereby seems to turn the reason for liking the food into a predictable feature of likable food, so there is no reason not to try the other one.

Wiggins (2004a) showed in a study on family mealtimes without dietary restrictions that evaluations of the food were open to direct challenges, since the food was available to all speakers. In contrast, in our corpus we found almost no challenge to the child's food

evaluations and, if available, they were done indirectly. This shows that the boundary between the child's and the parents' territory is treated as a delicate one.

Again, a YNI is used to manage the tension between the child choosing her own food, and being restricted by her mother to only certain types of food in the face of health requirements. By using this kind of interrogative, the mother on the one hand concedes self-determination to the child by letting her confirm the tastiness of the food but on the other hand she exerts agency in terms of the kind of response that is appropriate. Wiggins and Hepburn (2007) found that in family mealtime conversations parents use formulations that resist the implication that they are forcing the child to eat, for example by, treating children as having greater access to their own appetite. At the same time, however, they continue to offer food in ways that manage to respect the privileged epistemic access of the children to their own physiological condition. Taste is a positive, commonly accepted subjective assessment. One is not entitled to decide for someone else what that person likes or does not like – to each their own taste. At the same time, it is a way to recommend or offer food (Extract 2, line 1). When the mother asks 'Do you/would you like a gluten-free cracker?' (Extract 1, lines 8–9), or 'Tasty?' (Extract 3, line 1), these are not simply informative questions but ways of offering food while managing the child's epistemic access to their own taste. However, there are also differences between the way tastiness queries are managed in our data and in Wiggins' research on food evaluations in families who were not explicitly noted as having special dietary requirements, as illustrated by the following extract from her study (Wiggins 2004a: 34):

Extract 4

1		(1.0)
2	Jane:	> right what do you < think-
3		(0.4) make of ↓ that then
4	Susie:	°nice°
5	Jane:	hmm? (0.4) lovely > in't it <
6		(1.2)
7	Matt:	don't ↑ know
8	Jane:	you don't ↓ know then (0.2)
9		you haven't tried ↓ it yet

In lines 2–3 there is a food evaluation request from Jane, the mother, in the form of an open-ended question. In our mealtime conversations of CD patients and their families, such open-ended tastiness queries were not found, and were only done through YNIs or first assessments, which exert a stronger pressure for affirmation. In line 9 Jane points out that Matt, who says he does not know what he thinks of the food, has not tried it yet. The word 'yet' is significant here, as it suggests that he will be required to try the food at some point. Since there are no dietary requirements, the food is available to all speakers and so evaluations of food are open to direct challenges. In our data, tastiness queries always occur only after the safety of the food has already been established. In this way, the topics of tastiness and allowability are kept separate, perhaps to be able to positively complete the food assessments, in a way that shows that the child's acceptance of the food has nothing to do with its allowability.

The way in which positive answers to tastiness queries are pursued and repeated, even when the child has given evidence of their positive stance toward the food, is not found in Wiggins' mealtime conversation data. Finally, whereas Wiggins found that evaluation requests may be ways of making sure that children have eaten their food and continue to eat

it, in our data tastiness confirmation is frequently requested before the food has been offered – as a way to stimulate eating rather than making sure that the children have eaten it. In these instances, it makes sense to use only YNIs rather than open-ended questions because a negative answer would entail rejecting eating the food (in the same way that a positive answer implies that now the child has to eat it).

We found a pattern in which, after elaborate offering and requests for confirmation of tastiness, the parent tells the child he can have food, even after he has indicated that he wants or likes it. Together with food evaluations not being directly challenged, this shows that the matter of food choice is handled as a delicate issue and a matter that may be in question. In addition, by first pursuing confirmation from the child that he wants the food, and then saying that he is allowed to have it, the mother establishes that the child can have the food he wants. Compare this to a reversal of the sequence, that is, first the mother offers gluten-free food to the child, and then asks if he likes it. In this latter case, tastiness is a subsidiary quality of the food. In fact, the child is restricted to eating gluten-free food whether he likes it or not, so in this case food evaluations are irrelevant to the choice of food. But when the child is allowed to have the food only after confirmation of its tastiness, tastiness – that is, the subjective self-determined assessment of the child – is built up as the reason for eating the food.

Softening denial by constructing denying food as a joint practice

In situations where gluten-free food is recommended, we see that tastiness rather than the food's safety is used as an account for offering and accepting it, constructing the eating of gluten-free food as a choice rather than something externally imposed. In situations where food is being denied due to its gluten content, tastiness is not used as a criterion to reject food, for example, as in 'I don't want it (anyway) because I don't like it'. Tastiness, however, still plays a role, as Extract 5 shows. In this extract, the family is discussing the problem of their daughter putting her fingers in her mouth after playing with clay (which contains gluten).

Extract 5

Family 2

- | | | |
|----|----------|--------------------------|
| 1 | Mother: | What did we now |
| 2 | | agr↑ee (.) that we |
| 3 | | would not ↓put your |
| 4 | | things (.) fingers in |
| 5 | | your mouth |
| 6 | | (0.5) |
| 7 | | Yes she finds |
| 8 | | that ↑tasty |
| 9 | Zuzanna: | °I find that ta:sty.° |
| 10 | | (4.6) |
| 11 | Mother: | What could ↑be = there = |
| 12 | | again on your fingers |
| 13 | | (0.6) |
| 14 | | after playing with |
| 15 | | cla::y or pai::nt? |
| 16 | Zuzanna: | °I didn't play with |
| 17 | | ↓clay° |

In lines 7–8, the mother accounts for the daughter putting her fingers in her mouth, despite her agreement not to, by referring to the food's tastiness, which is confirmed by the daughter

in line 9. Accounting for her daughter's food choice to someone else (in this case the father) in terms of taste shows that she treats eating food with gluten as an accountable activity. The daughter, right away, draws upon this as a reason for performing an activity that she had agreed not to perform. Now the mother cannot disagree with her daughter without violating the child's primary rights to assess taste. Interestingly, in lines 1–2 the account the mother gives for why the food is not allowed is not by alluding to the fact that it contains gluten but by referring to a previous agreement between her and her daughter. By referring to a self-made agreement rather than an external source, the mother manages the agency of her child. At the same time, however, she constructs the child as being responsible for avoiding gluten and accountable for violating an agreement she herself made. By establishing denying food as a matter of agreement, the mother simultaneously avoids responsibility for denying food to her child directly. Contrary to what we saw before in cases where food is accepted, now the gluten content of food is constructed as an external restraint that dictates food choices. This can be explained by the interactional goal in both cases being different: in the former it has to do with managing self-determination, whereas in the latter case the mother avoids constructing herself as the only source of the denial.

By using 'we' twice in lines 1–2, denying is constructed as a joint practice and a cooperative activity for which her daughter is co-responsible. However, the daughter resists this responsibility. The account she gives for taking the food anyway is that she finds it tasty, thus citing a subjective assessment for violating an agreement based on an objective assessment (gluten content). In this way the daughter treats tastiness as a quality that is superior to gluten content, repeating the mother's allusion to tastiness in lines 7–8. We could say that the practice of using taste to manage self-determination in situations where food is being recommended backfires in a situation where food is being denied.

In families with adolescents we found a more indirectly managed tension between being co-responsible for the wellbeing of the family member with CD while also dealing with her right to self-determination:

Extract 6

Family 4

- | | | |
|----|---------|-------------------------------|
| 1 | Maria: | I want the <u>real</u> |
| 2 | | chocolate |
| 3 | Sister: | Then do you have to (.) |
| 4 | | then would you like the |
| 5 | | one with ↑nu:ts? |
| 6 | Maria: | Yeah with n[uts] |
| 7 | Mother: | [Oh yes] |
| 8 | Maria: | yea:h I also find them |
| 9 | | tastier than the <u>other</u> |
| 10 | | kind |

In line 4 the sister of the CD patient performs self-repair to manage the self-determination of her sister – taking the food instead of having to take it. Her sister responds with accounting for taking the food by emphasising its tastiness rather than the fact that it is gluten-free. The YNI with self-repair reflects the sister's concern with Maria's right to self-determination by stressing choice rather than obedience to a rule. This framing also corresponds with Maria's use of 'want' in line 1. This is a way to manage self-determination, as well as to demedicalise dietary requirements. If food is treated as something that one has to take – that is, as medicinal – then constructing pleasure as the reason for eating is no longer possible.

In lines 8–10 Maria offers an extra account (besides real chocolate): she likes chocolate with nuts much better. This account is in terms of what she likes rather than what she is allowed to eat. Here we see how both the question and the response orient to self-determination by Maria: it is choosing rather than having to, and liking rather than being allowed. Both Maria and her sister reveal that they do orient to dietary requirements – her sister by using ‘have’ in the first instance and Maria by using the word ‘also’ in line 8. The difference is that the dietary context is used as a necessary condition, and tastiness as a sufficient condition. Maria’s account suggests that even if she did not have CD she would have made the same choice.

The fragment shows how both patients and non-patients orient toward dietary requirements but keep it unspoken in the background so as to be able to share the enjoyment of food in the face of potentially separating dietary requirements. In other words, they mitigate the fact that food choice is partly dictated by a health requirement that affects only one individual to be able to perform shared mealtime activities. Softening denial of food, then, is an important way in which participants demedicalise the diet and are able to perform normal family mealtime practices.

Gluten content as an explicit topic in situations of uncertainty

Where self-determination is managed with tastiness queries when gluten-free food is being recommended, and as a joint practice when food containing gluten is being denied, it is interesting to see how it is managed in situations where it is uncertain whether or not the food contains gluten. First of all, we look at a rather dramatic situation where, after offering a dessert to her two children, the mother starts to doubt whether it is gluten-free:

Extract 7

Family 1

- | | | |
|----|---------|---------------------------------|
| 1 | Mother: | I (.) I ↑thought that |
| 2 | | we looked this up |
| 3 | | already before = mummy |
| 4 | | wants = just to be <u>sure</u> |
| 5 | | look up whether you can |
| 6 | | <u>really</u> have it Pa↓scal |
| 7 | Pascal: | I can (.) I can ↑really |
| 8 | | have it |
| 9 | Mother: | Yes I <u>think</u> so too (.) |
| 10 | | but I first have to (.) |
| 11 | | you should <u>not</u> open it |
| 12 | | just now (.) I thought = |
| 13 | | that you can ha↑ve it |
| 14 | | just for a little bit |
| 15 | | leave it <u>closed</u> mummy |
| 16 | | is now going to °look |
| 17 | | it up again° |
| 18 | Pascal: | But it is ta:sty |
| 19 | Mother: | °Yes = it = is = tasty = but = |
| 20 | | you = should = <u>not</u> touch |
| 21 | | it° |

In lines 1–6, the mother accounts for not allowing Pascal to eat his ice-cream by saying that she wants to know for sure that he can have it. Refusing food is not only an accountable activity on the part of the recipient but perhaps even more on the part of the person offering

the food – especially if the refusal takes place after the food has already been offered. The mother shows this by portraying distress ('I (.) I', line 1), softening the denial of food with 'just' (line 4), and stressing the importance of being certain of the safety of food with the emphasised 'really' (line 6). Something that is normally only conditionally in the background is now in question.

Interestingly, the mother appeals to external authority – 'look up whether you can really have it' (lines 5–6) to account for her refusal of food. In response, Pascal asserts his right to self-determination by saying that he can really have it, treating his own judgment as being sufficient to resolve his mother's uncertainty. The mother's response, 'I think so too', reveals that she takes this as a subjective assessment and that this is not sufficient – there needs to be confirmation from an external source: 'mummy is now going to look it up again'. She also uses strong language in urging Pascal not to open the ice cream wrapper: 'you should not open it' and 'leave it closed'. Self-determination to assess food choice is temporarily suspended until there is certainty. Pascal's appeal to an established routine by referring to the food's tastiness ('But it is ta:sty', line 18) is also resisted. The mother's confirmation of tastiness, and the instruction that the child 'should not touch it' show the conditional relevance of the food being gluten-free – this has to be established before resorting again to the routine.

Fortunately, after looking up the product on the computer, it is established that it is gluten-free:

Extract 8

Family 1

- | | | |
|----|---------|--------------------------------|
| 1 | Pascal: | Can I have↓ (it) now? |
| 2 | Mother: | Yes (.) you can <u>have</u> it |
| 3 | | (.) otherwise mummy |
| 4 | | wouldn't have bought it |
| 5 | | if I thought that |
| 6 | | you = could = not ↓have it |
| 7 | | (0.7) |
| 8 | | But I <u>just</u> wanted |
| 9 | | to know for sure (.) come |
| 10 | | (.) Shall I ↑open it? |
| 11 | | (4.5) |
| 12 | | Mummy <u>also</u> really |
| 13 | | ↓likes this one |

Right away, after giving an account for why she had to look it up (wanting absolute certainty) the sequence is completed with – again – a taste evaluation: 'Mummy also really ↓likes this one' (lines 12–13). This comes after a long pause and could be an instance of using food assessment as a way to bring a disagreement sequence to a close and start a new sequence (Mondada 2009). In families with adolescent children, the checking is done in a much more indirect way:

Extract 9

Family 4

- | | | |
|---|---------|--------------------------|
| 1 | Maria: | Oh but I also ate some |
| 2 | | Ma:rs a while ago |
| 3 | Sister: | I have had so much candy |
| 4 | | ↑lately .hh |

- 5 Mother: Ma:rs? =
 6 Maria: Yes I am allowed Mars.
 7 (1.6)
 8 Mother: I found it very nice when
 9 also had taken Mars from
 10 the:h tennis
 11 (0.6)
 12 [Tha-]
 13 Maria: [Yes]
 14 But I just = cut = off = a = piece
 15 every time

The mother's question – 'Mars?' (line 5) – challenges the preceding utterance and is treated by the daughter as being a query about whether she is allowed to have Mars. The mother portrays sensitiveness to the daughter's right to self-determination by checking whether Mars is safe, without making the full question explicit. The daughter's emphasis on 'allowed Mars' (line 6) is a claim to her right to assess food and the mother takes this up by pausing and then moving the topic into safer waters by saying that she has taken the Mars bar from the tennis club and that she likes it – somewhat awkwardly formulated. Once again, the conversation proceeds to tastiness confirmations of various types of candy (not shown in this extract). Just as within the conversations of the families with a young child, the sequences that foreground uncertainty over the gluten-free status of the food were systematically followed by and completed with taste evaluations.

Discussion and conclusion

With the insights from this analysis we hope to make a contribution on two levels: practical insights into the everyday life of CD patients for researchers developing innovations that will affect these patients' lives, and expanding the body of research on food that uses discursive psychology.

We expected health to be a primary assessment criterion of food for CD patients and their families but surprisingly we found that it played a role only as a necessary condition. Although the food's safety was always established first, its tastiness was constructed and positioned so as to ultimately account for eating it. In the families with a young child, the persistent taste queries, even after the child had shown a positive stance toward the food, marked the offering and acceptance of food, and the basis on which this was done, as a delicate and uncertain affair.

More generally, patients and their families showed an orientation towards demedicalising the diet by constructing eating particular foods as a matter of choice rather than mere restriction. In situations where food was being denied, the child's self-determination was managed by referring to previous agreements so as to remind the child of a joint decision. In both recommending and denying food, various types of questions were used to manage the tension between choosing one's own food and being instructed in the face of health requirements. In situations where the allowability of food was presented as uncertain, self-determination was temporarily suspended. As soon as the food's safety was established, family members constructed food enjoyment again.

Although further research on this topic is needed, these results may be explained as a way of normalising eating practices in situations where medically imposed health criteria restrict

patients' food choices. Interactionally speaking, if medical criteria are constructed as the primary food assessment criteria, it becomes difficult to account for eating practices as a matter of choice. If the food is tasty this is an added value or a way to soften the burden, no doubt, but in this context food evaluations are also irrelevant in the sense that one is restricted to certain foods whether one likes them or not. If food is a choice, however, one eats it because one likes it – whether it is for tastiness, enjoyment, health promotion or some other reason.

In communicating new innovations to CD patients, their orientation towards self-determination rather than towards being seen as passive patients constrained by dietary restrictions should be taken into account. This finding is in line with a study that shows what happens when this self-determination is challenged by researchers in communications about a new pill for CD patients (Veen *et al.* 2010a). It is important for experts who are developing new innovations to know that CD patients orient toward demedicalisation in their daily life, at least during mealtime conversations. From their professional perspective, it makes sense to think of CD as a disease to be cured and to relate to patients in their identity as patients. But perhaps the patients may resist being related to as people suffering from a medical problem and might prefer to be approached a different way, for example, as consumers or as conscious eaters (paradoxically, if after diagnosis CD patients become 'good' consumers and eat suitable food consciously, their symptoms disappear, the small intestine usually recovers and they are no longer identifiable as patients except for their genetic makeup).

This study adds to the body of discursive psychological analysis of mealtime interactions (cf. Wiggins *et al.* 2001) by examining how medical requirements affect mealtime interaction. It shows that psychological categories such as normalisation are actually container concepts for a range of discursive strategies that are used to manage the tension between being normal and being ill (Gregory 2005). As Mondada (2009) shows, food assessments can be used for social practices other than evaluating the food. Our study has shown that in medical contexts they can be used to manage this particular tension.

We also found differences in the food talk by young CD patients and their families and other mealtime talk (cf. Wiggins 2004a). Tastiness confirmation was repeatedly sought even after this confirmation had already been given; food evaluations were not challenged directly; and taste queries were made after the safety of the food had been established and never in the form of open-ended questions. The combination of a strong pressure for affirming the food's tastiness while also persistently claiming it as uncertain, constructs the offering and acceptance of food as a tricky business. More research is needed on how medical contexts actually influence eating practices. This will yield valuable results in terms of concrete advice to families who find themselves in these situations and to the experts who assist them.

Concerning the limitations of our research, it has to be noted that, of the seven participating families, there were two in which the gluten-free diet never or only occasionally came up in mealtime conversations. In one family this can be explained by the fact that the child was about two years old and not yet talking. However, the fact that it did not arise in another family points to a limitation of our research. By focusing on one specific type of setting, other settings in which CD is discussed are excluded. And because of the labour-intensity of the transcription and analysis of data, the number of participating families was limited to seven. Therefore, it is recommended that further studies of both mealtime conversations and other types of settings are conducted. That the gluten-free diet seems to be a major issue in mealtime

conversations of one family and not at all of another is itself an interesting observation. However, explaining this anomaly at this point would be mere speculation, and further study is needed.

Finally, this research on mealtime interactions of CD patients and their families highlights an existential issue that is usually discussed under the heading of agency: people's need to exert their freedom of choice in the face of externally imposed conditions – whether it be illness or something else. The way in which CD patients construct dietary restrictions as a matter of self-determination shows that, although certain forms of human behaviour may be regarded objectively as being a function of imposed restrictions, people may still or, more precisely, subsequently construct a context that accounts for this behaviour in terms of freedom of choice.

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Note

1 We have opted to use the term 'patient' to indicate those who have been diagnosed with CD. However, our analysis does not start from the assumption that the participants themselves treat this individual as a patient. This term is used as a clarification for the reader and not as a participants' category.

Supporting Information

Additional Supporting Information may be found in the online version of this article:

Extracts 1–9 Original extracts in Dutch

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Appendix A: Participants’ characteristics

	<i>Participants (age)</i>	<i>Age of coeliac disease patient</i>	<i>Time since diagnosis</i>	<i>Hours and minutes of recording</i>
Family 1	Pascal Sister (3) Mother Father	5	2 years	15:50
Family 2	Zuzanna Brother (7) Mother Father	5	3 months	10:32
Family 3	Masha Mother	20	10 months	5:31
Family 4	Maria Mother Sister (18)	20	1 year	10:44
Family 5	Edith Brother (14) Mother	16	4 years	5:10
Family 6	John Mother	2	6 months	1:20
Family 7	Erika Sister (2) Mother. Father	4	4 months	13:15

Appendix B: Transcription notation

[text]	Overlapping speech
(x.x)	Pause of x.x seconds
(.)	Micropause, less than 0.2 seconds
(text)	Speech unclear
↑text,↓text	Onset of noticeable pitch rise or fall
te:xt	Colons show that the speaker has stretched the preceding sound
<u>text</u>	Louder and emphasised
° text °	Material between ‘degree’ signs is quiet
((text))	Transcriber’s remarks.
=	No pause between words, rapid speech
