

“It’s part of what makes me.”

**Women’s constructions of ‘anorexia nervosa’ in their identity
journeys over ten years.**

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ABSTRACT

This dissertation is interested in women's voices and some of the ways they negotiate their identities in relation to the discursively constructed category of 'anorexia nervosa'. Nine women who came to identify their experiences as 'anorexia nervosa' were interviewed three times over ten years. This sample of women was drawn from an initial sample of 21 women and therefore the 12 women who did not participate in the interviews ten years later were not included in the substantive analysis. The research interviews sought to provide a context for these women to speak on their own terms; terms not confined to the discursive field of 'anorexia nervosa'. A critical discursive analysis of the women's interviews identified some of the ways these women used, and were positioned by, the discursive resources available to them at the time. 'Anorexia nervosa' was found to be a troubled socially constructed category. In particular, it positioned the sum of their lives as disordered and dominated by illness. The discourse assumed that the person should regain a pre-morbid state in the form of a recovery. Within the discursive context of talk not confined to 'anorexia' talk, the women were active in refashioning alternative positions. Speaking on their own terms and through use of image and metaphor to author a complex social reality, they reconstructed their lived experiences as an identity journey where they connected with what they valued, which had strong implications for their lives as presently lived. The implications of this research are significant given that the majority of research to date confines the terms of speaking to the 'anorexia' discourse.

Statement of Candidate

This work has not been submitted for a higher degree to any other university or institution. All the sources of information used in this research have been identified. This research was approved according to the Ethics Review Committee, Human Research, Macquarie University (Ref: HE27APR2007-D05196) (Appendix 1c).

Signed:

Janet Conti

Date: 13th May 2013

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Within the context of this research study, I have been particularly fortunate to have met a number of other likeminded researchers who have also become my dear friends - Adriana, Alison and Jamie. These people and other members of qual (qualitative research) group at Macquarie University have been part of the dialogue that is this thesis. To Michelle Innis, thank you for completing the final editing of this thesis with sensitivity and care.

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Finally I would like to dedicate this thesis to my family – Paul, Jess, Tom, my parents, siblings and friend Karen. Through the ups and downs of this thesis you have been there for me. I look forward to the next chapter in my life with you all.

Preface

I have often heard it said that life gets in the way of writing a thesis. From my experience, life has paved the way for this thesis. Given that this dissertation has been 16 years in the making and that the ideas put forward are inevitably ‘stamped’ (Palmer, 1969, p. 7) with my experiences, ideas, values, knowledge and training (Gilgun, 2005), I begin with a preface that traces the context within which this research work has been constructed.

Early in this research, I experienced a major medical trauma in my family. This trauma was unexpected and unwelcome although, over time, it has presented a number of possibilities to me in the context of my life. One of these was that on resuming this thesis, I recognised that 10 years had passed since I had first interviewed women about their experience of so-called ‘anorexia nervosa’. This provided the opportunity to reinterview women and conduct one of the few longitudinal qualitative research studies into ‘anorexia nervosa’.

The intention of this thesis is to analyse and develop insights into some of the ways in which women negotiated and constructed their identities through their talk. However, this was not any type of talk. The conversations within which women spoke about their experiences were intended to generate space for speaking that existed both within and outside the discursive field of ‘anorexia nervosa’ (Hardin, 2003a). This thesis is built upon the proposition that ‘anorexia nervosa’ is a socially constructed category (Hepworth, 1999) that positions particular lived experience as illness and/or disorder that is located within the person. Hence when mentioned in this thesis, the medical term Anorexia Nervosa will be presented in the form ‘anorexia’ or ‘anorexia nervosa’ to signify this positioning.

The research interviews provided a platform for women to author and re-author their identity where they both revealed and became themselves (Bakhtin, 1984). Women’s constitution of themselves might therefore be understood as occurring not within themselves but through dialogue and ‘*on the boundary between one’s own and someone*

else's consciousness' (B. Conti, 1997, p. 53) and therefore this preface is intended to introduce the 'someone else' that is; myself as researcher.

My interest in researching stories of people who experience so-called 'anorexia nervosa' emerged in the early 1990s, when I was working as a dietitian in an eating disorder unit in a public health setting and also studying undergraduate psychology. Working within a public hospital system came with a price. Services were stretched. Interventions for many people ended up being mainly with a dietitian and only after a long wait, unless there was an emergency. At this time, few people had access to ongoing therapy with a psychologist, psychiatrist or social worker and only those most physically unwell were admitted to the inpatient psychiatric unit. There was a gaping hole in service provision between those with privileged access to the private sector treatment services and those without. Most research was conducted at the time through private facilities. I found myself working in a system whose values often clashed with my own. Voicing my concerns resulted in little or no action and I found my voice was filtered and at times, silenced. On a professional level I also found myself stretched. Frequently the sole practitioner seeing persons on an ongoing basis, I became burnt out. So what kept me working in this system? On reflection nearly two decades later, what stands out for me was first, the human spirit in adversity and second, that I stood with, and for, people in their adversity. What sustained me was the knowledge that I was not alone in this stance as several of my colleagues shared my values, concerns and ideas for change.

During this time, I became increasingly frustrated with what I read in academic literature on "eating disorders". The richness of the stories of people's lives was rarely captured in the theories that abounded. What I had initially assumed to be the truth about the experience became questionable. I found myself increasingly drawn to qualitative research, particularly the work of Catherine Garrett (1993) on recovery from 'anorexia nervosa'. I was drawn to her focus on the spiritual dimension of the experience and her suggestion that the often neglected stories of recovery hold out hope for those who experience 'eating disorders'. I became increasingly determined to research 'anorexia nervosa' from the perspective of the experiencing person.

With this in mind, I made the decision in the mid-1990s to return to full time study and enrolled in a Master of Clinical Psychology and PhD in 1997. I approached a number of academics in the psychology departments of three universities in Sydney. My refusal to frame my research within the dominant positivist research paradigm was received by the academic world with doubt and unease. Rather than becoming disheartened, I held onto the sense that what I was valuing in the stories of those who experience ‘eating disorders’ was worth researching. I was eventually given the name of Dr. Daphne Hewson who became my supervisor. I remember our first conversation to this day. Voice, excitement, and shared values are some of the words that come to mind more than a decade later.

I was introduced to a world of new ideas through narrative therapy and post-structuralism. This world of ideas had been obscured in my undergraduate studies that had presented empiricism and the scientific method as the only way to access so-called reality. Although initially overwhelmed by the dismantling of much that I had previously taken for granted, this sense quickly gave way to possibilities beyond the scope I had imagined. I also found that my valuing of the voice of the experiencing person was shared not only with my supervisor, but also with a number of other students and academics who formed a qualitative research group.

Over time I became part of a community of like minded academics (“qual group”) who were interested in expressions that did not fit comfortably with the dominant ideology embraced by academic and clinical psychology, which constructs human beings as individuals that exist largely outside any sort of social and political context (Fox, Prilleltensky, & Austin, 2009). This discourse community had a shared interest in social justice and addressing inequities that are generated from western ideologies that mark out the criteria for psychological health/absence of health, normality/abnormality, order/disorder etc. (MacSween, 1993). It probed our interest in how unexamined taking up of these ideologies has inadvertently led to inequity, loss of voice, marginalisation and discrimination against many of those whom our profession seeks to assist. I have continued to be a member of this group intermittently over the past 16 years and many of the ideas presented in this thesis have been generated within this context.

My introduction to narrative therapy (White, 2007; White & Epston, 1990) has had a profound impact on the shape of this thesis, including the processes leading to its development. Taking up a position in post-structuralist thought, I developed an understanding of how perceptions of reality, both within and outside oneself, are signs to which multiple meanings may be ascribed (Gilgun, 2005). This positioning extended my commitment to research individual's personal experiences and some of the meanings they ascribe and the identity conclusions they derive from such experiences. The questioning inherent in narrative therapy helped me to decide how to initiate and develop externalising conversations with women in this research through the unpacking of their meanings and through speaking on their own terms (White, 1991). The research interviews therefore provided these women with discursive space to speak outside the terms and conditions of the dominant 'anorexia' discourse that constructs women's actions as signifying illness and disorder. That is not to say that more usual ways of speaking and lines of enquiry would have been neutral in their effects. Whatever terms of speaking had been chosen to enquire into women's lived experience would have contributed to the shape of a woman's version of her lived experience.

The project began with two interviews with each participant between 1997 and 1999. I then discontinued my studies in response to the medical crisis in my family. During this traumatic time I intermittently found myself reflecting back on the stories from this research. I related more deeply to the women's experiences of isolation and inexplicable pain. I experienced on a profound level how little choice we have over the significant events of our lives, other than how we choose to respond. I found that my responses to what was happening in my life were both shaped by, and in turn shaped my values.

Returning to "qual group" in mid-2006, I recognised few faces. Many of my colleagues and friends had completed their theses and graduated. Although physically there, I felt I was not there and wondered if my world outside this group was going to hold together for me to re-embark on my Ph.D. Though the acuteness of the crisis had subsided, things were far from over. I now wonder if, as author Tim Winton writes in his short story "Aquifer", things are ever over.

Perhaps time moves through us and not us through it. [...] the past is in us, and not behind us. Things are never over.

(Winton, 2004, p. 53)

I felt changed by the recent events of my life, yet connected to the person I was. I was the same person, yet I was changed.

In 2007 I re-enrolled in a Ph.D. and recontacted as many women as I could to let them know about the reasons for my departure from the research and invited them to further participate in a research interview 10 years on. It's strange in life how unexpected opportunities may arise from adversity; this research is one such example. I found myself hearing the women's stories differently. Rather than being drawn to the "big" existential questions, I became curious about the meanings women ascribed to the events of their life that could be missed because of their everydayness. Having held onto a thread of hope over the previous five years, I was curious to know what steps the women took to hold onto their hopes, dreams and visions for their lives. I found myself journeying alongside the women, rather than viewing their lives from a distance.

Not only have my positions and taken-for-granted assumptions impacted on the women's accounts of their experience, so too have the women's accounts had an impact on me. This encounter between researcher and participant appears to be absent or inadequately theorised in the field of discourse analysis and more broadly within the profession of psychology itself. In an effort to address this gap, philosopher Hans Herbert Kögler (1999) has sought to 'fuse' two fields of thought that have been assumed to be philosophically opposed to each other, that is hermeneutics and discourse analysis of social power practices. Although the analysis at the heart of this thesis is a critical discursive analysis of 'anorexia nervosa', Kögler's (1999) theory of critical hermeneutics has implications for another dimension to this analysis that is, an appreciation of how the women's accounts shaped me as researcher.

To recognize the other as a person requires that I also allow her to say something to me.

(Kögler, 1999, p. 146)

In other words, through my dialogue with the women who participated in this research I acknowledge that not only did I have an influence in shaping their accounts of their experiences, so too have they said 'something to me'. In the words of Nancy Moules (2002) I have sought in this hermeneutic encounter with the women in this research to 'proceed delicately and yet wholeheartedly' (p. 12) and have similarly experienced myself as shaped through my conversations with these women - 'we carry ourselves differently, and we live differently' (p. 12). In addition to this, how I have heard what women have said will inevitably be shaped by my own taken-for-granted assumptions, some of which have been addressed through the critical reflective practice (Fook & Gardner, 2007) that has constituted my supervision with Dr. Hewson. My accountability as a researcher lies in the extent to which I understand the stories I am told and how meaningful those understandings are to their owners, the women themselves.

Chapter 1: Introduction

Of course, he had always known. He had been maintained in a state of innocence by the absence of a term for her condition. He had never thought of her as having a condition, and at the same time had always accepted that she was different. The contradiction was now resolved by this simple meaning, by the power of words to make the unseen visible. *Brain damaged*. The term dissolved intimacy, it coolly measured his mother by a public standard that everyone could understand.

McEwan (2007, p. 72)

In his novel, “On Chesil Beach”, Ian McEwan writes about the power of diagnosing personal experience as illness through making “the unseen visible” and measuring a person, in this case the protagonist’s mother, “by a public standard that everyone could understand”. The ‘public standard’ by which fasting and body shaping practices that produce an emaciated body has become known as ‘anorexia nervosa’. This thesis is an enquiry into the effects on women of their experiences being framed by this public diagnostic standard and also into how women respond to the realities of their lived experience being understood in these terms.

Located within the broad field of constructivism, the philosophical position at the heart of this thesis is that there exists ‘no ‘versionless’ reality’ (Wetherell & Potter, 1992, p. 62). In other words, how human beings understand, make meaning and construct their unique versions of their reality is open to multiple interpretations that are pieced together with language forms available in a particular place and time in history. These language forms or discursive constructions are, borrowing semiotic terminology, comprised of both the ‘word image’, or signifier, and the ‘the mental concept’ of reality that forms in our mind or the signified (Rice & Waugh, 1989, p. 5). Words are therefore ‘arbitrary symbols’ that acquire meaning through their connection to things of the world (Hermans, Kempen, & van Loon, 1992, p. 25) and there is a constant interplay between ‘the naming of a thing or concept and that reality itself’ (Calder, 2009, p. 22).

Through focusing on the discursive construction of so-called ‘anorexia nervosa’, the real effects of self-starvation are not denied. A person’s body will become emaciated if they do not eat enough, whether they understand their experience as a mental disorder or as a spiritual pursuit for union with God or as a protest against patriarchy. The bodily reality is, however, ‘no less discursive’ if the person dies and how this is understood is ‘constituted through our system of discourse’ (Wetherell & Potter, 1992, p. 65). Therefore it is implausible to separate people’s bodies and the materiality of existence from the practice of language itself, hence the implausibility of separating of the material from the discursive (Edley, 2001).

From this platform, the intention of this thesis is to produce a document that is a ‘thick description’ (Gilbert Ryle in Geertz, 1973, p. 6) of many versions of the reality of what is presently known as ‘anorexia nervosa’, with an intentional granting of privilege to the often marginalised voice of the experiencing person. ‘Thick description’ is comprised of multiple meaningful interpretations of any given reality (Geertz, 1973) that are produced and negotiated within particular communities, through particular cultural frames and at a particular time in history (White, 2000).

There is an Indian story – at least I heard it as an Indian story – about an Englishman who, having been told that the world rested on a platform which rested on the back of an elephant which rested in turn on the back of a turtle, asked ... what did the turtle rest on? Another turtle. And that turtle? “Ah Sahib, after that it is turtles all the way down”. Such indeed, is the condition of things.

(Geertz, 1973, pp. 28-29)

Human social realities (depicted by cultural anthropologist Clifford Geertz through this Indian story as “turtles all the way down”) are given meaning and constructed through language (Parker, 1992). Therefore any given reality or action (such as the act of self-starvation) may be multiply understood through a range of versions of that reality or action, some that are privileged and others repeatedly questioned for their veracity. Michel Foucault (1980) has argued that this privileging of certain versions of reality over others is an act of power. This power is un-interrogated, and therefore invisible, in contexts where there is an uncontested right to speak about particular realities and the production of ‘a sense of talk-independent reality’ (Sampson, 1993, p. 1222).

Modern power from Foucault's (1980) analysis is exercised through the elevation of particular versions of reality or discourses to a point where they become the unquestioned truth about the way things are and the way the world is. Discourses constitute particular 'meanings, practices and structures' (Halse & Honey, 2005, p. 337) through the construction of not only formalised systems of knowledge and truth claims but also the production of human subjectivities. Discourses are inherited from society (Allen & Hardin, 2001) and are a vehicle through which truth claims operate and are reproduced. Rather than discrete and deterministic entities, discourses mark out 'relations *between* things' and are 'the *rules* and *procedures* that make objects thinkable and governable' (Arribas-Ayllon & Walkerdine, 2008, p. 105).

The power of discourse is derived from its taken for granted-ness or naturalistic accounting whereby an individual's positioning in discourse may be unexamined and therefore exist outside their conscious awareness. For this reason, Foucault's analysis of power has been widely critiqued as antihumanist because of a tendency to position human beings as 'manifestations-of-discourse' and subjects constituted by discourse and, in doing so, reallocate human agency from the person to discourse (Burr, 1995, p. 90). In rejecting assumptions underpinning humanism, particularly the understanding of human beings as free and rational agents to define their own subjectivity and choose how they act in the world, alternative conceptualisations of human agency in Foucault's critical project tend to be limited to the capacity of individuals and groups of people to resist the implicit power of dominant discourses.

Where there is power, there is resistance [...] the points, knots or focuses of resistance are spread over time and space at varying densities, at times mobilizing groups or individuals in a definitive way, inflaming certain points of the body, certain moments in life, certain types of behaviour.

(Foucault, 1990, pp. 95-96)

How resistance is accessed, acted upon and the effects of such actions lacks clarity outside Foucault's geneological project itself. His critique of modern discourses, including those of medicine and human sexuality, have also given little attention to possible alternatives to these discourses nor have they sought to resolve the contradictions, tensions and inconsistencies that have been generated through his critical project (Sawicki, 1991).

With the “impersonal forces and tendencies in history” being beyond the scope of both individual and collective influence, the notion of resistance itself poses a dilemma (Sawicki, 1991). In responding to this dilemma, Jana Sawicki (1991) has argued that -

Foucault’s contributions consist primarily of attempting to bring into our awareness the deep regularities and broad impersonal forces that make us what we are, that define our sense of alternatives and what it makes sense to do in certain contexts in order to free us from them [...] our freedom consists in our ability to transform our relationship to tradition and not in being able to control the direction that the future will take.

(Sawicki, 1991, p. 99)

The capacity to “transform” one’s relation to tradition has been accounted for in the notion of positioning in discourse (Davies & Harré, 1990). Discourses mark out a range of subject positions (Parker, 1994) and humans may be understood as not only positioned by dominant discourses, a process that may escape their conscious awareness at the time, but also active in positioning themselves in discourse through reflection, negotiation, argument and ultimately ‘choosing’ from the positions that are available in a particular time and place.

She is also a subject able to reflect upon the discursive relations which constitute her and the society in which she lives, and able to choose from the options available.

(Weedon, 1987, p. 125)

These ‘options available’ for various subject positions are constrained by the prevailing culture in which the person is immersed. Within this context, human agency may be understood as ‘bi-directional’ whereby a person is active in taking up various discourse positionings that are available to them within the context in which they live and, in doing so, construct a unique sense of identity from these subject positions (de Fina, Schiffrin, & Bamberg, 2006, p. 7).

My choice of the critical discursive analysis of Margaret Wetherell and colleagues (Reynolds, Wetherell, & Taylor, 2007; Wetherell, 1998, 2007; Wetherell & Edley, 1999) as the methodology to analyse women’s interview transcripts rather than working solely through Foucauldian or ‘big discourse’ analyses (Wetherell, 2007, p. 673) has been guided by an intention to move away from research methods that confine the understanding of a

person as a ‘de-centred subject’ (Wetherell, 1998, p. 394) whose agency in the construction of identity is limited to their capacity to resist hegemonic discourses. Rather I have sought to analyse the women’s narratives through the understanding of identity as actively constructed within different discursive contexts whereby persons ‘make meaning’ of their lives ‘as they go’ through ‘patterned everyday methods, as psycho-discursive practices’ (Wetherell, 2007, p. 676). These identities make sense in the moment and are open to negotiation and renegotiation within different discursive contexts with the use and availability of different discursive resources. Through a discursive focus, analysis is centred on what participants are ‘*doing*’ as they speak and the processes through which they construct their subjectivity through their positioning and re-positioning in discourse over time (Allen & Hardin, 2001, p171). Foregrounding this analysis is the understanding that human beings negotiate meanings in a social or communal context and narrative works to simultaneously make sense of both the ordinary and the exceptional through human intentional states of ‘belief, desire and moral commitment’ (Bruner, 1990, p. 9). Narrative (re)construction may also function in ‘an ordering of inchoate experience into a durable sense of identity’ (Neimeyer, 2000b, p. 208).

Taking up the argument that there exists multiple versions of reality, narratives and ways of understanding human action and lived experience, however, are not free of dilemmas. For example, does this mean that all versions of reality are equivalent in their significance? Or do some versions emerge as significantly preferable compared with others? (Wetherell & Potter, 1992)

I have never been inspired by the argument that objectivity is impossible in these matters (as, of course, it is), one might as well let one’s sentiments run loose. As Robert Solow has remarked, that is like saying as a perfectly aseptic environment is impossible, one might as well conduct surgery in a sewer.

(Geertz, 1973, p. 30)

Objectivity may well be ‘impossible’; however, the antithetical position of relativism where all versions are considered equal (to ‘let one’s sentiments run loose’) is also highly problematic. Questions that inevitably follows on from this include – upon what criteria are judgments made to decide which versions ‘matter’? (Baker, 1991, p. 226) and

what versions are embedded in ‘principled positions’ (Gill, 1995, p. 176) and what versions generate moral and ethical considerations, questions and concerns?

There are many versions of what has become widely known as ‘anorexia nervosa’. Rather than arguing for the objectivity of one particular version over another, this thesis adopts the positioning that central to the construction of any psychological illness or disorder is ‘human dialogue and negotiation’ (Raskin & Lewandowski, 2000, p. 17). How human beings access their particular social reality is therefore never free of personal, social and cultural meanings (Raskin & Lewandowski, 2000) and therefore are neither neutral in their effects nor free of values. Neither too are the different constructions of the lived experience of so-called ‘anorexia nervosa’ equal and valid. Constructions may silence, speak for, speak on behalf of and/or seek to hear and represent the voices of the experiencing person. This thesis has sought to hear and represent the voices of a group of women who have committed to give their time and interest over ten years to share their stories of so-called ‘anorexia nervosa’.

Before analysing the women’s stories, I frame the socially constructed category of ‘anorexia nervosa’ within its context: social, political and historical (Chapter 2). Chapter 3 addresses the processes through which the women were engaged in this research. It details the procedures by which interview data was analysed through the practice of critical discursive analysis that has been developed and refined by Margaret Wetherell and colleagues (Edley, 2001; Wetherell, 1998, 2007; Wetherell & Potter, 1992).

Analysis of the interview transcripts begins with a critical discursive case study of the narratives of one woman with a particular focus on shifts in her positioning, both within and between the three interviews she participated in over 10 years (Chapter 4). The discursive materials, positionings and dilemmas analysed in this case study will foreground the analysis of the transcripts of the other eight women who participated in this research over 10 years to examine points of convergence as well as points of departure. Chapters 5 to 7 comprise a number of critical discursive analyses of these women’s narratives in relation to the socially constructed categories of ‘anorexia nervosa’ and ‘recovery’ and ways they navigated within and outside these discursive fields. The final chapter of this

dissertation (Chapter 8) draws together the analyses and implications of this research for both clinical practice and future research.

Chapter 2: Constructions of ‘anorexia nervosa’

[...] two distinct types needed to be separated. In the larger group, which I shall refer to as *genuine* or *primary anorexia nervosa*, the main issue is a struggle for control, for a sense of identity, competence and effectiveness. Many of these youngsters had struggled for years to make themselves over, and to be “perfect” in the eyes of others. Concern with thinness and food refusal are late steps in this maldevelopment. In the *atypical* group, no general picture can be drawn [...]. The concern is with the distorted experiences of the eating function itself; the loss of weight is incidental to this. These patients will continue to be confused with true anorexia nervosa because the severe emaciation and the superimposed conflicts and concerns make them look deceptively alike by the time they come to psychiatric attention.

(Bruch, 1973, p. 251)

I begin with the words of Professor Hilde Bruch, an American psychiatrist whose ideas have been influential in present day understandings of ‘anorexia nervosa’ and whose words capture what has been an ongoing project of the medical establishment to ascertain and scientifically define what is, and is not, “genuine anorexia nervosa”. This chapter briefly traces a range of perspectives on the experience of so-called ‘anorexia nervosa’ and how discursive practices that construct this socially constructed category function and gather momentum to have an ‘ideological effect’ (Wetherell & Potter, 1988, p. 169). This legitimises the power of the medical profession over the voice of the experiencing person.

Rather than reproducing a comprehensive analysis of ‘anorexia nervosa’ that has been produced elsewhere (for example Hepworth, 1999; MacSween, 1993; Malson, 1998), the intention of this chapter is to provide a brief backdrop that places the contested category of ‘anorexia nervosa’ in a historical context with a particular focus on knowledge that is both ‘privileged’ and ‘disqualified’ (White, 1995, p. 119) through this particular construction of human experience. To begin to address these questions, I will briefly trace how fasting practices were understood and constructed in the period before the rise of the medical construction of ‘anorexia nervosa’, that is, medieval constructions of women’s fasting practices.

Saint or witch? Medieval constructions of fasting practices

About this fear, Father, particularly about the matter of eating, I am not surprised; I assure you not only are you fearful, I myself also tremble with fear of a demonic trick. But I place myself in the goodness of God; and do not trust myself, knowing that in myself I cannot trust.

Catherine Benincasa, to a Religious in Florence (as cited in Bell, 1985, p. 22)

In this excerpt from a letter to her religious superior, written sometime between 1373 and 1374, Saint Catherine of Sienna related her fear of “the matter of eating” to whether or not this was understood as either in the service of God or “a demonic trick”. Whichever way she positioned herself on this question, however, she experienced a sense of diminished personal agency and ‘knowing’ that she could not trust herself, only in ‘the goodness of God’.

History that links fasting practices with demonic possession in Europe has been traced to anonymous writings from the 5th century (Vandereycken & van Deth, 1994). In medieval Europe, witches were accused of causing disease, inclement weather that impacted on harvests, miscarriages, impotence and emotions such as love and hate and their emaciation was understood as a requirement for the capacity to fly through the air (Vandereycken & van Deth, 1994).

Women who engaged in prolonged fasting practices in Medieval Europe walked the fine line between being construed as a religious saint or a person consumed by the devil and a witch. In the latter Middle Ages, some religious saints were also charged with witchcraft at Medieval Inquisition trials (Vandereycken & van Deth, 1994). Depicted in Figure 1, the reality of self-starvation during this period was therefore constructed as the work of a witch or the practices of a Saint. These constructions did not merely describe but also created versions of reality within which people slotted themselves and/or were classified by others. A person’s identity, their life and death were understood through these constructions; they were not merely descriptive but had real and material effects, including death if trialed as a witch.



Figure 1: Medieval constructions of practices of self-starvation¹

In addition to being attributed to both demonic and miraculous supernatural forces, fasting practices were also understood as being caused by natural forces (such as by illness) as well as deliberate attention seeking or a state of delusion (Bynum, 1987). In this period, illness for women was seen to be ‘endured’ (Bynum, 1987, p. 199) rather than cured. When physicians were consulted, persistent fasting, despite intervention, led to the conclusion there was supernatural involvement (Vandereycken & van Deth, 1994). Therefore women’s refusal to eat in the medieval period was marked by polarization of moral status between the venerated identities of a religious Saint to the demonized identities of a witch.

The medical ‘discovery’ of ‘anorexia nervosa’

The patient complained of no pain, but was restless and active. This was in fact a striking expression of the nervous state, for it seemed hardly possible that a body so wasted could undergo the exercise which seemed agreeable. It is sometimes shocking to see the extreme exhaustion and emaciation of these patients brought for advice.

(William Gull, 1874, in Hepworth, 1999, p. 29)

¹ Retrieved from http://gaylesbardblog.blogspot.com.au/2011_02_01_archive.html and

<http://stmaryscatherine.org/about-2/our-history/st-catherines-of-siena-church/who-was-catherine-of-siena/>

Credit for the medical ‘discovery’ of what is now known as ‘anorexia nervosa’ was contested between two physicians in the late nineteenth century. The experience was named ‘anorexia nervosa’ in England by Sir William Gull in 1874 and ‘l’anorexie hystérique’ in France in 1874 by Dr. E. C. Lasègue (Hepworth, 1999). Literally interpreted, ‘anorexia’ means ‘a lack or absence of appetite’ and ‘l’anorexie’ is the female noun for ‘anorexia’. This term has since been critiqued as a misnomer (B. S. Turner, 1990) as rather than somehow losing their appetite, the person is understood as intentionally denying their appetite and is actually ‘extremely hungry’ (Steiner-Adair, 1994, p. 390).

On finding no physical or medical cause for the person’s assumed absence of appetite, both Gull and Lasègue attributed the aetiology of ‘anorexia nervosa’ to the psychological. “Nervosa” means ‘of nervous origin’ (Vandereycken & van Deth, 1994, p.1) and “hystérique” is translated to English is hysteric or a person who is ‘morbidly or uncontrolledly emotional’ (The Concise Oxford Dictionary, 1976, p. 530). Hysteric has its origins in the Latin word *hystericus* or of the “womb” (Partridge, 1982) and through the location of the experience as a condition of women, Lasègue related ‘l’anorexie hystérique’ to young middle class women’s failure ‘to move without fuss into their pre-ordained marital and domestic roles’ (Hepworth, 1999, p. 33). In addition to individual psychopathology, Gull also argued that relatives and friends were ‘generally the worst attendants’ (Hepworth, 1999, p. 36). Both these physicians suggested that on unsuccessful attempts to encourage the person to eat, that ‘moral treatment’ commence where the person was isolated from their social network (Hepworth, 1999, p. 36). The conflation of the medical with the moral not only elevated medical treatment as implicitly good but also denigrated women’s practices of food refusal as implicitly bad.

During the first half of the twentieth century the construction of food refusal as pathology and a disease state resulted in the implementation of a number of invasive medico-psychiatric treatments (including prefrontal lobotomy and leucotomy, insulin therapy and electroconvulsive therapy) for ‘anorexia nervosa’ in contexts where the ‘disorder’ was considered intractable (Hepworth, 1999). Paralleling these irreversible and invasive medical treatments were psychoanalytic constructions of ‘anorexia nervosa’ that assumed food refusal to be an unconscious symptom of such understandings as an

‘internalised sexual conflict’, ‘failure to master sexual excitation’ (Bruch, 1973, p. 216) and ‘the wish to be impregnated through the mouth’ (Waller, Kaufman & Deutsch, as cited in Bruch, 1973, p. 216). Located in the unconscious, these meanings of food refusal were inaccessible to the experiencing person except through psychoanalysis.

The medicalisation of practices of food refusal as ‘anorexia nervosa’ culminated in its inclusion in the first version of American Psychiatric Association’s (1952) *Diagnostic and Statistical Manual for Mental Disorders* (DSM-I). DSM-I was intended to develop consistency in nomenclature of mental disorders and communication between treatment centres in the United States through addressing what had been identified as ‘a polyglot of diagnostic labels’ (American Psychiatric Association, 1952, p. v). Within DSM-I, disorders were conceptualized as reactions that fitted with the increased psychiatric caseload during WWII and in the post-war period (American Psychiatric Association, 1952). Within this context, ‘anorexia nervosa’ was constructed as a ‘psychophysiologic gastrointestinal reaction’ and understood as being caused by ‘emotional factors’ (American Psychiatric Association, 1952, p. 30). The introduction of DSM-II (American Psychiatric Association, 1968) marked a significant shift where mental disorders were construed as illnesses rather than contextualised as reactions (Tomm, 1990), thereby aligning psychiatry more closely to medicine. Within this context persons are assumed to present with symptoms rather than ‘problems or concerns’ (A. Lock & Strong, 2012, p. 2).

DSM-III (American Psychiatric Association, 1980) also marked out further extensive changes to the construction of mental disorders through the development of diagnostic criteria and symptom checklists for each disorder for which scientific empirical validation was sought (Tomm, 1990). This adoption of a scientific perspective in medical diagnosis has meant that knowledge of mental illness and practices such as diagnosis have been ‘aligned with reality’ (A. Lock & Strong, 2012, p. 3). This tendency to reify diagnostic categories as ‘naturally occurring phenomena’ has contributed to the understanding of disorders as existing independent of human and social construction (Raskin & Lewandowski, 2000, p. 16). The use of scientific discourse in the construction of mental disorders confers power to those who use it through being granted the uncontested right to speak about the true nature of the reality of the human condition (Sampson, 1993).

Also assumed in this discourse is that human beings have the capacity to access and discover reality in a way that is independent of language construction (Sampson, 1993).

On the other hand, DSM has also been critiqued as lacking in objectivity due to inadequate scientific support and the involvement of influential academics and practitioners in the field through the voting in and out particular diagnostic criteria for individual categories (Raskin & Lewandowski, 2000). What is obscured in this concern with objectivity is the reality of the human involvement and therefore the interpersonal context within which DSM disorders are and will continue to be constructed (Raskin & Lewandowski, 2000). Like other so-called ‘mental disorders’, ‘anorexia nervosa’ has been discursively constructed through symptom checklists that have been modified through successive editions of DSM and how it is defined continues to be contested. The most recent DSM-IV diagnostic criteria for ‘anorexia nervosa’ (American Psychiatric Association, 1995, p. 559) are documented in Box 1.

Box 1: Diagnostic Criteria for 307.1 Anorexia Nervosa

- A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g. weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
- B. Intense fear of gaining weight or becoming fat, even though under weight.
- C. Disturbance in the way one's body weight or shape is experienced, undue influence of body weight or shape on self evaluation, or denial of the seriousness of the current low body weight.
- D. In postmenarcheal females, amenorrhea, i.e. absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen administration.)

Specify type:

Restricting Type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e. self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Binge-Eating/Purging type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

This reification of DSM diagnostic categories so that the individual category itself becomes reality rather than one possible version of a person's reality has resulted in DSM categories being positioned as 'discoveries' rather than 'inventions' (Raskin & Lewandowski, 2000, p. 16). The planning committee for the unpublished DSM-V, in the context of arguing for the importance of a diagnostic system that may be utilized worldwide, has also warned that reification of DSM mental disorder categories to 'to be equivalent to diseases, is more likely to obscure than to elucidate research findings' (Kupfer, First, & Regier, 2002, p. xix). The reification of symptoms of 'anorexia nervosa' has underpinned the majority of research, particularly in the 1960s and 1970s that sought to define not only 'real anorexia nervosa' but also the sort of person who was eligible to be slotted into this category.

'Real anorexia nervosa'.

Early research that followed the inclusion of 'anorexia nervosa' in DSM-I sought to ascertain what motivated the person to starve themselves in the first place. Chosen to be pivotal in defining 'primary anorexia nervosa' (King, 1963), later repositioned as 'genuine anorexia nervosa' (Bruch, 1973), was presence of food refusal as 'a source of pleasure indulged in for its own sake' (King, 1963, p. 471). In seeking out causal relationships by characterising the sort of person (or woman) who fitted into the category itself, King (1963) concluded that these women were intelligent, perfectionistic, obsessional, reacted with disgust and withdrew from sexuality and were from families with domineering mothers and uninvolved fathers who developed symptoms of irritability, hyperactivity and hostility. Those who did not fit this category of 'genuine anorexia nervosa' were later accused of creating confusion around this real picture of what an 'anorexic' is (For example, see opening quote of this chapter from Bruch, 1973).

Attribution of some of the symptomatology to the mental disorder 'anorexia nervosa' and therefore to psychological causes, however, became questionable when viewed in light of research by Ancel Keys in the 1950s into the physical and psychological effects of human starvation and emaciation (Garner, Rockert, Olmsted, Johnson, & Coscina, 1985). A group of 36 men who were WWII conscientious objectors, who had no history of an eating disorder, were recruited into a starvation study and over six months of

semi-starvation lost on average 25% of their original body weight, followed by a period of three months of re-feeding back to their original body weight. The psychological effects of semi-starvation in these previously healthy men were not unlike what had been attributed to the mental disorder ‘anorexia nervosa’ in women.

[...] the psychological manifestations found characteristically in all subjects: an intense preoccupation with thoughts of food, emotional changes with a tendency towards irritability and depression, decrease in self-inflicted activity, loss of sexual drive, and social introversion.

(Keys, 1950, p. 881)

Key’s research therefore posed a challenge to the research that reified the category of ‘anorexia nervosa’ so the category itself became the person’s reality. Instead under-nutrition itself was found to lead to many of the characteristics of the person that had been previously assumed to be causes of ‘anorexia nervosa’ (Garner, et al., 1985).

Rather than abandon this project of seeking out causation of ‘anorexia nervosa’ that has been motivated in part by the assumption that discovery of the cause will result in a cure (Garrett, 1994), the medical project of ascertaining causes of ‘anorexia nervosa’ that implicate individuals and their families has nevertheless continued. Various aetiologies of ‘anorexia nervosa’ have focused on deficits and dysfunctions within both individuals and their families. Individuals have been accused of acuteness of certain personality traits (such as perfectionism and obsessionality), a lack of self awareness and ability to express and regulate emotions (Garner & Bemis, 1985) and too little of other characteristics many of which are revered in Western culture such as self esteem, independence, autonomy and sexual drive. Families have been accused of a lack of ‘necessary separation and individuation’ (Bruch, 1994, p. 7) with too much emphasis on over compliant behaviour in their daughters. Fathers have been accused of being too feeble (Palazzoli, Cirillo, Matteo, & Sorrentino, 1989) and ‘passive’ (King, 1963) and mothers of being too ‘meddling’ (Palazzoli, et al., 1989, p. 178), over-involved, ‘dominant and restrictive’ (King, 1963, p. 470); and the list goes on. Within many of these conceptualisations, ‘anorexia nervosa’ has been understood as a solution or pseudo solution to counter and conceal a defective self concept (for example, an inner sense of ‘emptiness or badness’ (Bruch, 1994, p. 5)) and/or the product of dysfunctional or ‘warped’ family dynamics (Palazzoli, et al., 1989, p. 14).

Paralleling the pathologising of ‘anorexia nervosa’ as disorder has been an unprecedented rise in the cultural prescription for women that equates beauty with not only slenderness but also “bare-boned skinniness” (Seid, 1994, p. 11). As standards of beauty for women in Western cultures have become increasingly embedded in a phobia against body fat, so too the criteria for real or genuine ‘anorexia nervosa’ has become more closely construed around the notion of weight phobia, which has been argued as being ‘the central organising motive in anorexia nervosa’ (Habermas, 1996, p. 317).

The push to make weight phobia resulting in ‘dysfunctional dieting’ central in the psychological disturbance in ‘anorexia nervosa’ has resulted in the argument to rename ‘eating disorders’ to ‘dieting disorders’ (Beumont, 1995, p. 151). Constructing dieting and weight phobia as central in ‘anorexia nervosa’, however, has been criticised as ethnocentric and culturally biased (Lee, Ho, & Hsu, 1993). Lee et al. (1993) have argued that regardless of the presence of weight phobia, triggers for ‘anorexia nervosa’ include struggles over issues related to power and control and propose that removal of fat phobia as the central feature of ‘anorexia nervosa’ may create the conditions to ‘... transcend local variations in the content of anorexia nervosa and come close to a culture free disease classification’ (p. 1014).

The search to define what real ‘anorexia nervosa’ is and the assumption that it is possible to ‘transcend’ culture assumes that it is possible for human beings to access reality in a way that is free of language constructions and therefore independent of talk. Clifford Geertz (1973) has argued that humans are thoroughly constituted by culture - ‘Without men, no culture, certainly; but equally, and more significantly, without culture, no men.’ (p. 49) and this brings into question the possibility of ever achieving a disease classification that is culture-free. That is not to say that engaging in food refusal practices that lead to an emaciated body do not occur in cultures outside the West but more so, that how these practices are understood within different cultures will have a constitutive effect on how this reality is experienced and understood by the person themselves and others.

Multidimensional models and the accommodation of culture.

With the central ‘cognitive disturbance’ of eating disorders being argued to be an ‘over-evaluation’ and control of eating and body shape control’ (Fairburn et al., 2003, p. 522) there has been an inescapable link between eating disorders and a culture that places excessive value and moral worth on those who achieve a thin body. In response to this, a number of researchers have accommodated culture into theoretical frameworks that are often termed multidimensional (for example, Tylka & Subich, 2004). Culture has been understood as a channel for women’s ‘dissatisfactions and distress’ and an individual’s focus on body shape has been construed as ‘an outlet for individual pathology’ (Polivy & Herman, 2002, p. 193). The extreme taking up of cultural prescriptions for thinness within these models is therefore construed as dysfunctional, not normal and in need of correction.

The more recent transdiagnostic model that has argued for a move away from discrete eating disorder categories to account for the frequent movement of individuals between categories continues to rely on the assumption that within the person there exists individual deficits or ‘core psychopathology’ (Fairburn, et al., 2003, p. 520). These so-called deficits are construed as ‘clinical perfectionism’, ‘core low self-esteem’, ‘mood intolerance’ and ‘interpersonal difficulties’ (Fairburn, et al., 2003, pp. 521-522). Therefore within these medical illness models there has been a tendency to add on or accommodate cultural influences (Sampson, 1993) along with other individual and familial causes of eating disorders, including many of those discussed already. These models assume a “stratigraphic” conception’ of human beings (Geertz, 1973, p. 37) whereby culture is added on and when peeled off, reveals an individual’s psychological makeup, which when peeled off is assumed to leave the biological foundations of the person.

Multidimensional models that seek to accommodate culture into their frameworks have been a response to a counter-movement inspired by feminism that has taken a stance against the medicalisation of ‘anorexia nervosa’ as individual pathology. Central to these feminist arguments has been the accusation against patriarchy for the genesis of women’s ‘new religion’ centred on body shaping practices and ideals (Seid, 1994, p. 13) and the increased prevalence of ‘eating disorders’.

Feminism and ‘anorexia nervosa’

When psychiatry labeled the behaviors we have come to call anorexia and bulimia, the naming process rendered invisible the meaningful aspects of these soulful struggles. “Anorexia” means “absence of hunger”, “absence of appetite”; this is not an accurate description of the experience of anorexic girls and women, who are extremely hungry but willingly deny their bodily appetite in their drive to make their feminine matter extinct. What is missing from the psychiatric label is the power of the drive for starvation in order to make extinct the corporeal feminine form. (Steiner-Adair, 1994, p. 390)

Since the 1970s, the feminist movement has sought to understand women’s distress in ways that exist outside medical disorder constructions. Within this context, ‘anorexia nervosa’ has been positioned as both a protest and solution to modern patriarchal oppression of women (Wolf, 1990), including an illusionary ‘entry into the privileged male world, a way to become what is valued in our culture’ (Bordo, 1993, p. 179). Over the past 40 years, there has been a number of ways that feminists themselves have understood women’s struggles with food and their bodies. These divergent theories have been influenced by shifts in philosophical thinking at the time, most markedly the move from (and between) structuralist and post-structuralist conceptions of reality. I have therefore structured this analysis of feminist conceptualisations of ‘anorexia nervosa’ into structuralist and post-structuralist feminist constructions with the understanding that not all feminist theories fit neatly within these categories and some move between the divergent assumptions that assume these different modes of thought.

Feminist structuralist constructions of ‘anorexia nervosa’.

Positioning ‘anorexia nervosa’ as protest and a solution to modern patriarchy has led to arguments that women’s attainment of a skeletal body is a form of protection against sexual attention and harassment by men (Wolf, 1990), a reclaiming of power through self denial and control (Lawrence, 1979) and a way to voice struggles as they take on new found rights in a patriarchal society (Chernin, 1985). Suzie Orbach (1986) has also depicted ‘anorexia’ as a ‘metaphor for our time’ (p. 24) through which women struggle with the contradiction between striving to be either invisible or visible in their lives. Therefore in seeking to de-pathologise and humanise the individual, these early feminist theories have tended to take up a position that valorises women’s body shaping acts of food refusal as a viable solution to modern patriarchy. What remains unanswered within these arguments is:

how can an act that has the potential to lead to an individual's death be a solution to disempowerment?

In seeking to address why some women become 'anorexic' and others don't when they are immersed within the same culture, a number of feminist theorists and therapists have drawn on psychological theories that prevail at the time. For example, Suzie Orbach has argued that beneath the social context is 'the workings of the unconscious' (Orbach, 1986, p. 103) and a defective self concept where 'anorexia' is understood as a defence against a sense of 'inner emptiness' and 'the absence of an integrated ego' (Orbach, 1986, p. 108). Marilyn Lawrence (1984) has likewise valorised 'anorexia' as a defensive structure, a 'protective outer shell', that conceals and protects the 'real self' who exists underneath or behind this defence (p. 22). Cultural context is construed as outer to these inner happenings where 'we collectively project onto fatness bad qualities that really do not belong to it at all, but to ourselves' (Lawrence, 1984, p. 39). The identity crisis at the heart of 'anorexia' is also construed as an irresolvable 'struggle for autonomy' (Lawrence, 1984, p. 49).

Underpinning these feminist structuralist theories, like the multi-dimensional medical models, is a multi-layered conception of human beings where culture is accommodated onto an experience that is construed as a disorder of the self. Within many of these theories, the self is assumed to be a bounded unity that exists at the core of a human being where the ideal self is equated with the Western patriarchal ideal of an autonomous self or the 'ideal *man* not the ideal woman' (MacSween, 1993, p. 43). This human-centred view assumes the person to be a unified being who is at the centre of meaning and action (Rice & Waugh, 1989), which Clifford Geertz argues as being 'a rather peculiar idea within the context of the world's cultures' (Geertz, 1975, p. 48).

In utilising a feminist phenomenological methodology, Catherine Garrett (1997) has sought to fill a gap in the research literature that had been saturated with attempts to explicate a cause or develop and evaluate treatment interventions for 'anorexia nervosa'. Through researching recovery narratives, 'anorexia nervosa' is conceptualized as a rite of passage where through fasting practices a person separates from who they once were and from their community through a paradoxical attempt to conform to the same culture's

limited prescriptions (Garrett, 1998). 'Anorexia' is construed a period of marginality or liminality, which is 'betwixt and between' (V. Turner, 1969, p. 95) where the person is no longer who they once were and not yet who they will become (Garrett, 1997). As a person moves to reincorporate themselves into the community they reconnect with themselves (through body, mind and spirit), others and nature and experience a sense of themselves as having been empowered through suffering. Through this analysis, 'anorexia nervosa' is understood as a '*quest for meaning*', which for some is experienced as a spiritual quest much like a '*religious conversion experience*' with an accompanying sense of 'joy, peace and certainty, following a period of despair and suffering' (Garrett, 1998, p. 187). Although some people may experience contentment and certainty after suffering, there nevertheless exists a risk that this understanding becomes an expectation for all individuals who recover from 'anorexia nervosa'. Even though recovery is construed by Garrett (1998) as an ongoing cyclical process rather than an endpoint, an implication of this overarching rite of passage metaphor is that there is something missing or wrong with a person if their recovery is not experienced and construed in terms such as 'joy, peace and certainty' (p. 187).

Therefore within structuralist feminist constructions there has been a tendency, like in multidimensional medical models, to accommodate culture as one of the many layers that constitute the experience of 'anorexia nervosa', thereby leaving the prevailing discourses largely intact and 'the new is simply added onto the old without fundamentally changing the old' (Sampson, 1993, p. 1220). On the other hand, later feminist constructions have become increasingly informed by post-structuralist ideologies that understand culture as constitutive of not only 'anorexia nervosa' but of human reality itself. These post-structuralist feminist conceptualisations have sought to make visible the power of dominant discourses in not only defining what 'anorexia nervosa' is but also in shaping the identity, subjectivity and reality of the experiencing person who engages in such practices (Sampson, 1993).

Post-structuralist feminist constructions.

The 1980s marked a shift in theorising where, rather than an object that was shaped by external influences, the body became understood as a site for the inscription of cultural

discourse (Hepworth, 1999). Influential in this shift was Foucault's early concept of 'docile bodies' (Foucault, 1979, p. 138), where modern power was theorised as being exercised through discourses that incite individuals to operate on themselves and their bodies to fit prescribed cultural norms and ideals. This power, rather than repressive was theorised being experienced by the individual as not just doing as they wish but *operating* as they wish (Foucault, 1979).

'Anorexia nervosa' became a subject of post-structuralist analyses of the body because of the seemingly clear association between the uptake of discourse through practices of self-monitoring and self-surveillance and its inscription on the body (Hepworth, 1999). Feminist post-structuralist analyses have argued that women's bodies are 'deeply inscribed with an ideological construction of femininity' (Bordo, 1993, p. 168) that erases differences between women and coerces them towards a normalised ideal. Within these analyses, symptoms (such as "feeding others while starving oneself" and "whittling down the space one's body takes up") have not only "symbolic" but also "*political* meaning" (Bordo, 1993, p. 168). In addition to this, the focus of these analyses shifts from the understanding of social pressures as external forces that impact upon a self-contained individual to the understanding that it is within social and cultural contexts that identity is multiply constructed and contested (Hepworth, 1999).

For example, Malson & Ussher's (1996) post-structuralist analysis has drawn on a Foucauldian discourse framework to analyse how discourses play out and converge on 'the anorexic body' (p. 270). Analysis of women's narratives in this research argued that these women were caught in a paradox of meaning where the thin body is assumed to both attract a powerful male (romantic discourse) as well as signifying independence through control of the mind over the body (dualist discourse) (Malson & Ussher, 1996). Although Malson and Ussher (1996) argue that making transparent the operation of these discourses creates 'a form of knowledge which can be made available to clients to do with as they see fit' (p. 278), there is little indication as to what the individual might do with this knowledge or even how they might access this knowledge in the first place. If theorizing lived experience in terms of how women are positioned by powerful of hegemonic discourses that may be largely beyond their conscious knowledge and control, then there is also limited scope in

which to understand how women reposition themselves and generate alternative subjectivities and lived experiences when they continue to be subjected to the same cultural discourses.

Malson (1999) has further conceptualised the 'anorexic body' as 'disappearing bodies that signify a (feminine) 'anorexic' identity constructed as an identity-put-under-erasure' (p. 137). This disappearance of the body in 'anorexia' is argued to be not only literal with the physical effects of self-starvation but also in the displacement of the body with 'the-body-as-image' where the body is experienced as something to work on and shape into culturally produced images (Malson, 2009). Within this conceptualisation a paradox is highlighted where the production of 'body-as-image' that is about looking a certain way, and denial of embodied subjectivity is also about not wanting to be looked at and wanting to disappear (Malson, 2009).

Within these (and other such) analyses of discourses, the body is assumed to be a medium upon which discourses are mapped and etched. This assumption may limit the understanding of first, human consciousness as a means by which power may be actively resisted and second, the possibility that the nature of the body's surface (as related to racial and gender specificity) may influence the meaning of inscribed messages (Grosz, 1994). There may also be a neglect of the discursive context of research interviews to (inadvertently) reproduce particular and possibly problematic identities.

Liz Eckermann (1997) has argued that Foucault's later work moved from the assumption of a 'docile self' to a more 'active self' (p. 154) and that within his work there is the potential for agency to be exercised within different discursive fields that has implications for the generation of alternative subjectivities. The conceptualisation of 'anorexia nervosa' as a 'discursive object' (Allen & Hardin, 2001, p. 167) that marks out a range of subject positions provides scope to understand the person as able to negotiate and "choose" the positions that they take up that are constitutive of their subjectivity. For example, in an analysis of virtual 'anorexia' internet bulletin boards, persons who were positioned or positioned themselves as desiring to be 'anorexic' were construed as disingenuous or fake (Hardin, 2003a). This subject position of "fake" anorexia positions such individuals as 'other' than the dominant medical construction that assumes 'anorexia'

results from individual and/or familial psychological issues and is not consciously brought about by the individual. Understanding ‘anorexia’ as marking out a range of subject positions enables analysis to focus on how the individual is not only situated but also as active in refusing, adapting, adopting and negotiating their identities when the discursively constructed category of ‘anorexia nervosa’ is applied to them (Hardin, 2003a). Following on from this, a range of other questions may be asked; including how people are recruited into speaking about themselves in relation to their actions and concerns and what other terms of speaking might be available to them? Within which discursive contexts might alternative subject positions that are less damaging be generated, taken up and sustained? (Hardin, 2003a)

Julie Hepworth (1999) has argued that retaining the term ‘anorexia nervosa’ creates a ‘discursive dilemma’ (p. 104) for feminist researchers because of the implications of use of this term itself in locating the experience outside the realm of the socio-cultural and inside the realm of individual disorder and psychopathology. This dilemma has also been identified in therapeutic practices that have been informed by post-structuralist ideas, particularly narrative therapy (White, 1991; White & Epston, 1990), where the use of language in therapy is understood as not merely descriptive but also constitutive of identity and generative of experience (Freedman & Combs, 1996).

Post-structuralism and narrative therapy

In therapeutic work with a woman struggling with ‘anorexia nervosa’ (“Amy”), Michael White (1991) has drawn on Foucault’s ideas to locate her actions of policing and disciplining her body as ‘technologies of the self’ that were intended for self transformation ‘into an acceptable shape’ (p. 36). Through engaging Amy in an externalising conversation that enquired into the real effects of anorexia nervosa on her life, he argued that these ‘practices of self government’ became questionable, ‘the ruse was exposed’ (White, 1991, p. 36) where what had been previously assumed to be practices of the self were understood instead as practices of power and alien to her identity. Amy was then in a position to explore ‘alternative and preferred practices of self and of relationship’ (White, 1991, p. 36). Questions of human agency are central in this process -

This sense (of agency) is derived from the experience of escaping “passengerhood” in life, and from the sense of being able to play an active role in the shaping of one’s own life according to one’s purposes and to the extent of bringing about preferred outcomes. This sense of personal agency is established through the development of some awareness of the degree to which certain modes of life and thought shape our existence, and through the experience of some choice in relation to modes of life and thought we might live by.

(White, 1991, p. 38)

Fish (1993) has labelled White & Epston’s (1990) appropriation of Foucault’s project to locate aspects of narrative therapy, particularly the alignment of personal stories with discourse, as ‘selective and flawed’ (p. 222) and perpetuating rather than solving questions of power. He also argues that therapeutic intentions to assist persons to shift from a damaging to more sustaining narrative is potentially reinforcing of the prevailing oppressive cultural discourse, which constrains their narratives in the first place (Fish, 1993). He exemplifies this critique by stating that therapy that assists a person to shift from the identity of a “mental patient” to a story where he or she is “normal” and not a “mental patient” (Fish, 1993, p. 223) is important, but the person continues to be constrained by the terms of the overarching, dominant medical discourse. Whilst I agree with Fish’s position, his critique of White’s project of incorporating deconstruction in therapy could also be critiqued as selective and de-contextualised from the broader concerns of narrative therapy to assist persons to speak outside the terms of the dominant medico-scientific discourse.

At times, especially when persons have been encouraged to use “scientific classification” to describe their concerns, persons offer problem definitions in terms that are informed by “expert knowledge”. These retranscriptions [...] do not provide definitions that enable persons to review their relationship with the problem or allow for unique outcomes to be identified. Thus, these retranscriptions frequently diminish the possibilities for persons to experience a sense of personal agency. It is often important to encourage persons to construct alternative definitions of problems: definitions that are most relevant to their experience [...]

(White & Epston, 1990, p. 53)

Over the course of his work, White (1995, 2007) prioritised not only therapeutic practices of deconstruction in therapy but also the understanding that such practices provide a context for persons to take up alternative positions to both define their experience on their own terms as well as to re-author preferred identity narratives, particularly in terms of

human intentional states of values, hopes and purposes for their life (Bruner, 1990). With the cognitive revolution, Bruner (1990) argued that these intentional states have been marginalised and relegated the status of ‘the folk psychology of ordinary people’ (p. 32) through the privileging of knowledge produced by the cognitive sciences. This shift from a cognitive sciences based psychology to a cultural psychology was part of Bruner’s (1990) project to make central in psychology how human beings organise and make meaning of their lives and identities through such forms as narrative that ‘relies on the power of tropes – upon metaphor, metonymy, synecdoche, implicature’ (p. 59) and are sensitive to the context within which they are used. Few theories of ‘anorexia nervosa’ have invested in understanding how the person themselves construes their lived experience of so-called ‘anorexia nervosa’, makes meaning of their actions ‘under the sway of intentional states’ (Bruner, 1990, p. 9) and re-authors an identity that is sustaining rather than pathologising of their actions in terms of the sort of person they were, are and hope to be.

My choice to interview women in this research with questions drawn from the paradigm of narrative therapy has been intentional. It is consistent with the aims of this thesis to provide a context for women to have a voice to speak about their experiences of ‘anorexia nervosa’ on their own terms that are not confined to the dominant medical discourse. This research seeks to develop insights into the extent by which it was possible within this specific discursive context for women to be able to break free from the prevailing medical discourse and experience freedom to speak on terms outside the discursive field of ‘anorexia nervosa’.

In summary, this thesis is not intended to add to the already established argument about what is, and what is not, ‘real anorexia nervosa’. Far more important to me than the question of what is ‘real anorexia nervosa’, is the acknowledgement that any decision on what ‘anorexia nervosa’ is or how it is labelled is a philosophical choice, laden with value judgements that change over time and place (Elfran, Lukens, & Lukens, 1990).

Julie Hepworth (1999) has argued for a ‘move beyond the language of psychopathology’ (p. 123) in ‘anorexia nervosa’:

[...] the shift in reconceptualising anorexia nervosa requires a dialogic framework that involves participants in a process of positive change [...] to

move beyond positioning individuals diagnosed with anorexia nervosa as psychiatric patients and towards enabling their participation in the public domain as citizens.

(Hepworth, 1999, p. 124)

This thesis intends to embody Julie Hepworth's question. How do women themselves reconstruct the narratives of their experiences of so-called 'anorexia nervosa' in a discursive context that does not confine their talk to the terms and conditions of illness discourse? In the body of research into this thing called 'anorexia nervosa' few studies see 'anorexia nervosa' as a construction in and of itself, nor has consideration been given to the impact of this construct on a person's identity, or who they understand themselves to be. Even fewer have explored the processes through which a person generates alternative positionings and thereby constructs alternative subjectivities and senses of identity and how these alternative constructions are performed in a person's life. In other words, where does a person move to when they move away from speaking about their experience in terms marked out by the dominant 'anorexia' discourse? Are these alternative positionings arrived at by accident or through active and examined re-positioning? Before addressing these questions that are the heart of this thesis, the processes through which this research sought to answer these questions will be outlined.

Chapter 3: A critical discursive analysis of ‘anorexia nervosa’ narratives

At the heart of this thesis are questions of identity in relation to the experience discursively constructed as ‘anorexia nervosa’. This chapter further develops the platform for this enquiry into women’s experiences of so-called ‘anorexia nervosa’ through the lens of critical discursive analysis, particularly drawing on the methodological and analytical work of Margaret Wetherell and colleagues (Edley, 2001; Potter & Wetherell, 1987; Reynolds & Wetherell, 2003; Reynolds, et al., 2007; Wetherell, 1998, 2007; Wetherell & Potter, 1988). This approach both converges and diverges from other discursive approaches and, in doing so, seeks to develop a framework to analyse ‘questions of identity and people’s investments in particular identity positions’ (Wetherell, 2007, p. 662).

Outlined thus far, I have taken a constructivist position in this thesis where language is understood as carving out and building different versions of reality. From this perspective, ‘anorexia nervosa’ may be understood as one version (of many possible versions) of the reality of persons who engage in practices of food refusal in western society in the 21st century. This is the dominant version and assumes the person to be sick and to have an illness and/or disorder that meets the diagnostic criteria for ‘anorexia nervosa’ specified in the continually modified versions of DSM. Within this context, ‘anorexia nervosa’ is a ‘discursively constructed social category’ (Reynolds & Wetherell, 2003, p. 492) that marks out ‘an array of subject positions’ (Parker, 1994, p. 245) as well as a discourse (Reynolds & Wetherell, 2003). The carving out of reality through the dominant medical discourse of ‘anorexia nervosa’ creates what Foucault has referred to as both a positive and negative space that ‘may define the boundaries of what may be said and done’ (Allen & Hardin, 2001, p. 165) and therefore how a person speaks of and makes sense of their lives. This discourse therefore directs the terms of this speaking and the subject positions that are available to individuals. This discourse categorises, pathologises, clarifies

and obscures particular ways of being, whilst also setting a standard for normality (Reynolds & Wetherell, 2003).

I chose to analyse women's interview transcripts by using this critical discursive approach for a number of reasons. First, my central concern in this research was to analyse the women's experiences and through attending to their words to analyse how they actively portrayed, negotiated and constructed their identities within the discursive context of the research interview. Second, I was also concerned not to impose an analysis of abstract discourses onto women's narratives in an effort to make political statements, however important these might be, and in doing so 'do a social injustice' (Widdicombe, 1995, p. 124) to the women who participated in this research by missing the significance of their words and stories in the construction of their identities. Therefore my choice of research methodology was to keep alive the notion that women were not only positioned by hegemonic discourses that may have escaped their conscious awareness at a particular time, but also that they were active in positioning themselves both within and outside the discursive field of 'anorexia' as they sought to make sense of their lives and identities (Reynolds & Wetherell, 2003).

Understanding the person as an active user of discourse provided scope to understand how personal meanings and social identities were continually (re)constructed, (re)negotiated and (re)formed through argument, dilemmas and rhetoric (Billig et al., 1988; Burr, 1995). Of relevance in this analysis was the discursive contexts of the research interviews that were intended to create a discursive climate for women to generate alternative positions that existed outside the discursive field of 'anorexia' and how from these divergent positions, women authored alternative versions of their experiences and identity. This chapter therefore introduces the women who participated in this study, the discursive context of their interviews and details the analytic dimensions of critical discursive analysis.

The study

The research data comprised of transcripts of interviews with nine women (of an initial group of 21 women interviewed when this research began in 1997) who participated in three research interviews between 1997 and 2007. The first interview was conducted in

1997-1998, the second one year later in 1998-1999 and the third interview was in 2007, between nine and 10 years after the first interview. Although the dataset that was selected for analysis was the nine women who were able to be recontacted in 2007 and were interested in further participation, all 21 women who participated in this research from the outset shaped the course and lines of enquiry of this research. Therefore this chapter will draw in some of my reflections related to stretches of text from these interviews with the 21 women who first participated in this research to provide a backdrop to the further lines of enquiry that were chosen in later interviews.

Participants and research news stories

In 1997, 21 women volunteered to participate in this research. Seventeen of these women responded to a news story published in a Sydney tabloid newspaper (Sheather, 1997, Appendix 1a) and four responded to a news story published in a local newspaper (Appendices 2b and 2c). The news story in the Sydney-wide newspaper described how I, as primary researcher, had previously worked as a dietitian with people who experienced eating disorders and that this research was part of my PhD in psychology. The news stories stated that I was interested in hearing and researching the experience of ‘anorexia nervosa’ from the perspective of the experiencing person and the meanings they ascribed to their lived experience. Although seeking at the time to research new and different ways of understanding the experience of ‘anorexia nervosa’, from the benefit of hindsight, these news stories signify how my positioning continued to be shaped by the dominant medical discourse, which I had taken up in the context of many years of working within a medical model.

The extent to which I was inadvertently positioned by the dominant medical discourse is most notable in the version that was generated in the larger news story (Sheather, 1997) published Sydney-wide. The research question, co-constructed by Wendy Sheather and I, was rhetorically positioned as “the changing demographics of anorexia” (Sheather, 1997, p. 158), within which there was an assumption that the demographics of those who experience “anorexia nervosa” had indeed changed. Rather than the women’s experiences being understood in terms outside the dominant ‘anorexia’ discourse, framing the research question in this way meant extending the category to include those who do not fit into

the stereotype or ‘classic category’ rather than questioning the category itself. What was obscured in this research question was my enduring concerns (after having worked in the public hospital system) that access to many treatments and treatment studies was reserved for the financially privileged or ‘middle to upper classes’ thereby silencing those less financially privileged and contributing to the stereotype depicted in the opening sentence of the news story. Therefore the focus of this research study on the changing demographics of ‘anorexia nervosa’ rendered invisible the previous presence of this less privileged group of persons and failed to make transparent the imbalance of power between these so-called ‘groups’ of people (J. Conti, 2005). Expressing my concerns and intentions for this research using the only language I knew at the time (that is the dominant medical discourse) is one way I look back and see not only how ‘people use discourse’, but how ‘discourse uses people’ (Potter, Wetherell, Gill, & Edwards, 1990, p. 213).

All the 21 women who consented to participate in this research identified themselves as having experienced ‘anorexia nervosa’ either currently or at some point in their lives (see appendix 1 for information and consent forms and ethics approval). Sixteen of the 21 women had been medically diagnosed with ‘anorexia nervosa’ and for eleven of these women treatment included inpatient hospitalisation in an eating disorder and/or psychiatric unit. (See Table A in Appendix 3 for details related to these women’s diagnosis and treatment history). Given that the position of this thesis is that ‘anorexia nervosa’ is a discursive field and one of many ways of looking at the experience of food refusal and body shaping practices that lead to an emaciated body, I sought less to define those who fitted DSM-IV criteria for ‘anorexia nervosa’ and rather to understand the processes through which women took on this classification as relevant to their lived experience. All the women interviewed had engaged in food refusal practices and lost significant amounts of weight at some point in their lives that incidentally could have led them to meet criteria for a DSM-IV diagnosis of ‘anorexia nervosa’. Nevertheless, using the term ‘anorexia nervosa’ itself required participants to identify with this term as relevant to their lived experience and inadvertently excluded those who may relate to their experience with other terms, such as ‘eating issues’ or ‘starvation’ or ‘controlled eating’.

Seventeen of the 21 women resided in a diverse range of locations within the Sydney metropolitan area, three from country New South Wales and one from another capital city in Australia. These women ranged in age from 19 to 44 with an average age of 30. The majority of women interviewed were similar in terms of ethnicity (white Australian), had variable levels of education and employment. All were fluent in English, both spoken and written (See table B in Appendix 3 for more detailed demographics of the women who participated in this research).

At first glance what stands out from this community sample of volunteers is the absence of men. Although the female-to- male ratio for ‘anorexia nervosa’ is more than 10:1 (Hoek & van Hoeken, 2003), the absence of contact by men is worth comment. The majority of women who participated in this research had responded to the news story in the Sunday tabloid newspaper (Appendix 2a). Much of this news story was focused on girls and women, culminating in the statement:

“The only certain factor about anorexia now is that it still affects women predominantly”

(Sheather, 1997, p. 158)

‘Anorexia’ was therefore positioned as a problem of women closing down space for men to participate, albeit unintentional at the time. On the other hand if the same proportion of men had volunteered for this research as that reported in the literature (based mainly on clinical samples), only one to two men would be expected to participate. This, however, was neither an epidemiological study nor a study concerned with generalising its findings to all people who experience so-called ‘anorexia nervosa’, so therefore the main implication for this research is that it focuses on these women’s experiences of so-called ‘anorexia nervosa’.

The interviews and data

All women participated in a semi-structured open ended interview for between 90 and 120 minutes after consenting to the research. A year later, 18 of the 21 women were re-interviewed and then around 10 years after the first interview, nine women were re-interviewed.

In 1997, this research commenced with the intention to engage in a cross sectional analysis of the experience of ‘anorexia nervosa’. Due to the unexpected turns in my life, outlined in the preface of this thesis, what emerged was an opportunity to analyse both cross sectional and longitudinal shifts over 10 years in women’s positioning in relation to the discursive field that constructs ‘anorexia nervosa’ as illness. Not only did women shift, but so too did I as researcher over this time (as outlined in the preface of this thesis) and my lines of enquiry were shaped by an interweaving of my own shifts and through the process of analysing women’s interview transcripts; hence the recursiveness of the research process. The remainder of this chapter will address the process of this research enquiry including the questions that were asked of women over 10 years. Interviews in 1997-1998 will be referred to as the women’s ‘first telling’, interviews in 1998-1999 as the women’s ‘second telling’ and interviews in 2007 as the women’s ‘third telling, 10 years on’.

Conversations with women – first telling

Prior to commencing this research in 1997, I was interested in researching the experience of ‘anorexia nervosa’ through tapping into these women’s meanings and understandings. My conversations with women who participated in this research were intended to be a site through which they could explore their experiences from a number of perspectives or thick description (Geertz, 1973), rather than to reproduce research that was confined to the terms and conditions of the dominant medical discourse.

Between 1997 and 1998, 21 women told me their story of ‘anorexia nervosa’. The lines of enquiry that were chosen for this first telling focused on exploring how women ascribed meaning to their lived experience and a number of these questions were drawn from the paradigm of narrative therapy (see Appendix 4a). Within each conversation only a selection of questions were used to engage women into this particular type of telling of their story of ‘anorexia’ and therefore each interview was unique and guided by the individual woman’s responses.

The interview questions in this research sought to use the principles of externalisation of the problem as developed by Michael White and David Epston (1990) in the practice of narrative therapy. The type of externalisation used in this first telling

focused on mapping the effects (White & Epston, 1990) of ‘anorexia’ on the women’s lives and relationships and how they ascribed meaning to these effects. This is the first of ‘two sets’ of ‘relative influence questioning’ (White & Epston, 1990, p. 42) in externalising conversations². Through using the narrative practice of externalisation of the problem (White & Epston, 1990) there is a difference in the way reality is carved up compared to the language of medical discourse. This linguistic shift in questioning provided a discursive climate for women in this research to reconstruct their narratives on terms that linguistically separated their identity from the problem (Tomm, 1989) and re-positioned themselves on problems dominating their life that are supported by ‘unitary knowledges and “truth” discourses that are subjugating of them’ (White & Epston, 1990, p. 30). The practice of externalising their struggles on their own terms resonated with the uncomfortable sense I had felt for many years when witnessing individuals being pathologised and blamed for being ‘anorexic’ and treated as though *they* were the disorder.

In addition to this, the women were also asked if they named their experience ‘anorexia’ or whether they had another name for their experience. I now recognise that asking the participants this question on opening our first conversation, before I had opportunity to explore in detail the meanings and their positioning on the label ‘anorexia’, reduced the opportunity for them to name their experience on their own terms rather than on the terms of the dominant ‘anorexia discourse’. Nevertheless, I remained curious throughout the research interviews about the terms that women used to talk about their experiences, terms that were not confined to the terms and conditions of the ‘anorexia’ discourse.

This deliberate choice of questions from the practice of narrative therapy inevitably leads to the question, were these interviews narrative therapy? As raised earlier, language is not neutral in its effects. If I had chosen to reproduce the more available talk of the dominant medical discourse that internalises and locates ‘anorexia nervosa’ as a disorder that resides within (Gergen & McNamee, 2000), women’s identity narratives would likewise have been shaped and potentially confined to this discursive field. Therefore, my

² The other set of relative influence questioning was taken up more extensively in interviews with the women in their third telling, 10 years on, and will be discussed in the section of this chapter ‘Conversations with women 10 years on’ (p. 43)

choice to ask women externalised questions that created dialogue that was not confined to the discursive field of ‘anorexia’, although not therapy, may have had a therapeutic effect.

Not only were women shaped by the research interviews and the questions asked, so too was I as researcher shaped by their responses and perspectives. My shaping influenced my subsequent questions and reflections that in turn shaped the women’s narratives. Research is never neutral in its effects and, rather than seeking to conceal this inevitability through claims of researcher objectivity and neutrality, this research seeks to highlight, examine and make transparent this recursive process.

A significant body of research into ‘anorexia nervosa’ minimises or sidelines the influence of a researcher, including the shaping influence of the researcher’s questions. From a constructivist position, human dialogue in any form, is information generating rather than information gathering (Freedman & Combs, 1996) and a site for the production of meaning. Hence, throughout this research I have sought to examine and make transparent my positionings and influence as researcher rather than assume I am somehow a neutral observer. On the other hand, I have brought to this research many assumptions and positionings that escaped my awareness at the time and/or endure to this day. Supervision of this research, through critical reflective practice (Fook & Gardner, 2007), has provided opportunity to examine the effects of some of my assumptions on the women’s telling of their stories. As outlined previously, the analysis will examine the parallel process between both my own and the women’s assumptions that may have escaped either my or their conscious awareness at the time of the interview.

Despite the intention of the first telling to invite women into externalising conversations that were focused on the meanings these women ascribed to their experience, I also asked them ‘some medical questions’ (Appendix 4b). The first reason for this was to ascertain whether any of these women were at possible medical risk and whether referral for ongoing therapy for reasons of safety might be indicated. These questions were also included to address my concerns at the outset of this research to ascertain whether or not women fitted DSM-IV criteria for ‘anorexia nervosa’, either at the time or in the past. Although from these questions a DSM-IV diagnosis could be made for each woman, this research was not intended to reproduce this practice. The purposes of this research was

instead to examine how the category of ‘anorexia nervosa’ is constructed rather than who fits into it (Reynolds & Wetherell, 2003) and to explore some of the real effects of the discursive categorisation of ‘anorexia nervosa’ on the meanings women ascribe to their lives and identity, including impacts of the practice of diagnosis.

Transcription and early drawing out of themes (first telling)

I transcribed the first two interviews and the other 19 interviews were transcribed by two professional transcribers and reviewed by the researcher for accuracy. The method of transcription used a method of light transcription (Edley, 2001) (see Appendix 5) as this was congruent with the purposes of the research question through broadly tracking variations in subject positioning and the emergence of divergent accounts of identity within the spaces of authoring created through dialogue. Transcription aimed to keep a flow in the conversation and coherence in meaning within an account, despite variations in subject positioning and discursive resources, rather than paying attention to the more conversational elements to speaking, such as length of pauses (except if notably long), repeated phrases that broke up the flow of conversation, intonation (except clear emphases) etc. This form of transcription served the purposes of ‘complete rather than a merely “technical” analysis of conversations (Wetherell, 1998, p. 394).

For reasons of confidentiality, the women were given a copy of their transcript and asked to remove any aspects of the transcript that they felt were potentially identifiable in addition to the requested sections that I had already removed or de-identified with their chosen pseudonyms. Early engagement with these transcripts focused on summarising the women’s narratives and drawing out broad themes that ran through a number of the women’s accounts. Appendix 6 contains brief summaries to introduce each participant that were developed from this early sorting out of broad themes from the interview data. At their second telling each woman was asked to reflect on the relevance to them individually of these diverse themes that were generated across all participants’ accounts (See Appendix 4c for these questions).

Conversations with women – second telling

Between 1998 and 1999, one to two years after their first interview, 17 women from the original sample were contactable and were interested in participating in a second telling of their relationship with ‘anorexia’. This second interview provided scope for the women to reflect on the summaries of their first tellings and was therefore a practice of accountability whereby there was the opportunity for them to modify any aspects of my summaries and emerging ideas that failed to resonate with their experiences.

The intention of this re-telling was also an opportunity for the women to further thicken the meanings they ascribed to their narratives and to explore possible shifts in their relationship with ‘anorexia’ over the previous one to two years. Particular focus was given to exploring how women’s narratives not only described the events of their lives but also provided the material from which they constructed accounts of their identity (White, 1995; White & Epston, 1990). For example, women were invited to reflect on how aspects of their lives, including those described in the first telling, shaped their view of themselves as a person. This and other such questions are what Michael White named ‘landscape of identity’ questions (White, 2007, p. 81).

Within the women’s narratives, particular focus was also given to storylines that did not fit with the dominant ‘problem saturated’ descriptions of women’s lives (White & Epston, 1990, p. 16). During the course of these early interviews the focus of analysis was on the various positions that women took up as they sought to ascribe meaning to their experiences. My interest at this time was not only how women were positioned by the dominant medical discourse but also how they were active in piecing together narratives on their own terms. At the same time, my concerns were also being drawn to my power as researcher in analysing women’s positionings in discourse, many of which may escape their awareness at the time – in other words the problems associated with taking an ‘expert’ stance on women and their lives (J. Conti, 2005).

Following on from this, came the unexpected break in this research, outlined in the preface of this thesis.

Conversations with women - ten years on

On returning to the research in 2006, I saw an opportunity to extend this study to a longitudinal focus over 10 years. Twelve of the 21 women interviewed a decade earlier (first and second tellings) were able to be contacted and nine consented to further participation. Within the context of this third telling, women were again engaged in externalising conversations, although this time there was a greater focus on the second set of relative influence questions that invite a person to ‘map their own influence in the “life” of the problem’ (White & Epston, 1990, p. 42). By tracing the women’s influence over ‘anorexia’ as well as ‘anorexia’s influence over their lives, relationships and identity formation, externalisation was a relational practice. Enquiry was made into ways that the women had shifted their relationship with ‘anorexia’ over ten years (Appendix 4d (i) and (iii)). Within this context, they were in a position to not only define but also to author ways that they had shifted and revised their relationship with ‘anorexia’ over time.

This more relational use of externalisation opened up the possibility of understanding women’s narratives as ‘double or multi-storied’ (White, 2000, p. 41) and within this interview I became increasingly aware of the possibility for ‘double listening’. This involved listening to the first story, that is the circumstances surrounding the person’s experiences of ‘anorexia’ and its impact on their life and identity, as well as a second story, that is the person’s response to these experiences and ‘opportunities to step into alternative identity conclusions that challenge those negative accounts of identity that have been constructed in the context of disqualification’ (White, 2000, p. 41). These responses reflect the person’s skills, what they give value to and what sustained them, which are linked to their ‘history, to their family, to their community, and to their culture’ (White, 2006, p. 87). Michael White (2000) has termed this interest in these multi-storied conversations as engagement with the ‘absent but implicit’ (p. 38) in a person’s account of their experience.

This relational externalisation also overcame some of the difficulties that have been identified with externalising the problem where the focus is exclusively on the first story of the effects of the problem on a person’s life. When externalisation is confined to this framework, ‘the anorexic is constructed as a victim or a casualty of an uncontrollable, mightier force that is external to the physical and psychological self, erasing the stigma of

pathology and exonerating sufferers' (Halse & Honey, 2005, p. 2145). Although I support this move away from pathologisation and stigmatisation of the individual, I was also concerned with this possibility for externalisation to strip the person of personal agency in the face of what was assumed to be a force that was potentially uncontrollable because of its complete separation from the person.

Lines of enquiry that guided these re-tellings 10 years on were those that (a) explored women's re-positionings as a vantage point for re-authoring the stories of their identity, (b) explored the 'absent but implicit' and (c) the positions women took up in relation to the discursively constructed category 'recovery'.

a) The women's re-positionings 10 years on as a site for re-authoring the stories of their identity

A particular focus of the final interview was to explore not only the women's continued struggles but also narratives within their accounts that were not dominated by problematic storylines (White, 2007). Within these different storylines, focus was made on the distinction between accounts of identity focused on 'motive, attributes, strengths, needs etc.' and accounts that 'privilege purpose, values, commitment, pleasure, community and spirituality' (White, August, 1998). That is, accounts of identity that resonated with women's values, purposes and dreams and what mattered to them (See Appendix 4e (ii) for samples of these questions).

Women were also asked to reflect on shifts in their relationship with 'anorexia' through questions drawn from the practice of motivational interviewing developed by William Miller and Stephen Rollnick (2002) (Appendix 4e (i)). For example;

I was wondering what you *like* about your relationship with anorexia*? Is this different to what you liked about anorexia 10 years ago? How?

What *concerns* you have about your relationship with anorexia*? Are these concerns different to your concerns 10 years ago?

(* referred to the possibility of substituting the term 'anorexia' with women's preferred name for their experience)

These questions were intended to explore ambivalence in women's positionings assuming that unlike medical discourse, not all aspects of 'anorexia' were problematic to the woman.

b) Exploration of the absent but implicit

Within this re-telling 10 years on, there was a particular focus on the women's less explicit storylines, those that were hidden and frequently invisible. The dimension of the 'absent but implicit' (White, 2000, p. 35) was one means through which these less explicit storylines were explored. Michael White has developed the notion of the 'absent but implicit' through a person's expression of 'despair' (2000, p. 37). After enquiry into the contexts of 'despair', the interviewer can explore what is implicit in 'despair', that is, what hopes or values have been betrayed, undermined or lost, resulting in despair. The conversation can be extended further by exploring what they have been relying upon to get where they are now and how connecting with these hopes might be sustaining for them in the face of despair (White, 2000).

The construction of an idea or concept (such as despair) marks out the opposite or the 'other side' of an expression (White, 2000, p. 36). Exploration of the 'absent but implicit' therefore seeks to make explicit the conditions through which a person is able to see, discern and access their knowledge of this other side of an idea or expression of lived experience.

c) Women's (re)positioning on the discursive category 'recovery'

For 17 of the 21 women in their first telling, I was surprised by women's responses to my questions regarding the notion of recovery from 'anorexia'. For example –

Nicole: I don't think I'll ever get rid of it. I think always a bit of it will be there, but I feel that I have control of it rather than it controlling me.
(First telling, p. 12)

Fluff: I think you learn how to live within the limitation or you learn how to control it.
(Second telling, p. 49)

Catherine: I think I don't know if I can ever get rid of it because I don't know if it is me, still my mind hanging onto that certain element that's like a

security thing, it makes just that little bit different too, to everybody else, you're not exactly the same.
(First telling, p. 5)

Avalon: *Recovery isn't so much about the disease process, or recovering from it, it's about recovering yourself, it's about reclaiming your place in the world, understanding that there is a choice, of thought processes now. [...] So I don't consider that you um, ever get over this disease, because I don't think that it is something to be gotten over.*

(Second telling, p. 40)

For Nicole and Catherine, recovery meant an absence of illness. Recovery was unable to provide scope for Fluff to author how she has made a life around 'anorexia'. Avalon used the term recovery in a different way where it is centred upon reclaiming an identity and place in the world rather than "something to be gotten over". For most women in this research, 'recovery' was a troubled socially constructed category (Reynolds & Wetherell, 2003). For three women who positioned themselves as recovered in their first telling, this notion became troubled in later tellings. Only one woman in the early tellings maintained that she had made a 'recovery'; unfortunately she was unable to be re-contacted 10 years on. See Appendix 7 (a) for detailed sample of the women's extracts related to their positioning on recovery.

At their re-tellings 10 years on I was therefore interested in how women talked about shifts in their relationship with so-called 'anorexia', some of the meanings that they ascribed to these shifts and possible implications for their identity formation (Appendix 4e (iii)). In their earlier telling, a number of women had used the term 'moving from' to designate shifts in their relationship with 'anorexia' over time. In response to this, I borrowed their term 'moving' and these two quotes from Tim Winton's short story 'Aquifer' to construct interview questions to further enquire into this topic.

Life moves on, people say, but I doubt that. Moves in, more like it.
(Winton, 2004, p. 37)

... the past is in us, and not behind us. Things are never over.

(Winton, 2004, p. 53)

The questions were, 'Would you describe changes in your relationship with 'anorexia' as 'anorexia' moving in? If so, how has 'anorexia' moving in affected your view

of yourself as a person?’ (Appendix 4e (iii)). The interview concluded with women’s reflections on the sorting of the interview data from their first and second tellings into broad topics and summaries of their stories (Appendix 4e (iv)).

Due to the longitudinal nature of this research and the complexities that developed due to my shifts in positioning, Figure 2 summarises some of the key shifts in my positioning as researcher and the shaping of lines of enquiry in the research interviews.

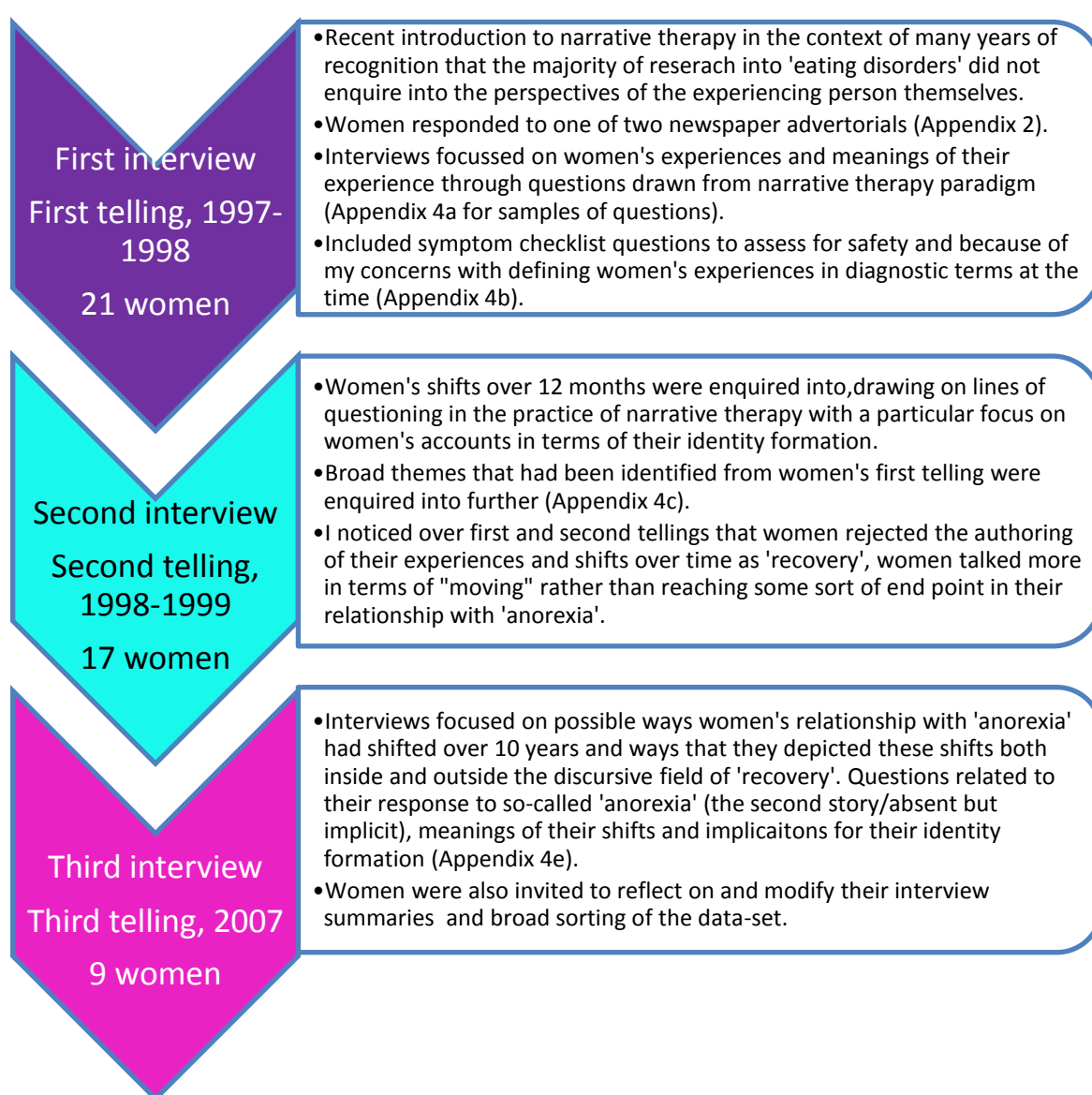


Figure 2: Summary of research process over 10 years

Analytic concepts and procedures

Analysis focused on analysing the women's words and also on the discursive context within which they constructed their identity narratives. Congruent with this discursive analysis is the understanding of conversation as dialogical space for women in this research to re-position and re-author the stories of their lives from which they derive a unique sense of identity. As discussed thus far, the discursive context within which I invited these women to talk about their experiences of so-called 'anorexia nervosa' was not neutral in its effects as research shapes the terms of speaking within which research participants are allowed to speak. Women's identity narratives were shaped by the type of talk that I chose as a platform for them to tell their stories.

The following section details how analysis proceeded in relation to the analytical dimensions central to a critical discursive analysis – positioning, interpretative repertoires and ideological dilemmas (Edley, 2001) and the questions that were asked of the text of these women's transcripts when using these analytical tools.

Positioning

A subject position is a particular location within a conceptual space that a person or community of persons has access to or the right to occupy (Davies & Harré, 1990). In other words, subject positions are the diverse locations that are constructed through discourse and are available for people to take up or resist. Inherent in these positions is a taken-for-grantedness and naturalistic accounting for this process, which frequently escapes the awareness of the experiencing person. Whether conceived of as intentional or not by the person, taking up a particular subject position in discourse then frames the sense of who we are in the world (Burr, 1995). It is also a vantage point through which the person sees the world and makes 'relevant' particular images, symbols, stories, concepts and metaphors 'within the particular discursive practice in which they are positioned' (Davies & Harré, 1990, p. 46).

Positioning offers a way through the question of personal agency with an understanding of the person as simultaneously *positioned* in dominant discourses, a process

that frequently escapes their conscious awareness and intentions, as well as *positioning themselves* and therefore active in reflecting on and choosing the subject positions they take up in discourse (Weedon, 1987). These ‘options available’ for various subject positions are constrained by the prevailing culture in which the subject is immersed and therefore, as discussed in Chapter 1, within this context, personal agency may be understood as ‘bi-directional’ (de Fina, et al., 2006, p. 7) whereby a person is active in taking up various discourse positionings, yet constrained through the availability of subject positions in a particular place and time in history.

Positioning may be thought of as a place that persons construct the stories through which they make sense of their own and other’s lives (Davies & Harré, 1990). It is from this place that a person constructs a sense of identity within a social context. The sense of oneself as unique may be derived from a sense of place or a ‘system of locations’ (Harré & Gillett, 1994, p. 103). These locations include our embodied existence in space, the sense of existing in a particular moment in ever unfolding time, the sense of personal responsibility as agents and ‘a social place’ in relation to others through age, gender, status, reputation etc (Harré & Gillett, 1994, p. 104). Although the sense of oneself is derived from these systems of location may have different origins, they come together through language to construct a sense of self that is closely linked to personal identity (Harré & Gillett, 1994). It is from this place that a person perceives themselves and acts from as well as providing scope to understand how persons are also ‘acted upon’ (Harré & Gillett, 1994, p. 104). Therefore through taking up a particular positioning people invoke social identities (Antaki, Condor, & Levine, 1996). Through social interaction the boundaries of these identities are enunciated and then exist as part of an ‘accumulated record’ of identities that have emerged over time (Antaki, et al., 1996, p. 488).

The diverse locations in which a person is positioned and positions themselves come together and are constructed through language. One way they come together in the English language is through the use of the first person pronoun, “I” (Harré & Gillett, 1994).

Selfhood is discursively produced for others by the use of the first person pronoun, and at the same time is discursively produced for ourselves. It reflects and in part engenders my sense of my own personal identity.

(Harré & Gillett, 1994, p. 108)

A person's sense of self or personal identity is derived from both a sense of oneself as a unique individual (the "I") as well as the question of 'what type of person do I believe myself to be?' (the "me") (Harré & Gillett, 1994, p. 102). Harré and Gillett (1994) argue that the focus of psychology has been on the latter, that is a person's beliefs about themselves through notions such as 'self concept' and in doing so has failed to pay attention to 'the question of my individuality to myself, my sense of uniqueness' (p. 102) . They argue that this sense of uniqueness and how a person acquires it is fruitfully addressed through the realm of the discursive.

William James (1890, as cited in Hermans, et al., 1992) highlighted the distinction, already made in linguistic circles, between the pronoun "I", or self as object, and "me", self as subject. This has been depicted in a number of contexts, for example the "I" as the observer and "me" as the observed, "I" as the knower "me" as the known, "I" as 'seeing "me" as the main figure in the story of one's life' (Hermans, et al., 1992, p. 26). From a semiotic perspective, Mead (1934 as cited in Wiersma, 1988) refers to the self as a symbol that is made up of the signifier "I", or the knower, and the signified "me", or concept of selfhood that is known and presented to oneself and others. Following on from this,

Understanding of the self must always be accomplished by symbolic movement as the signifier (the "I") must refer to the "me" (signified) which in turn refers to the "I". The point here is that one must always understand the "I" in its social context (it's "me"-ness) and vice versa.

(Wiersma, 1988, p. 220)

Within western culture there is the tendency to link the signifier self with the Cartesian ideal of an 'inner entity' (Harré & Gillett, 1994, p. 101). This results in the self being organised as having a singular "I" position which is the author of a singular "me" story. In other words there is a domination of one "I" position over others. On the other hand, Davies and Harré (1990) seek to understand 'the fleeting panorama of Meadian 'me's'' (p. 47) as the diverse selves that are constructed through multiple discourse positions that are available to the "I".

As discussed thus far, the discursively constructed category 'anorexia nervosa' provides a number of subject positions or 'locations' within any stretch of talk from which

people construct particular versions of themselves and the world (Davies & Harré, 1990). At the risk of fragmentation of an individual's identity, these diverse subject positions that arise from within and outside the ideological field of 'anorexia' are held together and made sense of through the development of personal narratives (Reynolds & Wetherell, 2003, p. 493). In this research 'anorexia nervosa' has been researched as not only 'a set of *personal narratives and subject positions*' (Reynolds & Wetherell, 2003, p. 493, italics in quote) but also a set of personal narratives that have been re-authored from the vantage point of the positions that have been obscured by the dominant medical discourse that has framed the terms of what is allowed to be said about so-called 'anorexia nervosa'.

Identification of shifts in women's positioning has sought to see what women 'accomplish' within a text in relation to particular identity performances and to develop an understanding of the 'broader ideological context' in which their talk was situated through the range of positions made available to them (Edley, 2001, p. 217). Shifts in women's positioning has been analysed through identifying variability, contradictions and inconsistency in these women's transcripts and then '... asking why this (different) formulation at this point in this stretch of talk? (Wetherell, 1998, p. 395) Any talk of positioning must be considered in light of the possibility of re-positioning. Therefore another level of analysis has focused on the discursive context within which women generated alternative positions outside the discursive field of 'anorexia' as well as how women both took and challenged my positioning as researcher through the questions I asked and the reflections I made. Analysis therefore has sought to develop an understanding of not only how women were positioned, but also how they positioned themselves and how this was influenced by the research conversations that were, as discussed thus far, 'highly situated and occasioned' (Wetherell, 1998, p. 401). Therefore the questions asked of the research texts in relation to positioning included -

- How were women simultaneously positioned and active in their positioning their experiences with the discursive resources available to them?
- How were these various positionings held together in narrative form and what were the implications of taking up a particular position in terms of the women's identity narratives over time?

- What differences were women marking off through their speech and who else marks off differences in this way? (Allen & Hardin, 2001)

The processes through which a person takes up and argues for particular positions and in doing so, negotiates a unique sense of identity involves the piecing together of a range of discursive resources. Discursive resources that provide the material through which a person constructs a particular subject position include interpretative repertoires (Wetherell, 1998; Wetherell & Potter, 1988, 1992) and ideological dilemmas (Billig, et al., 1988).

Interpretative repertoires

Interpretative repertoires are culturally inherited language resources that constitute different, and ‘relatively coherent ways of talking about objects and events in the world’ (Edley, 2001, p. 198). Although a form of discourse, interpretative repertoires overlap and diverge from Foucauldian or capital “D” perspectives. These Foucauldian frameworks propose that discourse constructs institutions (such as psychiatry, the law and science) and understand human beings as subjectified by this institutional power to speak in an uncontested way about the way things are (Edley, 2001). Analytic practices that use a capital “D” discourse framework, such as Foucauldian discourse analysis (for example, Arribas-Ayllon & Walkerdine, 2008), focus on the processes through which certain discourses become the official word on any particular subject of interest. Analysis of these official discourses draws substantially on Foucault’s work on subjectification where human beings are construed as subjects who are acted upon and regulate themselves, their lives and their bodies to fit dominant cultural forms that are situated within a ‘moral order’ (Arribas-Ayllon & Walkerdine, 2008, p. 99). As argued in the opening chapter of this thesis, to solely position the analysis within these capital “D” discourse analyses risks that human agency is assigned to and reduced to discourse itself (Wetherell, 1998) or reduced to Foucault’s (1980) notion of resistance.

Interpretative repertoires or small “d” discourses are the smaller pieces of language and grammatical forms that are offered to humans to piece together a range of different positions and arguments (Edley, 2001). Within a critical discursive perspective, discourse is

understood as a situated practice, in other words, people do things with discourse (Potter, et al., 1990). Persons are therefore understood as social actors who are both active in the piecing together of particular versions of reality and constructions of self and other and yet also acted upon, by discursive materials available to them at the time (Wetherell, 1998; Wetherell & Potter, 1992).

As argued in Chapter 1, in an effort to move away from the humanist assumption that persons are free agents to choose how to define their reality and subjectivity, what has been left unclear in Foucault's analysis of power is the extent to which persons and/or groups of people are capable of critical reflection and then choice in relation to the options available to them at the time (Burr, 1995). From a critical discursive perspective, human beings are neither marionettes to capital "D" discourse nor do they have space to push against what they are not. Rather, it is in the uptake of small "d" discourses in relation to the capital "D" discourses that alternative positions are fashioned and experienced. Within the context of this research, a capital "D" discourse is medically defined 'anorexia nervosa'. Although an intention of selecting questions that provided scope for women to generate identity narratives on terms that exist 'anorexia' discourse, I do not assume that this to be the only avenue for the person to take up alternative positions. Women who participated in this research frequently resisted my reflections and questions that were (often inadvertently) articulated on the terms of the dominant 'anorexia' discourse. Within these contexts, analysis was focused on how they refashioned alternative positions and re-authored alternative identities using small "d" discourses that were available to them at the time.

Positioning involves drawing on interpretative repertoires that together produce a relatively coherent account of any given phenomena and, when pieced together, form particular ideological stances (Wetherell, 1998). Interpretative repertoires may be thought of as the books that make up a library that are 'permanently available for borrowing' (Edley, 2001, p. 198). History provides these terms with which people use to speak or think and therefore, '[...] conversations are usually made up of a patchwork of 'quotations' from various interpretative repertoires.' (Edley, 2001, p. 198). Sense may therefore be made of the different and frequently contradictory subject positions within any stretch of text

through the understanding that a person is drawing of different interpretative repertoires to do different things. For example, the use of liberal repertoires, such as individual rights and equal opportunities, has been found within the same person's account to be used in arguments for fairness within Maori-Pakeha relations as well as for the opposite, namely racist arguments to legitimise situations of inequity in social relations (LeCouteur & Augoustinos, 2001; Wetherell & Potter, 1992).

Although seeking to be flexible rather than formula driven (Wetherell & Potter, 1988), this analysis focused on these 'patterns' or ways of talking that, when pieced together, constructed these women's accounts of their experiences of 'anorexia nervosa' (Edley, 2001, p. 199). Therefore within any stretch of text, the identification of interpretative repertoires signposted possible limitations within which the women constructed accounts about themselves and the world within which they lived at that time (Edley, 2001).

The questions asked of the research texts in relation to the identification of interpretative repertoires included -

- What culturally inherited patterns of speech, or interpretative repertoires, do these women take up and use to piece together their accounts and argue for a particular position within and outside the ideological field of 'anorexia nervosa'?
- Within what discursive contexts do women talk about their experience differently? How and why do statements change over time? (Arribas-Ayllon & Walkerdine, 2008)

Analysis also focused on ways in which interpretative repertoires of the same discursively constructed category were frequently constructed 'rhetorically' in the form of ideological dilemmas (Edley, 2001, p. 204).

Ideological dilemmas

Within the expression of any idea or ideological tradition is the presence of alternative points of view that are constructed rhetorically and create any number of dilemmas. These ideological dilemmas, like interpretative repertoires, provide the material

for the construction of a range of subject positions (Edley, 2001). A dilemma may be explicit or may emerge in the context of an argument for the counterpoint of an idea and therefore, be implicit (Billig, et al., 1988). Central to this analytic dimension is an interest in how particular ideas, thoughts and ways of living are transported between the intellectual traditions and everyday common sense and vice versa. This passage of ideas in the form of ideologies is rarely seamless and more often characterised by argument, rhetoric and debate. Rather than a passive recipient of ideas and ideological traditions, the person is understood to be an 'argumentative debater' (Billig, et al., 1988, p. 19) and therefore active in the construction of their position in relation to particular ideologies. The strength by which alternatives within any idea are argued for will depend on the value the individual or group places upon not only each alternative but also on the dilemma itself.

Central to the work of Michael Billig and others (1988) is an interest in dilemmas, argument and debate that arise with the transportation of formalised intellectual ideas (such as those emerging from philosophy, politics and medicine) to the everyday thinking and common sense of an individual and community. For example, liberal ideologies argue for conceptions of human beings as self-contained individuals who should be free to act on their own behalf. Transporting this ideology to everyday living raises questions in relation to whether an individual in a particular context should act in self or collective interest (Billig, et al., 1988). For example, should the soldier flee from the battlefield to save his/her own life or stay and risk their life for the potential benefit of the community? (Billig, et al., 1988) What labels are attached to his/her choices - selfish or a hero? Or should a person starve themselves to attain a sense of being in control of an aspect of their life or start eating for others who are desperately concerned for their wellbeing? Is starving the act of a person who is in control or who is selfish? Conflicting themes and dilemmas are therefore not only present within and between cultural idioms but within the fabric of our vocabulary (Billig, et al., 1988). Language does not neutrally describe a person and the world within which they live. Many words transmit moral evaluations and the terms chosen therefore powerfully shape the meanings that are ascribed to a person and life events.

Questions and struggles emerging in the form of arguments and competing perspectives (Edley, 2001), rather than being disorganised and incoherent are like "folk

psychology” structured through narrative (‘how things are’) and through beliefs, desires and what matters (‘how they should be’) (Bruner, 1990, pp. 39-40). In relation to ideological dilemmas, narrative is a powerful way of making sense of events through scaffolding links between the ordinary and exceptions to the ordinary, assisting in the process of the negotiation of meanings within a particular culture (Bruner, 1990). Rather than ignoring or rendering these narrative processes as meaningless, stories give meaning to the exceptional and the dilemmas that arise in everyday living.

Analysis of ideological dilemmas provided a context for understanding some of the ways that women in this research negotiated the uptake of particular positions (Edley, 2001) as well as how dilemmas impacted on how they made sense of themselves in the context of their lives. Analysis of the women’s narratives in terms of ideological dilemmas focused on how the women negotiated their way between opposing ideals that emerged and how they handled the multiple contingencies, uncertainties and complexity of their lived experience. Rather than focusing on how arguments are resolved, the analysis was centred upon the context in which these arguments were generated (Edley, 2001). The questions asked of the interview data in relation to ideological dilemmas included –

- What were some of the explicit and implicit dilemmas that arose for women in the form of arguments, debate and rhetoric within and outside the ideological field of ‘anorexia nervosa’? What competing perspectives do these dilemmas give rise to?
- Within what capital “D” discursive contexts do these dilemmas arise?

In summary, within everyday talk there is the presence of shared symbolic systems, embedded within culture, that people use to construct meaning (Bruner, 1990) and are also constitutive of individuals. Interpretative repertoires, ideological dilemmas and subject positions may be understood as forming part of this shared and public symbolic system that constitutes and is constituted through discursive practices (Bruner, 1990).

Human dialogue as a recursive site for re-positioning and re-authoring

Taking the position that discourses frame the way people see and experience themselves in the world, and that discourses are frequently outside conscious awareness or

are taken for granted, the question inevitably arises as to what the processes are through which re-positioning in relation to discourse becomes available to a person? From the previous chapter, dialogue may be thought of as a site for re-authoring the stories of one's life. An important aspect of this re-authoring from a discursive perspective is the capacity to re-position oneself on implicit assumptions and ideas about the way things are and should be. This re-positioning requires a person to stand outside and evaluate these assumptions and in doing so, what may be generated is alternative and transformed positions that the person may prefer. From standing outside one's understandings and assumptions, or self-reflexivity, a new context of understanding is created. Through analysing the process through which these women engage in re-authoring the stories of their identity, the aim is to develop understandings into not only the processes through which they form a sense of personal identity but also the 'kind of person' that they are and are in the process of becoming (Wetherell, 2007, p. 672). In this way a discursive analysis may go some way into understanding the person who is doing the positioning (the "I") in discourse.

Dialogue, however, was not only a site for these women to re-position and re-author the stories of their lives. It was a site in which my positioning as researcher was also stretched. In an effort to extend the field of discourse analysis, Hans Herbert Kögler (1999) has suggested that in the absence of acknowledgement of the hermeneutic encounter between researcher and research participant, the researcher is positioned outside the encounter, which is precisely an, albeit possibly unintentional, act of power.

...whereas the subjects may experience their views as, and believe them to be, true and authentic, the theorist is supposed to possess methods and conceptual tools that reveal the natural perceptions and beliefs of subjects at best as naive, and at worst as dangerous and misguided distortions of social reality ...This view thus presupposes a sharp distinction between the nonsituated, undistorted gaze of the theorist and the perspectival, illusionary vision of socially situated subjects.

(Kögler, 1999, p. 256)

Therefore as researcher, through living in the same world as the research participants, I was likewise discursively constrained. I therefore brought a number of implied assumptions into conversations that, alongside the participants' assumptions, invited particular ways of framing the person's experience of 'anorexia nervosa'. Both our

assumptions were stretched through dialogue with each other, although implicit in this encounter was my status as researcher and this inevitably shaped the framework and the terms available to women to situate their lived experiences. This dimension of analysis is therefore focused on the recursiveness of dialogue and how I as researcher shaped the women's accounts and how the women's accounts shaped me as researcher. The women's assumptions, and mine as researcher, became visible in relation to what it means to experience so-called 'anorexia nervosa' through talk. Within this dimension of analysis, the questions asked of the women's transcripts included:

- In what ways does a particular type of dialogue, shaped by the questions asked, contribute to a shift in how these women position their experiences both within and outside the ideological field of 'anorexia nervosa'?
- How do these women construct, position, argue and account for particular shifts in and versions of their reality over time?
- What are some of the more neglected storylines in these women's narratives (White, 2007), including those that are present as 'absent but implicit' in their accounts (White, 2000), and within which discursive contexts did these storylines become present and explicit?
- How do these women's positions shape and stretch the ideological field constructed by myself as researcher and contribute to my re-positioning within and outside this field?

Text selection for analysis of interview transcripts

Early stages of analysis focused on summarising what I understood women had told me about their stories of 'anorexia'. To familiarise myself with the broad structure of the women's narratives of 'anorexia', summaries were compiled into 'large files by topic' (Edley, 2001, p. 197), including:

1. Narratives and meanings of 'anorexia'
2. Experiences of treatment (including diagnosis)
3. Positioning on discourses related to 'anorexia'

4. Identity descriptions
5. Control and personal agency
6. Narratives of “recovery” or moving on from ‘anorexia’

From these larger files, summaries were constructed of the 21 women’s account of their relationship with ‘anorexia’ taken from our conversation/s between 1997 and 1999. Providing these summaries enabled me to place the relatively small pieces of texts analysed in depth within a broader context of the women’s stories. Although not intended as analysis (Antaki, Billig, Edwards, & Potter, 2003), summarising had the benefit of condensing a large amount of text into narrative form onto which a more detailed discursive analysis of selected pieces of text could be anchored. Although some texts chosen for analysis have been drawn from these large files, choice of texts have not been limited to this early construction of broad topics, with a number of texts selected after revisiting and re-reading the original transcripts.

As discussed earlier in this chapter, the transcripts of the nine women who participated in this research over 10 years were chosen as the texts for analysis of both cross-sectional and longitudinal shifts experienced by these women. Transcripts for six of the nine women who consented for their inclusion in this thesis are supplied on a disc at the end of this thesis (Appendix 8). As already outlined, my conversations with all 21 women have shaped the course of this research, including the focus of interviews 10 years on. Therefore the findings of this thesis would not be possible without the participation of all the 21 women who volunteered to participate in this research.

When choosing particular stretches of text for analysis, primary consideration was given to the issue at the heart of this research, that is the discursive context within which women author and re-author their identity narratives from the discursive resources available to them at the time. Therefore the samples of texts chosen for analysis were those which reflected the diversity in discursive practices, dilemmas raised and subject positions that women used to piece together their unique account of the experiences.

Each stretch of text was presented in full with longer stretches assigned line numbers to track the position of analysis. As my conversations with women took place in

the past, any summaries of women's narratives and extracts of text will be reconstructed with use of past tense. As analysis is a dynamic and ever changing process in terms of interpretation and understanding, I have chosen to present the analysis of the women's extracts in present tense.

With the research questions in mind, one woman's account (Anne) will be analysed in detail as a discursive case study analysis. The choice to analyse Anne's interviews in depth was based on the diverse range of subject positions that she traversed, including the dilemma she faced around whether or not to participate in this research. In addition to this, analysing Anne's interviews in detail enabled a more detailed analysis of the discursive climate constructed in the three different research interviews over 10 years. These findings will then be transported to discern points of convergence and divergence with other women's narratives, particularly in terms analysis of the positioning of their experiences both within (Chapter 5) and outside (Chapter 6) the discursive field of 'anorexia'. The final analysis chapter (Chapter 7) will focus on ways that the women authored and re-authored their narratives over time both within and outside the discursive field of 'recovery'.

Chapter summary

Within the context of this research, 'anorexia nervosa' is understood as a discursive, 'ideological field' that is organised through inherited /culturally embedded patterns of speech, or interpretative repertoires, within which context dilemmas arise in relation to different representational forms (Reynolds & Wetherell, 2003, p. 493). My intention through this research study is to develop understandings of how these women were both positioned, and active in their positioning both within and outside the discursively constructed (and contested) category of 'anorexia nervosa'. In doing so, I seek to bring to the fore their local and disqualified knowledge and provide discursive space for these women to inhabit alternative and preferred positions that may be understood as a platform for the authoring and re-authoring of their identity narratives. Clifford Geertz (1973, p. 4) has argued that 'centrally important scientific concepts' do not explain everything and risk obscuring more than they reveal. The aim of re-thinking theories of 'anorexia nervosa' is so that they can reveal more than they obscure.

Chapter 4: Looking in a different way

Anne: I think it's only because I've done this exercise with you, that I've started to look at it in a different way.

(Second telling, p. 15)

Anne was the second woman who chose to participate in this research. She responded to the smaller newspaper advertorial published in the Northern District Times in 1997 (Appendices 2b & c). As outlined in the previous chapter, I have chosen to analyse Anne's transcript in depth because of the noticeable shifts in her positioning in relation to the discursive category 'anorexia nervosa', both within our conversations and over the course of ten years. My intention in beginning this analysis with a detailed case study has been to examine first, the discursive resources that Anne used to construct and reconstruct her narrative over time and the implications of these for her identity formation. Second, a detailed case study analysis provided opportunity to analyse how within the discursive context of externalised talk that was not confined to the language of illness, Anne generated a range of alternative positions that had implications for her identity formation and life as lived. This critical discursive analysis is therefore oriented towards action with a particular interest in the discursive context of identity shifts that depicted to Anne who she understood herself to be and was in the process of becoming.

Background to Anne

At the time of our first conversation in 1997, Anne was living with one of her two daughters. She was 43 years old and working in the field of natural therapies. Anne left school in year 10 to embark in a career in dance. After many years of working as a professional dancer, she became a teacher of professional dance. She traced the context of her concerns with thinness to her teens, recounting stories of being "indoctrinated" and "brainwashed" (First telling, p. 10) into taking on the value of thinness in an effort to please her dance teachers and choreographers and work towards a career as a professional dancer. She retrospectively understood this as a process whereby she took on and internalised the value of thinness as her own. Anne conceptualised anorexia as "multilayered" in which

control, self-esteem and attention seeking were interwoven. Thinness embodied a sense of herself as a little girl, being boyish and androgynous. Anne had never sought treatment for, nor had she ever been medically diagnosed with, ‘anorexia nervosa’; she had however sought psychiatric treatment for anxiety and depression in her late twenties. At the time of reading the advertorial for this research, she struggled to identify her present experiences in terms of the category of ‘anorexia nervosa’ although retrospectively understood herself as “really anorexic” in her twenties in the context of her marriage breakdown.

The first stage of analysis of Anne’s transcripts will focus on stretches of text where she struggled to find an identity for herself within the discursive field of ‘anorexia’. Following on from this, analysis will shift to other extracts of text where she generated different versions of her lived experience and the implications of these different ways of looking at her experience in terms of who she understood herself to be. The stretches of text chosen for analysis, although lengthy at times, have been retained as whole texts (with the lines numbered) to analyse not only the discursive shifts in Anne’s positioning through talk not confined to ‘anorexia’ talk but also the discursive context within which these shifts were generated.

Am I ‘an anorexic’?

EXTRACT 1

1 **Anne:** [...] there’s a huge gap in helping these girls. Because the only place they
2 can go that I have found is to a psychologist, psychiatrist or a hospital
3 which sets up the fact that they are ill, either mentally or physically ill;
4 and there’s got to be somewhere in between that these people can be
5 helped, these young women can be helped.

6 **Interviewer:** Mm. Tell me more about that [...] It’s interesting that you say
7 that, that (**Anne:** Oh, I feel passionately about) people when they go to
8 the psychiatrist, psychologist, to the hospital that they feel ill [...]

9 **Anne:** Well they, they feel that they have an illness either psychological or a
10 physical illness. (**Interviewer:** Hm, hm.) Well it’s like, it’s like me when I
11 thought oh, do I really need to ring this woman up? It was like a big jolt,
12 I’m, I’m not an anorexic but something in the back of my head said yeh,
13 you are you are, you were and you still are, and you probably always will
14 be. Even though you’ve never been on a drip, you know (laughed), you
15 are an anorexic, and for, and it’s funny I’ll add another thing in there,
16 that I’ve still been able to control that. I can get myself out of it so I’m

17 *even in control of it, I don't let it get the best of me, to the point that I*
 18 *have been that sick. It will just take somebody saying to me, "you look*
 19 *dreadful, you look too thin", my little monitoring device will click me out*
 20 *of it again and I'm very aware of that.*

21 **Interviewer:** *Tell me what it is in that, in that context that your "monitoring*
 22 *device" gets –*

23 **Anne:** *It's that I don't want to be out of control that way either, yeh,*
 24 *(Interviewer: Right) and that's a very important component of it that it*
 25 *gets to the stage that I can, it's like I my, my internal control monitoring*
 26 *de., monitoring device will not allow me to go too far one way or too far*
 27 *the other way either. (Interviewer: Mm, hm). So I will never let myself get*
 28 *really fat, I will never let myself indulge um myself with food, but on the*
 29 *other hand I will never get to the point when I am sick with the anorexia.*
 30 *[...]*

31 **Janet:** *Mm, mm. Hm, hm. So when you were saying that people would have to go*
 32 *to a psychiatrist, psychologist, hospital (mm, hm) and they would be*
 33 *made to feel they had an illness (yes). Do you see anorexia as an illness?*

34 **Anne:** *Yes I do. I do now. I wouldn't have then. It was just me trying to be the*
 35 *very best I could be to please other people and to be the very best I could*
 36 *in my chosen profession. That's how it started out. In my mind it becomes*
 37 *a mental illness and then it becomes a physical illness.*

38 **Janet:** *Right. Do you want to explain that to me?*

39 **Anne:** *Because (pause) it starts off from a mental point of view and the body*
 40 *follows and of course if you're not feeding your body correctly it becomes*
 41 *a physical illness, but the mental side of it has to be addressed first with*
 42 *information and education on what it can do to your body. See I've talked*
 43 *to the girls that I teach about it and I said right now you are young,*
 44 *you're healthy, you can feel that you are invincible, you can do anything*
 45 *to your bodies and it will still keep going. I'm a forty three year old ex-*
 46 *dancer who has the spine of a sixty year old because of calcium depletion*
 47 *in my formative years. [...] So when you're older you suffer the*
 48 *consequences. You're not invincible anymore, you're mortality is*
 49 *suddenly becoming very apparent to you and the health aspect of it is*
 50 *also becoming very apparent.*

(First telling: pp. 10-11)

Implicit in Anne's question "do I really need to ring this woman up?" (Line 11) is a dilemma. This dilemma is centred on the question of whether or not she was "an anorexic" (lines 12-13) and is raised in the context of her argument that the "only place" (line 1) for girls to seek assistance for issues related to eating and weight is with professionals who

adopt an illness perspective to understand and talk about their experiences. This medical perspective does not merely construe the person as “ill”, assumed as “fact” is that they are “ill, either mentally or physically ill” (line 3). Medical discourse is built on a scientific repertoire (Gilbert & Mulkay, 1984) that reifies the medical version as the only real version of the person’s lived experience. This version of the person’s reality is assumed to **be** their reality and therefore to exist independent of talk (Sampson, 1993).

Medical discourse also draws on a dualistic repertoire that categorises those who are sick and/or disordered from those who are not. Refusing to author her experiences on these terms, Anne argued for an alternative “in between” (line 4) position where the person is not required to occupy the positions marked out by illness discourse of either “anorexic” or “not anorexic”. A dilemma in taking up this “in-between” position was that Anne was then left questioning whether or not she was eligible or not to participate in ‘anorexia’ research.

Anne’s argument that “I’m not an anorexic” (line 12) was built upon the negation of a checklist of symptoms - “never been on a drip” (line 14), or gone “too far” (line 26) or become “sick with the anorexia” (line 29). This symptom checklist produces the version of a ‘sick anorexic’ and Anne used this for many years to disqualify herself from membership to the category of ‘anorexia nervosa’. On the other hand, if Anne had completely excluded herself from the category of “an anorexic”, then why did the newspaper advertorial for this research catch her attention? Her decision to participate in this research did not fit with the actions of a person who is “not an anorexic”. Through participation in this research, whether or not she was aware of this at the time, Anne was in the process of constructing the possibility of an alternative understanding of what it means to take on the identity of “an anorexic”.

Directly following from her argument that “I’m not an anorexic” (line 12), Anne then conceded using the third voice “you are you are, you were and you still are, and you probably always will be’ (lines 13-14). Taking on the version of herself as ‘anorexic’ meant reconstructing an alternative identity with an internalised repertoire where her experience is understood as a disorder that existed within her (Gergen & McNamee, 2000). This internalisation of her experience as disorder not only totalised her identity as “an anorexic”, it also mapped out future possibilities - “you probably always will be [an anorexic]” (lines

13-14). Taking on the identity of “an anorexic” risks totalising a person and their future through the discourse of disorder; they are then left positioned on ‘the boundary of normalcy’ where there will always be the ‘lurking’ (Gergen & McNamee, 2000, p. 338) tendency to remain ‘an anorexic’.

A central dilemma to Anne taking on the version of herself as “an anorexic” was not only whether or not she met diagnostic criteria through symptom checklists but also the question of “control” (line 16). What excluded Anne from the category of ‘anorexic’ was the sense of herself as being “in control of it” (line 17). The medical version of “an anorexic” assumes the person has an out of control illness. Anne argued that she was not a ‘sick anorexic’ who was out of control but instead she was a ‘safe anorexic’ who was in control. Implicit in Anne’s active negotiation of the terms upon which she will take on the version of herself as “an anorexic” is an ideological dilemma - how can a person have an illness and also be in control of their illness? Anne addressed this ideological dilemma through generating an alternative version of her experience with the discursive tool of metaphor. Re-authoring her experience as “my internal control monitoring device” (lines 25-26) enabled her to author a complex social reality (Geertz, 1973) where this device was experienced as both “internal” (line 25) to her, yet also used by her to stop herself from getting “really fat” (line 28) and “sick with the anorexia” (line 29).

Although Anne renegotiated the terms upon which ‘anorexia’ was or was not relevant to her experience, she did not completely reject the understanding of ‘anorexia’ as “illness”. Further into our conversation she adopted an illness perspective to account for physical effects of food restriction on her spine (line 46). The dualistic splitting of the body from the mind is characteristic of medical discourse with the separation of physical illness from mental illness. In taking up illness as relevant to her experience, Anne argued that the illness starts from “mental” (line 39).

The process of Anne negotiating the terms of taking up ‘anorexia’ as relevant to her experience was further troubled by another dilemma that she faced when choosing to participate in this research, that is whether or not she was a ‘real anorexic’.

‘Am I a real anorexic?’

EXTRACT 2

- 1 **Anne:** (pause) Because I think that in all honest, in all honesty it's I've only just
2 really admitted to myself (laughed) that I am anorexic (**Interviewer:**
3 Right, right) and it's only through me calling you up the other day.
4 (**Interviewer:** Mm). It was like I saw that thing in the paper, and I it took
5 my attention and I thought no I'm not re..., I'm not a... anorexic and I
6 thought about it and I thought about it and I thought yes I am.
7 (**Interviewer:** Mm). I am. [...] I have this little force in my head, this little
8 thing in my head that says don't do it. (**Interviewer:** Mm, mm). You know.
9 Then I got thinking about it and then I saw your thing in the paper and I
10 thought, oh no I'm not, yes I am, I am, I've been really skinny
11 (**Interviewer:** Mm.) and I think about it all the time constantly, and I'm
12 yeh. So I've only just come to the saying to myself yes you are
13 (**Interviewer:** Mm.) and I was even, as I said I was even embarrassed to
14 ring you because I'm not really, am I really enough of an anorexic for
15 you? You know (laughed).
- 16 **Interviewer:** Mm, mm. What does being enough of an anorexic mean for you?
17 That's the second time you've said that, you said I'm not sure if I'm
18 enough of an anorexic?
- 19 **Anne:** It's funny, I mean It's quite embarrassing to say things I actually thought
20 today, that you'd walk in and say, think oh she's not really that thin, she
21 can't be an anorexic. (**Interviewer:** Mm, mm). You know, it's like you've
22 got to (pause) I guess if, OK an anorexic is if you open up the women's
23 day and you see someone who's 25kg and they're on their death bed.
24 (**Interviewer:** Mm). You know that to me is a real anorexic (**Interviewer:**
25 Mm), which I would certainly never want to be but there I've certainly
26 acknowledged to myself that I have symptoms of anorexia.
- 27 **Interviewer:** Mm, mm, and how does it feel, when you said that you thought I
28 was going to walk in the door and think that you're not anorexic, how did
29 that feel?
- 30 **Anne:** Um, here's another Pandora's Box that's opening in my head. It's like I
31 have to please you. (**Interviewer:** Mm.) I have to make, how can I put it,
32 um, (pause) it's like I have to please you, it's almost like you have to
33 please the person with the right answers as well. (**Interviewer:** Mm)[...]
34 Yeh, it's funny that one. Mm, it's more pondering on that one, I have to
35 do.

(First telling, p. 15)

Extract 2 illustrates the recursiveness of dialogue between Anne and myself as researcher that is of interest in this analysis. Anne returned to the question of whether or not

she was “an anorexic”, although this time in relation to questioning my position as a researcher who is part of the community that constructs and defines what ‘anorexia nervosa’ is and who qualifies for this diagnosis. Following from taking up the identity of “an anorexic”, she questioned whether or not she qualified for this identity slot on my terms - “Am I really enough of an anorexic for you?” (lines 14-15). Implicit in this question is the power of medical discourse and those who use it to reify the category of ‘anorexia nervosa’ so that the category becomes the person’s reality rather than a DSM-IV construction (Raskin & Lewandowski, 2000) of their reality. Through the reification of DSM-IV categories of disorder, power is also allocated to medical professionals and researchers to define who does and who does not qualify as a “real anorexic”. Membership to this category of “real anorexics” was assigned to those other than herself - “someone who’s 25kg and they’re on their deathbed” (line 23). Implicit in her questioning whether or not she was “enough of an anorexic” is the sense of fraudulency that is created when the category is assumed to be reality and the person’s reality is reduced to the question of whether or not they are eligible to fit into the category.

Failing to meet my expectations, real or imagined, left Anne wondering how she could make her experience into what I might want as a researcher in ‘anorexia’. Fitting her experience into a diagnostic label, on the other hand, was a ‘thin description’ (Geertz, 1973, p. 7) that risked reducing her reality to a description of her actions rather than a ‘thick description’ (Geertz, 1973, p. 7) where reality is multiply interpreted, explained and negotiated into meaningful structures within a particular community and time in history (Geertz, 1973; White, 2000).

Or is this “just me”?

EXTRACT 3

1 **Anne:** [...] when I read this again, and I still felt that it’s just a part of me, it’s
 2 such a part of me that I even find it unusual to be talking about it as
 3 though it seems to be a problem. It’s just (pause) a component of my
 4 personality, or of my being that has always, well has been with me for a
 5 very, well most of my life, since I was probably fifteen or something,
 6 fourteen. So it’s thirty years, it’s been with me. So therefore I have a bit
 7 of a difficulty talking about it as if it’s a problem and you almost want to
 8 justify it, you know. You know, this is me, I’m functioning OK, why should

9 *anybody be terribly interested in it? Unless of course it came to the point*
10 *that you're physically killing yourself.*

11 **Interviewer:** *You were sort of saying that you can stop it (Anne: Yep) and that*
12 *was something (Anne: Yes, that came up in the interview) and I wonder*
13 *whether that's got something to do there too, is that, like you were saying*
14 *that you got physically ill, but it's like you can stop it before you get*
15 *physically ill. (Anne: Yes, and I have done.) Mm. So, that's sort of where*
16 *you feel you can control anorexia (Anne: Yes) but there is an element of*
17 *you feeling that anorexia controls you too.*

18 **Anne:** *Yes that's right, it's a double-edged sword but I think I'm fortunate, if I'm*
19 *going to have "this affliction" in inverted commas, I probably have it*
20 *(pause) better than those who can't control it and end up really, really*
21 *physically sick from it. So I think that if you're going to have it, **it**; it's*
22 *probably best to have **it** the way I've got it, so you're not having*
23 *something that's detrimental to your wellbeing.*

(Second telling, p. 3)

Participation in 'anorexia' research that assumed her lived experience to be problematic was not only a dilemma but also "unusual" (line 2) for Anne. Her ambivalence in taking up 'anorexia' as relevant to her lived experience is a refusal to take up the identity of a dysfunctional and disordered person. Her justifications are built on a moral repertoire - "I'm functioning OK, why should anybody be terribly interested in it?" (lines 8-9) Anne rejects that she is disordered, instead she minimises, internalises and normalises her experiences as "just a part of me" (line 1). Measuring herself against the question of whether or not she is disordered or dysfunctional leaves Anne bound to a discourse that is unacceptable to her. Whether or not a person is disordered or functional invokes a repertoire about their moral worth as a human being. Anne's refusal to author her experience in disorder and problem saturated terms (White & Epston, 1990) signified her refusal to take on the moral status of a person who is assumed to be dysfunctional. She then marked out a threshold at which these justifications were no longer tenable, a "point" at which she would concede to a disorder perspective and the implied moral status of a person who is disordered and "sick" that is, "the point that you're physically killing yourself" (lines 9-10).

My reflection that raised shifts in Anne's positioning in relation to whether or not she controlled or was controlled by 'anorexia' (lines 15-17) led to her active negotiation of

the meaning of the word “affliction” (line 19). Through placing “inverted commas” (line 19) around the word “affliction”, Anne qualifies the extent to which this is relevant to her lived experience and refuses to take on the association that this means she is out of control - “I probably have it (pause) better than those who can’t control it” (lines 19-20). Anne’s modification of the label ‘anorexia nervosa’ to “affliction” could also be interpreted as denial in DSM-IV terms.

Individuals with Anorexia Nervosa frequently lack insight into, or have considerable denial of, the problem and may be unreliable historians.

(American Psychiatric Association, 1995, p. 554)

By accusing people who refuse to concede to the medical diagnosis of ‘anorexia nervosa’ of being in denial, the medical establishment asserts its influence over the experiencing person in defining and denying that person the opportunity to define their subjectivity on their own terms and ascribe their own meaning to the real effects of their refusal to eat.

At the end of this extract, Anne’s use of the terms “it” (lines 18-21) and “something” (line 23) signify her struggle to find a language for her experience outside ‘anorexia’ discourse. After seeking to qualify her experience within the discursive field as having a pseudo affliction or as a pseudo-anorexic (White, 1984), Anne is left without a language to author this dimension of her lived experience. What is significant here is the power of medical discourse to speak on behalf of the person, such that the person no longer has words to define their own subjectivity. Although Anne struggled to find an alternative language to define her subjectivity, she nevertheless did find words to express the emotional experience of what it was like to be defined on the terms of others.

EXTRACT 4a:

- 1 ***Interviewer:*** *I was also interested in how you were talking about anorexia as*
2 *not a problem, “It’s who I was, who I was” and you still feel very close to*
3 *that.*
- 4 ***Anne:*** *Yes. Yes. In fact can I interrupt? When I was reading the transcript,*
5 *something about that, I wrote anger next to it because it made me feel*
6 *angry that we were dissecting part of me that was me. It was this is just*
7 *me, this is who I am, and even when I read part of it, I can’t remember*
8 *what it was exactly, but I wrote the word “anger” because it made me*

9 *angry when I read it 10 years later and I went, hang on this is who I am*
10 *and we're, you know, making it sound really not constructive.*

11 **Interviewer:** *[...] Can you tell me about that sense of self that didn't fit with*
12 *that conversation and, dissecting anorexia in that way.*

13 **Anne:** *No. I think it was difficult reading back on the transcript. You perceive*
14 *yourself in a certain way right and then you see them in black and white*
15 *written about something you felt 10 years ago and delving into a part of*
16 *you that's I know I keep saying it I guess it's just me, yeah. Well what's*
17 *wrong with that part of my personality? It's like saying to somebody*
18 *you're happy, you shouldn't be happy. You shouldn't like knitting, you*
19 *know it was just that part of my, part of me.*

20 **Interviewer:** *So do you find that helpful that seeing as part of you, or unhelpful*
21 *or a bit of both? (Anne: Helpful.) Helpful and why is it helpful?*

22 **Anne:** *Well it was helpful in as much as if I saw it as just as just a part of me*
23 *and not as an enemy of me then I guess the mental anxiety and the sense*
24 *of guilt over it is not well it's there, but it's not as intense. You're not*
25 *struggling with the issue you've accepted it as just being a part of how*
26 *you exist and how you operate in the world.*

(Third telling, 10 years on, p. 4)

Ten years on, implicit in my question opening extract 4a was my own struggle to understand how ‘anorexia’ may be experienced in any other way than as entirely problematic (lines 1-2). Second, I had assumed the internalised construction of her experiences as “part of me that was me” (line 6) and “who I am” (line 7) to be problematic because this understanding internalises the cultural conditions and circumstances for which her experiences were an expression, or ‘local manifestation’ (Neimeyer, 2000b, p. 213) and reduces personal agency for alternative action (Tomm, 1989) because this is “me”. Through these assumptions, I was unable to see that by arguing that her experiences were “just me”, Anne was defending her identity against the version of herself as disordered, and “wrong” (line 17). Her response of anger within this context may be understood as Anne defending identity against a pathologising disorder perspective. Adam Phillips has argued that –

It is though our morality, as disclosed by our anger, is [...] a secret personal religion of cherished values that we only discover, if at all, when they are violated.

(Phillips, 1998, pp. 98-99)

Anger was Anne's response to the discursive climate of our previous research interviews that she experienced as "not constructive" (line 10) or an identity violation through the implication that she was dysfunctional. She defended her identity against this assumption through the rhetorical question - "what's wrong with that part of my personality?" (lines 16-17). Seeing her experience in any other way than as "just me" would also have meant taking on the perspective that she was disordered and led to a heightened sense of "mental anxiety" and "guilt" (lines 23-24) in relation to her actions. Anne's anger may therefore be understood as her refusal to take up negative claims on her selfhood that are inferred through taking on a problem-saturated, disorder perspective. In refusing to take on the identity of a person who is dysfunctional and the emotions linked to this, Anne also looked away from examining the real effects of acts of food refusal on her life that will be taken up further into this chapter.

EXTRACT 4b

Anne: [...] but in reading back, when I read the transcripts I felt anger at having to dissect it and dissect my personality and defend what I was doing and let this little, I guess this little friend of mine be exposed.

(Third telling 10 years on, p. 31)

Anne's response of anger to my totalisation of her experiences as problematic related to what had emerged as a censoring out of the position that this was also her "little friend". The totalisation of 'anorexia' as problematic limited the terms of our talk to problem talk. Anne's response is an example of some of the hazards of any approach that totalises lived experience as entirely problematic. This raises a significant dilemma for those who work with people experiencing so-called 'anorexia nervosa' that I was struggling with at the start of extract 4a in the context of Anne's internalisation of her experience as "just me". How can therapists take a stand for their client's safety through addressing some of the powerfully negative real effects of practices of food refusal without alienating the person they seek to assist?

Summary.

Anne's decision to participate in 'anorexia' research was an act that was situated within a cultural setting that she authored within a particular discursive climate (Reynolds

& Wetherell, 2003). Within this discursive context, she bargained with herself (although not with full awareness) as to why, on the one hand, she was eligible to participate in 'anorexia' research and, on the other hand, how she did not fit into the broad cultural slot of 'anorexia nervosa'. This bargaining may be thought of as inchoate and brought into her awareness and examined within the discursive context of the research interviews. Central within Anne's process of bargaining were questions of identity including who am I if I participate in 'anorexia' research? Her decision to participate may therefore be understood as a negotiated identity performance.

'Anorexia nervosa' was drawn from a discourse that was unacceptable to Anne and taking on this term as relevant to her experience was dilemmatic. This discourse is built on a dualistic repertoire where the individual is either 'anorexic' or not 'anorexic'. Although Anne related to some of the symptoms marked out by the disorder 'anorexia nervosa', she did not take on the version of herself as out of control. Standing up to the dominant medical discourse through a refusal to take on the identity of an out of control and 'sick anorexic', Anne negotiated the terms upon which she took on 'anorexia' as relevant to her experience. These terms included the negotiation of an alternative position of a 'safe anorexic' who was in control and not sick. Therefore, through her arguments as to why she did not fit into the cultural slot of 'anorexic', Anne re-constructed a version of herself as 'not a typical member' (Reynolds & Wetherell, 2003, p. 502) of the category of 'anorexia nervosa' or a pseudo-anorexic (White, 1984).

Outside the discourse of 'anorexia' Anne struggled to find a language to author her subjectivity. She did, however, find words to express the feelings that were generated within the context of my assumptions totalised her lived experience as problematic. Some of my earlier assumptions were embedded in 'anorexia' discourse that, through a dualistic repertoire, marks out two available subject positions where a person is either disordered or normal. Anne refused to take on the identity of a person who was disordered and dysfunctional. In this refusal, the most available position for her take up was the antithesis of disorder that is, this is "just me". "Just me" worked to minimise and internalise her actions and the circumstances of her life. "Just me" was a position from which she normalised what she was doing and refused to take on the moral status of a person who was

disordered and/or dysfunctional. Her arguments that she was “functioning OK” used a moral repertoire to preserve her status as a functional human being. Anne’s anger may therefore be understood as a response to her identity being violated through my unexamined assumption that totalised her actions as problematic.

My presence as researcher was also visible through Anne’s questioning of whether she was ‘enough of an anorexic’ for me, and enough of an ‘anorexic’ to not only qualify to participate but also to respond with the answers of a ‘real anorexic’. Confining her responses to those of a ‘real anorexic’ risked reproduction of a thin description (Geertz, 1973) of her lived experience and limited opportunity for her to ascribe a range of alternative meanings to her life as lived.

‘Anorexia’ discourse therefore totalises the person’s experience as problematic and disordered. In rejecting this discourse, Anne struggled to find an alternative language to re-author her subjectivity and continued bound to defining her experiences through arguments for the antithetical identity of a person who was not dysfunctional and the normalisation and minimisation of her experience as “just me”. Looking away from the conceptualisation of her experience as ‘anorexia’, through arguing that this is “just me” however, obscured other ways of looking at and ascribing meaning to her lived experience. Anne’s rejection of ‘anorexia’ and seeking to retain the identity of a functional person raises an important dilemma for therapists working with people who engage in body shaping practices of food refusal. For example, how might therapists engage those with whom they consult around change without totalising their lives as problematic and their identities as disordered? In addition to this, how can therapists assist people to see and examine their experience from a range of vantage points, including the real effects of their actions on their life and, in doing so, develop a thick description (Geertz, 1973) of their life as lived?

Thick description

Examining the real effects – a different way of looking.

EXTRACT 5

- 1 **Anne:** [...] *I’ve never talked about it, it’s just me, it’s how I am. See that’s what I*
2 *mean if you can just talk about it and you’ve got somebody to speak to*

3 *without feeling like you have a mental illness or a physical illness, you*
4 *can just chat about it, it all starts to, all those little tight boundaries start*
5 *to relax. [...]*

6 **Interviewer:** *It's interesting that you said that seeing someone that would not*
7 *make you feel like you had an illness so that you could, your "tight*
8 *boundaries" could relax, could you tell me a little more about what you*
9 *mean by the "tight boundaries" relax?*

10 **Anne:** *Because if you operate with that anorexic mentality it does feel like, it's a*
11 *real restriction on you. It's a restriction on every area of your life and it*
12 *would (pause), it would be actually be a huge relief not to have that*
13 *there. I'm seeing it now in my head how (pause) the picture that's coming*
14 *to my mind, it's like my mind in this steel trap that's always being*
15 *controlled by these thoughts and every part of my day, every part of my*
16 *everything I do and think is controlled by this, and it would be a huge*
17 *relief not to have that there and I didn't realise until now how much of an*
18 *effect it had on me. [...]* *the mental pain that I just thought was normal.*

(First telling, pp. 16- 17)

At the end of her first telling Anne reflected how within a discursive context of talk not confined to illness discourse ("somebody to speak to without feeling like you have a mental illness or a physical illness", lines 2-3), she experienced "all those little tight boundaries start to relax" (lines 4-5). Following on from this, she examined the real effects of operating in this way in her life - "it's a real restriction on you" (lines 10-11). This restriction is first located within 'anorexia' discourse as "that anorexic mentality" (line 10). She then re-authored her experience using an alternative discursive resource that depicts her experience as "my mind in this steel trap" (line 14). This alternative metaphor marks out her experience on her own terms or on terms that are 'experience near' (Geertz, 1975, p. 47) and creates associations that were previously unavailable to her when she accounted for her experiences as "normal" (line 19).

Metaphor is a discursive tool that uses an externalised repertoire so that rather than "me" her experience is objectified (White & Epston, 1990) as a "steel trap". The therapeutic implications of externalisation are that through linguistically separating themselves from the problem people are assisted to revise their relationship with problems rather than problems being understood as fixed and stable characteristics of persons that eschew change (White & Epston, 1990).

For Anne, being asked to face ‘the fact’ that she had ‘anorexia nervosa’ was met with argument as to why her experience did not fit within the terms of medical discourse. Although she chose to repudiate the label ‘anorexia’ because it was not helpful, she was not repudiating “it” but renaming “it” on her own terms. Prior to the interview she justified “it” as “just me” and “normal”. Within the context of this conversation, where her own terms were privileged, Anne was able to see other possibilities. The metaphor of “my mind in this steel trap” (line 14) helped her see the options of a life lived differently - “a huge relief not to have that there” (lines 16-17). On the other hand, turning away from this thing and looking at her experience as “normal” (line 19) was not helpful because this obscured the real effects of the “mental pain” (line 18) that she had come to accept part of her life as lived.

In her second telling Anne further examined the real effects of this thing on her life. Anne reconstructed an alternative meaning of her lived experience, one that she had previously accounted for as “normal” or had ambivalently positioned as ‘anorexic’.

EXTRACT 6

- 1 **Anne:** [...] it [my self esteem] really, really is, all boils down to what goes in my
 2 mouth. I had a lot to eat yesterday, what I think is a lot to eat, didn't do
 3 anything all day and that governs how I feel today; and to me that must
 4 be an anorexic way of thinking. [...]
- 5 **Interviewer:** So with “self esteem” being very much linked in with food and what
 6 you put in your mouth (**Interviewer:** Yeah), how does that affect how you
 7 view yourself, or the picture you get of yourself as a person?
- 8 **Anne:** (laughed). The first word that came to my mind was shallow. Yeah, I
 9 thought isn't that a shallow way to operate. That's the first thing that
 10 popped into my head. [...] (**Interviewer:** What does shallow mean for
 11 you?) (pause) Self-absorbed, yeah well isn't there anything more
 12 important in life than that? You know I mean it just sounds so shallow.
- 13 **Interviewer:** Mm. Earlier on³, you were talking about how other people might
 14 see it as being “self-absorbed” (**Anne:** Yes), but that's not how you see it.
 15 Could you say a little bit more about ...

³ “Earlier on” was at the point in her interview where she said – **Anne:** In fact your ego and your self-esteem aren't that high, but to another person, it appears to be an egotistical self absorbed situation, but it's not that because it's such an isolated situation and you're operating on your own agenda and really what other people think of you per say, is not important .
 (Second telling, p. 2)

16 **Anne:** No, but I guess when you asked me that question to look at myself –

17 **Interviewer:** So that's almost from the outside.

18 **Anne:** Yes, from the outside looking in, and that's how it would appear.

19 **Interviewer:** Yep. So from the outside it appears like that. Can you look at it from

20 the inside?

21 **Anne:** It's a mish-mash and it's a huge well of many, many components of

22 reasons, of emotions, of experiences that cause that seemingly shallow

23 (pause) way of living or way of operating. Mm. So in my head I'm seeing,

24 if I could draw something right now I would draw this big well, like this

25 big dark well thing down in the earth, that is all that stuff [...] and this is

26 a very strong picture in my head [...]

27 **Interviewer:** Does that have a particular meaning for you right now, that

28 picture?

29 **Anne:** Well I guess the first thing that comes into my head would be I'm

30 dragging this thing around and nobody else can see it. (**Interviewer:** Mm,

31 mm) On the outside everything is sunny and bright and light-hearted and

32 in fact if I was still drawing that picture for you for some reason I'd have

33 a butterfly or something, it's all - that here underneath the ground is this

34 thing that nobody knows is there, that I **drag** around with me. That's very

35 interesting actually.

36 **Interviewer:** What's interesting about that for you?

37 **Anne:** Well because I never really, until this point saw it as a burden to drag

38 around with me. It was oh, this is just a part of me, so there you go, but

39 obviously talking about it just brings it into a different light and yet I

40 think it does really feel like a burden that I'm dragging around with me

41 that nobody else can see.

42 **Interviewer:** What's that –

43 **Anne:** Using some form of I guess visualisation or your drawing thing and just

44 leaving it behind and see what would happen, you know. (**Interviewer:**

45 Mm) It would probably feel like a great freedom.[...] whereas when I, we

46 talked about it not being with me I think in here, um in my last one

47 [interview], I think I, I, I felt afraid of not being there or didn't want it to

48 be there anymore um, (pause) yes I think it would be a very freeing

49 experience not to have it there now that I can picture it (pause), in a in

50 my mind as a, as a picture.[...] this picture of me dragging this thing

51 underneath the ground. It's like a big, um I know what it is, it's like the

52 um (pause) the slug, the caterpillar with the big cocoon thing. You know

53 and (pause) yeah, it's amazing. [...] you could look at the little butterfly

54 as being that, (pause) that freedom component, that if I got rid of that big

55 *sack of (pause) stuff that was holding me into this pattern of, and, you*
56 *know, eating disorder mentality um, maybe the freedom would be quite*
57 *(pause) resemble a butterfly.*

(Second telling: pp. 9-11)

In developing an association between “what goes in my mouth” that “governs how I feel today” and “my self esteem”, Anne argued that this “must” qualify as “an anorexic way of thinking” (lines 3-4). Following on from location of her experience within the discursive field of ‘anorexia’, I asked her a ‘landscape of identity’ question (White, 2007, p. 82) that enquired into what this association said about her as a person (lines 6-7). From this vantage point, Anne generated a different version of identity that linked her concern with “what goes into my mouth” with the identity of a person who was “shallow” (line 8) and “self absorbed” (line 11) that had implications for her moral worth as a person. This identity did not fit with the person she understood herself to be through her rhetorical question - “isn’t there anything more important in life than that?” (lines 11-12). Implicit in this rhetorical question is the understanding that there is more to who she is as a person and an attempt to find a narrative that is acceptable to her (Wetherell, 2005). This narrative is of a person who valued more than “what goes in my mouth” (lines 1-2).

Through talk that enquired into multiple ways of looking at and ascribing meaning to her experience, Anne repositioned this version of herself as “shallow” and “self absorbed” as a perspective from the “outside looking in” (line 18). This opened the possibility for me to enquire into looking from “the inside” (lines 19-20) and within this discursive context, Anne re-authored an altogether different version of her lived experience as a “burden” (line 37) that encapsulated the real effects of practices of food refusal on her life. This alternative metaphor brought forth a new way of looking (“I never really, until this point saw it as a burden to drag around with me”, lines 37-38) at what had previously been assumed and minimised as “just a part of me” (line 38).

Anne then commented on the importance of talk in this reconstruction of meaning of her experiences “talking about it, just brings it into a different light” (line 39). As argued previously, this was not ordinary talk. This talk was intended to provide a discursive context for the women in this research to generate thick description of their experience and that privileged the terms that the women themselves found to be meaningful rather than

being confined to the terms of the dominant ‘anorexia’ discourse. Piecing together her account using an externalised repertoire through the generation of her own metaphor to depict her experience provided discursive opportunity for Anne to author alternative possibilities for her life where she was in a position to decide whether or not she wanted to continue to carry, put down and/or separate herself from the experience that she had re-authored as “a burden”. Externalisation through metaphor provided opportunity for Anne to connect with a sense of agency in two different ways. First, through the possibility of change through shifting her relationship with this “burden” and second, through a capacity to choose her terms of speaking rather than being confined to ‘anorexia’ discourse. This ‘choice’ for a person to speak outside the dominant ‘anorexia’ discourse and on their own terms will be referred to as discursive agency and will be discussed in more detail in the following chapter.

Anne depicted this capacity to change through extending this burden metaphor to a cocoon (line 52) and butterfly (lines 53) metaphor, which carved out the possibility of migration from the old to the new, whereby the new is an embodied transformation of the old, or a metamorphosis (A. Armstrong, personal communication, June 2009). Therefore what becomes accessible to Anne through metaphor is who she imagines herself to be. Metaphor within this context therefore provides and gives coherence to her lived experience through tapping into imagined future possibilities. Mark Johnson (1987) has argued that, rather than merely linguistic, metaphor is ‘one of the chief cognitive structures by which we are able to have coherent, ordered experiences that we can reason about and make sense of’ (p. xv) and therefore an imaginative structure that provides meaning for human beings to understand the world. This metaphor continued to provide a meaning structure for Anne to narrate her experiences in her third telling, 10 years on.

EXTRACT 7

- 1 ***Interviewer:*** *What comes to my mind is that metaphor [...] and the cocoon or the*
- 2 *burden that was holding this butterfly down, and I wonder if this butterfly*
- 3 *is what you are talking about now? [...]*
- 4 ***Anne:*** *Yes. Almost brought tears to my eyes because that’s exactly how it is*
- 5 *mmm.*

6 **Interviewer:** *Do you want to tell me a bit more about that what the tears mean*
7 *for you?*

8 **Anne:** *Well I just, I think I'm really grateful to you for putting me through this*
9 *process to make me realise that I am happy, that I am lucky. There's*
10 *nothing to worry about and I do have all this freedom of choice, of*
11 *lifestyle of even, how can I put it, even more freedom in my thought*
12 *processes. [...] There was a couple of things in here that made me*
13 *observe how I would, how I do things now. There was a story in there like*
14 *I wouldn't be able to go into a coffee shop and order a big piece of cake*
15 *or something without feeling oh my God. I can't eat for the next year or*
16 *something or I've got to go and run around the block 20 times but I, I go,*
17 *yeah, I'll do that now, I do that now and it might have the slight little oh*
18 *my gosh, you know, but it doesn't torture me anymore.*

(Third telling, 10 years on, pp. 8-10)

A decade later when Anne was talking about shifts in her relationship with 'anorexia', I enquired into whether her life had moved in the direction of the metamorphosis into a butterfly. Anne responded with "almost [...] tears" (line 4) that signified recognition of how she had lived what was previously accessible only through metaphor and in doing so experienced "freedom of choice" (line 10) in her "lifestyle" (line 11) and "thought processes" (lines 11-12) and acting differently through a different relationship with eating. Anne not only imagined freedom, she was living freedom where "it doesn't torture me anymore" (line 18). What Anne's observations make visible is that the discursive shifts in authoring and understanding her lived experience that she marked out a decade earlier not only were meaningful to her at the time but through their meaningfulness provided a vision for life lived differently and a map to guide her actions; in other words these discursive shifts did not merely describe experience they '*generate(d) experience*' (Freedman & Combs, 1996, p. 113).

There were many points in my conversations with Anne where she reconstructed a different meaning for her life as presently lived that had implications for future possibilities of a life lived differently. Although it is beyond the scope of this thesis to analyse all these stretches of text, the following section analyses how Anne reconstructed the meanings she ascribed to a particular time in her life that she initially referred to as when she was "really anorexic".

Reconstruction of meaning between tellings.

EXTRACT 8

1 *Anne:* This thing was expected of me that wasn't really intrinsically me and
2 that's why I felt out of control. (*Interviewer:* Right. Yep). Yeh. I was
3 getting the pressure from outside sources rather from within myself and
4 then as the years went by I took it upon myself to be the judge. That was
5 my dance teachers and my choreographers and what have you along the
6 way. I replaced them as my own judge.

7 *Interviewer:* Right, and when did, did that happen very gradually or did that?

8 *Anne:* Yeh, um, yes it's like a little voice inside my head all the time that will
9 stop me uh, overindulging with food. In times of great stress I just um, my
10 throat just closes up, I can't eat and I enjoy that feeling of being in
11 control of something, if my environment is out of control at least I know
12 um, I'm in control, but there's another component that goes with it as
13 well, it's a sort of a multi-layered, sort of (pause) um, psychological thing
14 for me. There's the control, there's the self esteem and it's also a,
15 attention seeking, it that became, that came later on. [...] The attention
16 seeking side of it is, um, [...] after I had my first child, the relationship
17 broke down very badly. (*Interviewer:* Uh, hm.) That's when my worst
18 anorexia, that's when I'd say I was really anorexic. I mean I was two
19 stone lighter than I am now and that a, was within a few months of
20 having my child. I just didn't eat and I wasn't getting the attention that I
21 felt I deserved from my partner and it started off gradually and it's the
22 first time that I operated that way with the eating, it was, oh suddenly
23 everybody's attention was to me, I was at the table, but I wasn't eating.
24 Um, Anne come on eat something. So all of a sudden they were taking
25 notice of me.

26 *Interviewer:* Hm, hm, and what did, what, what did it, it feel or mean to you to
27 be, for some people to be taking notice of you at that time?

28 *Anne:* Oh, gosh, it was, um, it was very, very beneficial. I was in another
29 country, without my family, I was in my early twenties and I was being
30 psychologically abused by people I was living with. It was a very, very
31 out of control situation and I was very on my own, um, and that was my
32 weapon. As stupid as it sounds from a realistic point of view that was the
33 only weapon I had and I've continued to do it.

34 *Interviewer:* Hm, hm. Would you describe anorexia as your weapon now?

35 *Anne:* Yes, yes, because I've recently been through a similar episode.

36 *Interviewer:* [...] and what's anorexia your weapon against? or for?

37 *Anne: Oh, yeh, I (pause). Of being, as I perceive it, um, not being validated as a*
 38 *human being. Yeh, it's difficult to um, I've never really thought about it.*
 39 *When I knew you were coming I thought I've, I'll really think about it, but*
 40 *I didn't I didn't really want to rehearse what I was going to say to you so*
 41 *I left my mind really open and I've never really, really it's just been a*
 42 *part of my life, it's like my arms and my legs and if somebody said to me*
 43 *we're coming over to interview you on your arms and your legs, I'd go*
 44 *but they're part of me. [...] It's just me. (First telling, pp. 1-3)*

In this stretch of text Anne reconstructed the meanings she ascribed to food refusal and body shaping practices that had dominated her life since her teens. In relating her history of food refusal practices to expectations of thinness from her dance teachers and choreographers that were outside of her “control” (lines 1-2), a paradox that is generated from her previous arguments (for example in extract 1, pp. 62-63) that she is in control of “this thing” (line 1). In seeking to make sense of this seeming paradox, she traced the processes of this change as “I took it upon myself to be the judge” (line 4) and “I replaced them as my own judge” (line 6). In his analysis of modern power, Michel Foucault (1988) has referred to this process as ‘technologies of the self’ (p. 16) whereby people operate on themselves to fit what is prized within their cultural context. This process is experienced by the person, not as repressive, but rather as their choice and their personal attempt to attain ‘a certain state of happiness, purity, wisdom, perfection or immortality’ (Foucault, 1988, p. 18). Through this framework Anne’s account fits with Foucault’s perspective that through taking up what was expected from her profession in order to achieve within that profession, she did not notice that she was taking on and living inherited cultural values that prize the thin body.

In lines 8-9 there is a shift where Anne generates a name that characterises her lived experience that is outside the terms of the dominant discourse – “it’s like a little voice inside my head all the time that will stop me uh, overindulging with food”. Anne experienced this “little voice” as a source of assistance in her life “in times of great stress” (line 9) and “if my environment is out of control” (line 11). Borrowing the concept of ‘anorexic voice’, Tierney & Fox (2010) argue that this voice although at times launching ‘a full-scale attack’ on a the ‘essence of their being’ also holds ‘the promise of a better life’, which explains a person’s ambivalence around change (p. 250).

Following on from this Anne generated “another component” to her experience that she positions as this “multilayered [...] psychological thing” (line 13). This is the second time she used the term “thing” (also in line 1) to talk about her experience, which signifies the absence of a name at this point for her experience outside ‘anorexia’. Although I used the term ‘anorexia’ repeatedly in our conversation, Anne’s use of the term “this thing” might be understood as a refusal to construct her narrative on these terms. The absence of a language to speak about her experience outside the dominant ‘anorexia’ discourse meant that the discursive resources available to her to construct her narrative that had implications for who she understood herself to be were confined to a discourse that she rejected. Following on from this, however, within the discursive context of talk not confined to ‘anorexia’, Anne generated alternative ways of speaking and reconstructed the meanings she ascribed to living a life with this “thing”.

In line 14, Anne shifts to author another layer of her experience where her actions signify “attention seeking” (line 15). She links “attention seeking” to a time in her life where (through use of the symptom criteria of weight loss) she justifies herself as being a ‘real anorexic’ at the time (“I was really anorexic”, line 18). Accounting for her experience at this time with the subject position of “attention seeking” functionalises her distress at the time. “Attention seeking” is built on a repertoire of secondary gain where a person is assumed to be actively and intentionally profiting from others through their own suffering and distress. When I enquired into how she ascribed meaning to people “taking notice of me” (lines 24-25), Anne reconstructed the meaning of her act of not eating from “attention seeking” (line 15) to “my weapon” (lines 31-32). This shift marks out quite a different meaning structure through an alternative metaphor where not eating becomes understood as a response to “not being validated as a human being” (lines 37-38). This was a new way of looking at an old experience (“I’ve never thought about it”, line 38) or a ‘new-old story’ (Hewson, 1991, p. 5) where Anne reconstructs her past history with a new meaning or into a ‘new story’. Using the analogy of a crossroads, Daphne Hewson (1991) has argued that ‘the new story is not a turn-off from the old road, but the continuation of a different, old road – one on which the person had been travelling without previously recognising they were doing so’ (p. 7). The old road that Anne was travelling on was that not eating was some form of attention seeking. The different, old road that was largely un-authored before

our conversation was that not eating was “my weapon” against “not being validated as a human being”. Absent but implicit (White, 2000) in this alternative new-old story was that to resist invalidation required Anne to see herself as worthy of validation.

Alan Wade (1997) states “whenever person’s are badly treated, they resist” (p. 27). Anne’s response to psychological abuse through the act of not eating is to resist taking on the identity position that she is invalid that has been allocated to her by others. In doing so, she retains the identity position that she is worthy of validation at a time when she was “expected to surrender it” (Wade, 1997, p. 33). It is important to note at this point, that resistance within this context as an effort to sustain a preferred identity position (that is, the sense of herself as worthy) has an entirely different meaning to the way resistance is framed within the dominant medical discourse. Resistance within a medical context is instead demonised and the person pathologised as resistant and non-compliant with not eating being understood as further confirmation that they are disordered and in need of correction through medical intervention.

Therefore within these stated confines, Anne ascribed a different meaning to her history of not eating. She reconstructed the meaning of her actions from a pathologised ‘attention seeking’ account that eroded her moral worth (old story) to an act of resistance that reinstated a sense of worth (new-old story). This new-old story took into consideration the social context of Anne’s life at the time in a way that was neglected by positioning not eating as signifying her to be “really anorexic” (line 18) or justified as “just me” (line 44). Nevertheless there is a risk in valorising Anne’s actions of not eating as an act of resistance because what is obscured by this narrative reconstruction of meaning is the real effects of her actions as a “real restriction” and a source of “mental pain” (extract 5). Anne’s resistance is important because it is in her resistance she preserves a sense of moral worth, however the action she took to resist (not eating) resulted in restriction and pain and nevertheless posed a real threat to her life.

What is also notable in extract 6 is the speed at which Anne shifted from further reflection on this new way of looking at her past experiences. Her shift back to her previously influential position that “it’s like my arms and my legs” (line 42) and “it’s just me” (line 44) may signify that further talk about past experiences of psychological abuse

was unsafe at this point in her first telling. Nearly a decade later, however, Anne continued to re-author this painful time in her life.

EXTRACT 9:

1 **Interviewer:** Can you tell me what it is about the quality (“integrity”) that makes
2 you proud to have it?

3 **Anne:** I see integrity and honesty go hand in hand and, and maybe it’s more the
4 honesty part of it that I can relate to more you know, I think if you
5 haven’t got honesty then and I think because in the past I was, I was lied
6 to in such a, a big way and we, that whole marriage thing, and my
7 husband was having an affair with my friend, blah, blah, blah, while I
8 was pregnant, I mean that is not being an honest person and it’s not a
9 person with integrity so I think what I gained from that were the two
10 qualities that I felt that I expected from somebody else and they wanted
11 they didn’t come through with those. Yeah and that’s and that’s just been
12 my moment of realisation from where I got those important qualities from
13 mmm and why they’re so important to me. Now I’ve given you your
14 answer, but I’ve given myself the answer because there had to be a, a
15 reason or an incident that made those important, those qualities
16 important to me and it was (pause)

17 **Interviewer:** Got you touch with those qualities because they were so strongly
18 crossed, boundaries. (**Anne:** Absolutely. Yeah.) So strongly crossed.

19 **Anne:** Yes. Yeah. Yes and I think I expected them from my partner because they
20 were important to me. (**Interviewer:** Because they were things that you
21 took for granted in some ways.) Exactly. Exactly and those two qualities
22 were just dashed on the rocks yeah. Interesting.

23 **Interviewer:** Can you just before we finish up can I get an idea of what stands
24 out for you recounting that. You said that’s interesting. [...]

25 **Anne:** There’s been quite a profound moment just then realising that I came out
26 of that experience that was very horrendous at the time and you know
27 what doesn’t kill you makes you stronger. (**Interviewer:** Yes.) So it’s
28 interesting that the qualities that I gained from that, qualities that I
29 expected to be afforded me at the time that weren’t (pause), very
30 profound moment there.

31 **Interviewer:** Is there something you want to tell me that is important for you not
32 to forget right at this moment about that?

33 **Anne:** Oh, I just feel so at peace with myself now I feel quite happy that my life’s
34 unfolded the way it has mmm because its only through experience do we
35 have acknowledge where we are at the moment, you know.

(Third telling, 10 years on, p. 14)

In this extract, Anne continued to generate meaningful structures to account for her actions at the time that are construed as a response to her values of “honesty” and “integrity” (line 3) being violated (“dashed on the rocks”, line 22) by the actions of significant others. This different way of looking at her response of not eating in terms of values is a “profound moment” (line 25) of understanding and insight for Anne. Why was this moment “profound” for Anne? What Anne is negotiating in this stretch of text is an identity position to account for her past acts of not eating that is neither internalised as “just me” nor medicalised as “an anorexic”. Instead the meanings ascribed to her actions at the time have implications for the sort of person she was, is and hopes to be. Through a vocabulary of values she uses this identity position to re-author a narrative of survival and strengthening of identity – “what doesn’t kill you makes you stronger” (line 27). Within this statement she takes into account the real effects of her actions that could have killed her at the time but also how through this painful time she survived with a clearer sense of identity in terms of what matters.

Within a discursive context not confined to ‘anorexia’, Anne’s re-authoring of a past narrative from “just me” to an act of resistance against psychological abuse to a stance against important values being violated by others is what Michael White (2007) has referred to as a ‘narrative analysis of storymaking’ (p. 128) that contributes to a settled story of past experiences for Anne (“at peace with myself”, line 33) that has implications for who she understands herself to be in the past, present and future contexts of her life. This notion of settled story ‘refers to people sorting out their ideas and their experiences, making meaning for themselves and getting to a settled place about the things that trouble them’ (Waldegrave, 1999, p. 178). From this settled place, she renegotiates an identity that is not only acceptable to her (Wetherell, 2005) but also sustaining for her in the context of her life as presently lived – “it’s only through experience do we have acknowledge where we are at the moment” (lines 34-35).

Re-authoring identity in terms of values.

EXTRACT 10

- 1 **Anne:** *I think, it’s only because I’ve done this exercise with you, that I’ve started*
- 2 *to look at it in a different way. I mean I didn’t even really address the fact*

3 *that I was an anorexic, I would never have even said it. So this has been a*
4 *whole learning process for me, reading these [transcripts from first*
5 *telling] back again and just going oh this is boring, this is boring. You*
6 *know, you're so (pause) **into** yourself and even though I say to people*
7 *'oh, I'm not self obsessed by things', I read this and I go, well yes you*
8 *are. So having it in black and white and reading it over and over has*
9 *been a very helpful exercise in distancing myself from it, well a)*
10 *accepting it and verbalising it and reading it and **then** being able to put it*
11 *into a different perspective. [...]*

12 **Interviewer:** *So when you say self obsessed (Anne: Yeah.) how did that affect*
13 *how you see yourself as a person? Like you said self-obsessed.*
14 **(Interviewer: Yeah.)** *What does that mean for you as a person to see ...*

15 **Anne:** *Oh selfish (pause) mmm. I don't, I don't enjoy thinking of myself that*
16 *way.*

17 **Interviewer:** *Yeah. So, so seeing yourself in the effects of anorexia in black and*
18 *white and then seeing that affecting your view of yourself (Interviewer:*
19 *mm, mm) as a person as self obsessed and selfish, that you perhaps take*
20 *resist or take a stand against that view of yourself.*

21 **Anne:** *Yeah, I didn't like (Interviewer: It didn't fit.) I didn't like what I saw.*
22 **(Interviewer: Mmm. So it didn't fit with ...) What I thought I was.**

23 **Interviewer:** *What did you think you were?*

24 **Anne:** *(pause) Well I certainly didn't think I was self-obsessed (laughed), but*
25 *reading this, it is a self-obsession (pause) and I was a little bit*
26 *uncomfortable with that feeling*

(Second telling: pp. 15-16)

As discussed in the previous chapter, the discursive context of the second and third tellings moved increasingly toward conversations centred upon the question of identity and more specifically enquiry into identity in terms of values. In her second telling (extract 10) Anne reflected on how the research interviews had provided a platform for the generation of different ways of looking (“look at it in a different way”, line 2) at herself in the context of her life. Again, she returns to the identity position of “self obsessed” (line 7) as relevant to her. This identity position does not fit with the person Anne understands herself to be – “I didn’t like what I saw” (line 21) and it didn’t fit with “what I thought I was” (line 22). Anne’s presentation of self in the transcript (first telling) on these terms did not fit with who she understood to be in terms of her preferred values and may be understood as a ‘values clash’ (Calder, 2009, p. 191). Rather than “self obsessed” being internalised as

pathology, what Anne is doing with this notion in this stretch of text is to mark out her preferred values identity.

Anne's uncomfortableness with what she read on the transcript of her first telling embodies a discontinuity between the narrative of the person she saw on the pages of her transcript and the person who she thought she was and hoped to be. From a cognitive constructivist perspective this discontinuity in her narrative may be understood as creating an opening for Anne to take steps towards a more coherent and acceptable account of her life story through "distancing myself from it" (line 9). This account could therefore serve to integrate these disparate experiences of herself and "*establish continuity of meaning*" (Neimeyer, 2000b, p. 212) where Anne aligns her actions with that which she accords value. From a social constructivist stance this uncomfortableness could be conceptualised as her resistance to, and repositioning on, the dominant ideologies that informed her ways of being. This resistance may signify the presence of counter narratives that are an avenue through which she can move to understand more fully, and step into, the person she wants to be (White, 1995). Or a 'relational alternative' could construe this uncomfortableness as giving direction to her 'existence' based upon her values (Neimeyer, 2000b, pp. 215-216). Perhaps Anne's response contains elements of all these conceptualisations.

EXTRACT 11

1 **Anne:** [...] *I think a defining thing for me was an experience for me as well if I*
2 *really look at it, was a visit to, two visits to India that I had and that, that*
3 *shifted my me a lot, but I mean I don't need to go into the, you know, the*
4 *obvious reasons why. I mean you're seeing poverty and you know those*
5 *two visits to India absolutely shifted me as far as how I observed my*
6 *position in the world and what my, what my thought and I was upset that*
7 *I felt so, I was so selfish and self indulgent. Mmm. So as far as physical*
8 *experiences go I think that, those, those two visits to India were a very*
9 *defining moments in my shift.*

10 **Interviewer:** *What did they define for you? [...]*

11 **Anne:** *Whoa, especially after the first time I came back and I just didn't know*
12 *where I was in the world. I mean I was just, you know, you come back*
13 *from that abject poverty, seeing women with their children living on a*
14 *garbage dump in the middle of the street and you come back to your*
15 *luxury and with everything, you know, every luxury and, that you could*
16 *imagine by comparison; and it just made me very uncomfortable and, but*

17 *grateful, but very grateful. So therefore it, it just levelled out my*
 18 *perspective on things. I think, you know I've never really experienced*
 19 *poverty to such a degree and it affected me profoundly in as much I guess*
 20 *as I was embarrassed that I had been so self indulgent with what I*
 21 *probably now look as not important issues such as what I put in my*
 22 *mouth and how my body looked or whether I was skinny enough or*
 23 *whether my collar bone stuck out. Or you know how petty and self*
 24 *indulgent was that in context of what's going on in the world? So I guess*
 25 *I, I moved from being introspective to viewing myself in the world in a*
 26 *different, on a different platform.*

27 **Interviewer:** [...] and can you tell me about that platform? [...]

28 **Anne:** Yeah. At the time I felt that I had put my platform really high. I put myself
 29 on this pedestal and I think that's a, an A plus personality pedestal that
 30 you put yourself on and you can never quite achieve that, but the values
 31 around that pedestal and what, what were they about? You know, until I
 32 had that grounding experiencing of observing India and then I think it
 33 just made that pedestal very shaky and not, not necessary. [...] I'm a
 34 really visual person so I'm seeing this in my head. I'm seeing me stuck on
 35 the top of this tiny little peak, precariously balancing on this tight little
 36 steeple, you know, I mean how uncomfortable is that? How (**Interviewer:**
 37 **Tortured**). How, yeah, exactly and you can't sustain it at any time you
 38 can fall off, but now I'm seeing I've used the word "platform" I guess so
 39 it's a broader, giving myself more space to move around. A freer area
 40 rather than being stuck up on this precarious little peak that is you can't
 41 stay there, you can't stay there. You can only, you can only fall. So
 42 platform analogy is quite good because the platform can get bigger and it
 43 can broaden your perspective on things and it can soften, you know
 44 (**Interviewer:** Falls?). Absolutely.

(Third telling, 10 years on, pp. 21-22)

Nine years on, the values clash that she experienced in her second telling was further intensified in the context of witnessing 'abject poverty' (line 13) when visiting India. At this time she examined the context of her life in comparison with those living in poverty and reached a threshold where she could no longer justify living the inherited cultural values that prized the thin body. She re-authored this as a "shift" in looking from a place where the meaning she ascribed to her actions and concerns (related to "what I put into my mouth and how my body looked" lines 21-22) was reconstructed using a moral repertoire as "selfish" (line 7), "self indulgent" (lines 7 and 23-24) and "petty" (line 23). Implicit in this repositioning was her own unstated values that led her to look at her life from this "different platform" (line 26) in the first place.

A key feature of this platform metaphor is a particular type of agency that is linked to the capacity to look at her life from a range of vantage points (in Anne's words, "broaden your perspective on things", line 43) and then being in a position to choose whether or not to continue to perform the values of the dominant western culture as though they were her own (Calder, 2009). The kind of person Anne wanted to be did not fit with the person she saw when she reflected on her life from this different platform. What Anne is doing with positioning her actions and concerns as "selfish" and "self indulgent" is to carve out and negotiate an alternative presentation of self that is acceptable to her, which is of a person who is capable of questioning the values supporting western cultural ideologies (of which prizing thinness is a dimension).

The 'choice' to realign the way she was living with her own preferred values, however, was not an easy step to take because departing from her life as known unsettled her place in the world - "I didn't know where I was in the world" (lines 11-12). Taking this step into the unknown could be understood as what Victor Turner (1969) has referred to as the 'betwixt and between' (p. 95) or the liminal phase of van Gennep's (1960) rite of passage metaphor (White, 1997). Anne however was not moving into nothing as she took this step into the unknown. Reconstructing the meaning of her life as known to living on "this tiny little peak" (line 35) that was "uncomfortable" (line 36) and "precarious" (line 40), the "platform" metaphor provided her with an image for life lived differently and a place to move towards with "more space to move around" (line 39). This space to move around might be understood as more space to define her subjectivity from having access to a greater range of positions from which to choose.

Discursive context of different ways of looking.

EXTRACT 12

- 1 ***Interviewer:*** *What do you see as some of the contributing factors that your life*
- 2 *didn't continue going down that, that way in that direction?*
- 3 ***Anne:*** *Okay probably repeating myself again. That (a) It was recognising it, (b)*
- 4 *separating it from isolating it from who I was, talking about it,*
- 5 *addressing about it without feeling protective towards it and then just*
- 6 *putting it into a healthy place and, and not a destructive place. So and I*
- 7 *don't know if you want experiences or actual experiences, but that,*
- 8 *they're just words that come up, but it's not, I can't say well this*

9 *experience made me move that step further away from it or that*
10 *experience. I can't pinpoint certain experiences, it's just yeah, it was just*
11 *addressing it and it's from these interviews, the initial ones that made me*
12 *realise that it's something I don't need any more or don't want anymore.*

(Third telling, 10 years on, p. 20)

In drawing this analysis of Anne's narratives towards a conclusion, this stretch of text captures many of the points raised thus far. In reflecting on what contributed to Anne's life not continuing in the direction it was going, Anne states first it was "recognising it" (line 3). What Anne recognised in the absence of a name outside the discursive field of 'anorexia', was the real effects of this thing on her life. Second, within the discursive context of externalisation, she generated an identity narrative that worked to isolate "it from who I was" (line 4) or linguistically separate this thing from her identity, which is a key feature of externalising conversations (Tomm, 1989). Third, within the discursive unconfined to an illness and disorder perspective, Anne talked about "it" on her own terms and was in a position that looked at and addressed it (lines 4-5) without being placed in a position of having to defend her identity against the version of herself as "an anorexic".

Through this talk she came to "realise" that this was a thing that she not only no longer needed but also no longer wanted (line 12). Integral to her capacity to evaluate her preferences is agency through the generation of a range of positions from which to author her preferred identity.

Chapter summary

Taking on the identity as "an anorexic" was troubled for Anne and for a number of reasons she struggled to position her experience within the discursive field of 'anorexia'. First, she refused to take on a label that assumed her to be an out of control and sick 'anorexic'. Instead she negotiated an identity of a safe 'anorexic' who was in control and able to stop herself from becoming "sick". Second, she refused to take on the identity of a person who was dysfunctional or a person with problems.

In order to turn away from looking at her experience on someone else's terms required Anne to recognise there was a thing to turn away from (Hewson, Germanos, & Faine, 2004). This thing, however, did not have a language outside a discourse that she

rejected. Her use of the externalised, yet nameless, terms of “thing”, “that” and “it” signified her struggle to name her experience outside a discursive field that troubled her. The absence of a name outside ‘anorexia’ confined her terms of speaking to the dominant discourse, which was itself ‘shielded from transformation’ (Sampson, 1993, p. 1220). This made transparent the power of medical discourse to mark out what is and what is not permitted to be spoken. Foucault (1980) has theorised that power both produces and represses discourse. Although Anne resisted the dominant discourse through argument, negotiation and clarification of the extent to which this discourse was relevant to her lived experience, her arguments that she was not dysfunctional and not out of control continued to bind her to the terms of the dominant discourse. In the absence of a language to author and re-author her experience other than on the received terms of the dominant discourse had profound implications in diminishing agency for Anne to define and determine her own subjectivity. This particular sort of agency will be referred to as discursive agency and will be discussed further in the chapters that follow as relevant to all the women who participated in this research.

Nevertheless, within the discursive context of speaking that was structured to provide scope for the generation of a range of ‘meaningful structures’ or thick description (Geertz, 1973, p. 7), Anne developed a number of alternative accounts of her life and identity that were not confined to the discursive field of ‘anorexia’. Instead of defending her identity against a disorder construction, Anne examined the real effects of this “thing” on her life and generated accounts on her own terms that frequently drew on an array of metaphors such as “steel trap”, “a great big well”, a “burden” and “cocoon”. Within these contexts of speaking on alternative terms, Anne looked at the real effects of this thing on her life and re-authored what she had previously argued as “normal” and “just me” as “a burden”, “restriction” on her life and painful. Carving out these images also carved out the outside of these expressions, which provoked images (such as a “butterfly”) of a life lived differently that was freer and less restricted. These alternative images or metaphors provided coherence and tapped into the imaginative dimensions of her selfhood; some images continued to hold relevance to depict her journey over the following decade. The significance of metaphor for Anne was therefore not only in its capacity for enduring

meaningfulness, but it also provided a map from which new experiences were generated (Freedman & Combs, 1996) over time.

The research interviews, although not therapy, had an effect. Through the intention to generate thick description, providing scaffolding so that participants could develop meaningful structures that were articulated on their own terms rather than confined to the dominant ‘anorexia’ discourse, Anne re-authored a range of past and present experiences on new terms and with new understandings. She renegotiated the meaning of a painful period in her life from the version of herself as “really anorexic” to the version of not eating as an act of resistance where she was defending the identity that she was worthy of validation. Nearly a decade later her acts were validated and understood as a response to her values being violated by those significant others around her. These accounts took into consideration the social context of Anne’s acts of not eating, rather than locating not eating as individual pathology through a disorder perspective. Rather than minimising the real effects of not eating, through this reconstruction of meaning she identified herself as having survived and become stronger from an experience that had the potential to harm her.

Re-authoring her identity into meaningful structures was also achieved within the discursive context of values talk. Having been indoctrinated into taking on the cultural ideology of thinness, within the dialogical space of the research interview, Anne experienced a values clash where she became increasingly aware that she had been living these inherited values that did not fit with her own. Marking out these concerns and how she had been acting in her life with terms such as “selfish” and “self obsessed” was dilemmatic for Anne’s presentation of self (Reynolds & Wetherell, 2003). These identity positions did not fit with who she understood herself to be, although in marking them out she renegotiated an alternative self presentation. She was also faced with the dilemma around how she might realign her actions and concerns with an identity that resonated with who she understood herself to be. This was unsettling and left her struggling to find her place in the world. Within this context, Anne’s change was not confined to moving away from something that was problematic but also about journeying towards something she judged as preferable that resonated with what she accorded value.

In conclusion, Anne's narrative is a powerful stance in relation to medical discourse that totalises lived experience as illness. I, as researcher, also positioned myself in relation to the medical discourse despite my intention to actively seek out a person's perspectives on their own terms. Nevertheless the research interview created enough discursive space for Anne to generate a diverse range of ways of authoring her life on terms that were not limited to the dominant 'anorexia' discourse. Anne was then in a position to select out those versions that she found to be meaningful and that had implications for her presentation of self and life as lived. Looking at her life from a greater range of alternative positions or vantage points was generated within the discursive context of a particular type of talk that both used an externalised repertoire and privileged the speaker's terms and meanings rather than the researcher's. Within this discursive context what was founded upon was discursive agency, which is characterised by the availability of a range of positions from which to select out and re-author preferred identities (White, 2007). This and other concepts raised thus far will be further expanded upon and linked to the analysis of other women's narratives in the following chapters. The analysis in the following chapters seeks to understand and keep alive the women's active participation in the construction of their narratives both inside and outside the discursive field of 'anorexia and some of the implications for their identity formation and life as lived.

Chapter 5: ‘Anorexia nervosa’ or ...?



I open this chapter with a cartoon that depicts how human beings within different discursive contexts are both positioned (“I felt that I was going insane”) and also active in arguing for particular versions of their reality (“I revised my concept of sanity”) (Jones, 1995, permission to reproduce by artist). This chapter begins to address the question of how women in this research were simultaneously positioned and active in positioning themselves in relation to the dominant medical discourse that constructs their experience as ‘anorexia nervosa’ (Chapter 2).

The detailed discursive case study analysis of the previous chapter generated a number of dilemmas linked to the construction of lived experience as ‘anorexia nervosa’, including the question of whether or not Anne qualified (in her eyes and/or the eyes of others) as a ‘real anorexic’. How were other women in this research positioned in relation to the application of this dominant ‘anorexia nervosa’ discourse to their lived experience; and what implications did their positioning have for who they understood themselves to be?

Selection of interview material was guided by these research questions. Analysis focused on a 'data file' (Wetherell & Edley, 1999, p. 339) that contained extracts of text where the other eight women who participated in this research talked about 'anorexia' in general as well as the processes through which they managed their identity in relation to the dominant 'anorexia' discourse. Analysis will focus on the range of discursive resources (interpretative repertoires, subject positions, rhetorical devices and metaphors) that these women drew upon to construct their experiences and author their identities both inside and outside the discursive field of 'anorexia nervosa'.

In control

Prior to taking on an 'anorexia' classification as relevant to their experiences, the women's actions signified to them that they were in control of something in their lives.

EXTRACTS 1

Jane: *I liked knowing that I was the controller of my destiny, I made myself happy, I made myself sad and nobody else was going to make me feel bad about myself.* (First telling, p. 7)

Katie: *I was fulfilling my dream of losing weight, I was achieving something for myself and it was just for me, I wasn't doing it for anybody else, it was just for me.* (First telling, p. 17)

Kelly: *I was in control, I was fantastic, I was, you know, 400 calories a day, heaps of vitamin pills, exercising, I was really good.* (First telling, p. 7)

Lisa: *I am still really pleased with myself if I can have a good day, like not eat a great deal- it's still like an achievement. When I have a bad day I feel like I've failed that day [...]* (First telling, p. 7)

Naomi: *I was a great success.* (First telling, p. 3)

Sally: *I think that I actually hooked onto something that I was good at and I wasn't going to let it go because I was getting better at it and I got incredibly good at it.* (First telling, p. 14)

Sarah: *[...] it is a form of control, it's a form of self control definitely, it's also a way of keeping everything in line as well.* (First telling, p. 5)

Susan: *At the time I thought it was making a difference because I finally had some kind of control.* (First telling, p. 25)

There were many quotes like these throughout our conversations. The women in this research relied on an understanding of themselves as individual, autonomous agents whose past and present actions signified self control, power, being the best, success and achievement, pleasing others and oneself, and being good at something. Their actions were internalised as ‘me’ in control and for some women being the best possible ‘me’. Within such accounts the women measured their success and achievement through the extent to which they could control their eating and the shape of their bodies. Hardly surprising that these women ascribed narratives of ‘control’ to explain their actions, given the cultural context whereby achieving a thin body not only signifies an aesthetic ideal, but is also what is valued in Western culture (Seid, 1994). These ‘control’ narratives valorised women’s actions and formed the rhetorical basis of their arguments that justified and associated their behaviours with a profound sense of self worth.

However, if these women’s lived experiences were fully accounted for by this control narrative, they would not have volunteered to participate in ‘anorexia’ research. What other meanings did women ascribe to their experience that would not be accounted for by a singular ‘control’ narrative?

Something “wrong”

EXTRACTS 2 (my emphases in bold)

Jane: *I was scared, scared as all hell. I didn't know **what was going on**, I just knew I had this food in my stomach, I had to get rid of it.*
(First telling, p. 20)

Kelly: *I was scared. I always knew there was **something wrong** with me. I mean it wasn't normal thinking, but then I never wanted to admit that, I was scared. I'd always search for something in that list (of symptoms of eating disorders) that would tell me that I was OK. (First telling, p. 34)*

Naomi: *I suppose the big thing probably that hit was when a girl a year older than me realised what was happening and she wrote me a letter telling me what I had, and I sort of thought yeah right. That letter actually stood really- it's an important letter to me now – I can still cry over that letter. [...] [at the time] I sort of just pushed it off I suppose, I don't know. So I suppose I knew there was **something wrong**, but-*

(First telling, pp. 4-5)

***Sarah:** There are times when [...] you'd think oh I'm not thin enough, and then other times you'd think oh I'm so thin, people will see and wonder **what's wrong** with me. It is a to-ing and fro-ing, it's a backwards and forwards, it's a constant struggle between, you can never maintain exactly your symptoms or what you look like or anything else like that, you view it from different aspects constantly. (First telling, p. 23)*

***Susan:** [...] it got worse and better but it was never severe enough that anyone would really suspect that **something was wrong** with me. I was just skinny, but not super skinny.[...] I didn't think I'm sick enough that anyone would notice [...] I remember when I was about fourteen at high school I remember a friend turning around to me once and saying are you anorexic and I just laughed at her.*

(First telling, pp. 1-2)

In their reconstruction of past narratives, each of these women talked about how at different times in their lives they knew that there was “something wrong”. However, this knowing did not replace the control narrative. For example, Sarah lived with multiple meanings through “to-ing” and “fro-ing” between seeing there was something wrong to seeing herself as not thin enough and Naomi actively pushed away her initial acceptance of her friend’s letter “telling me what I had”. Thus, the women lived with and simultaneously negotiated multiple meanings; no one meaning accounted for the entirety of their lived experience.

Medical discourse offered the women a language for naming the “something” that was wrong; they could have ascribed their experience to the DSM-IV disorder of anorexia nervosa. Like Anne, the fact that they volunteered for an “anorexia nervosa” research study indicates that they did recognise their experience as being associated with this perspective, but their use of the terms “something” and “it” signify that the anorexia discourse did not encompass their lived experience. By not embracing an ‘anorexia’ classification, women were faced with two challenges. The first was how to position their experience in relation to the dominant ‘anorexia’ discourse. The second was how to understand their lived experience outside of this discourse. The dominance of the ‘anorexia’ discourse is such that there is no readily available alternative positioning from which women can understand themselves. “Something” and “it” are women’s attempts to articulate their narratives outside the dominant ‘anorexia’ discourse.

This chapter explores the ways in which the women positioned themselves in relation to the ‘anorexia’ discourse, while the next chapter explores how, within a discursive context not confined to ‘anorexia’ talk, they ascribed language outside of that discourse to their experience.

The negotiation of positions in relation to ‘anorexia nervosa’ discourse

As women in this research negotiated their positions in relation to the dominant ‘anorexia’ discourse they drew on a range of interpretative repertoires that when pieced together produced subject positions and dilemmas from which they authored their identity narratives.

Dualism and reification of constructions of disorder.

EXTRACT 3a

Kelly: *I was scared that I was one of them. I’d read the list of symptoms, avoids eating, takes laxatives, do you worry about your weight, do you weigh yourself more than two times a day etc. I was scared. I always knew there was something wrong with me. I mean it wasn’t normal thinking, but then I never wanted to admit that, I was scared. I’d always search for something in that list that would tell me that I was OK. (Interviewer: [...]) and what did that list mean to you?) The list was not normal. I wanted to believe that I was pretty much normal. (First telling, p. 34)*

EXTRACT 3b

Susan: *[...] when I had gone to hospital to begin with and the Doctor and the whole weigh thing and then informed me that I was anorexic because my weight was anorexic, yet I know of another girl (text removed for confidentiality), her weight didn’t fall into that even though the behaviours were there, even though the mindset was the same, so she didn’t have anorexia and she was told that wasn’t what she had. I don’t know how it was worded or whatever and that’s kind of dumb. Like, isn’t that just so totally dumb? (Third telling 10 years on, pp. 26-27)*

EXTRACT 3c

Sarah: *[...] you’re supposed to have all these classic symptoms, and if you don’t have the whole set then you don’t have that disease. Now, that’s wonderful for a person with the “A word” because then they can say to themselves “well I don’t have it because I lack the symptom”, and it’s yet another way of letting yourself off the hook and pretending that you don’t have the disease and actually people without realising it, inadvertently they can facilitate your thinking and your denial by perpetuating that*

idea that you have to have a classic set of symptoms, before you can be classified as having it.

(First telling, p. 22)

Kelly wanted to believe that she was “ok” and “pretty much normal” (extract 3a). Although she “knew there was something wrong”, the option of identifying this “something” as anorexia did not fit with who she understood herself to be, particularly the idea that she was disordered and not normal. As discussed in the discursive analysis of Anne’s narratives (Chapter 4), diagnosis of ‘anorexia nervosa’ is based on a dualistic repertoire. Two identity positions are marked out - disorder (not normal) or its antithesis, normality. This either/or construction creates the ideological dilemma – am I normal or am I disordered/mad? Given the women’s powerful images of themselves as successful and in control (extracts 1, p. 95), it is hardly surprising that a ‘not normal’ label did not present itself as a good fit with their lived experience.

Another repertoire drawn upon by Kelly is the ‘categorical system’ (Raskin & Lewandowski, 2000, p. 20) of medical diagnosis that reifies lists of symptoms to identify the presence or absence of disorder. Kelly found something on the list of symptoms to un-diagnose herself from the label ‘anorexic’ so that she was not “one of them” (extract 3a). Thus, Kelly used the rigidity of the categorical system that reifies lived experience as disorder to argue why she did not fit with the ‘not normal’ discourse of ‘anorexia’.

Susan and Sarah each questioned the reification of the category of ‘anorexia nervosa’ based on the presence of particular symptoms. Susan noted contradictions in the use of the symptom lists and asserted that this is “so totally dumb” (extract 3b). Sarah argued that signifying ‘anorexia’ through the presence of marked out symptoms “can facilitate ... denial” when a person lacks one of the symptoms (extract 3c). As discussed in the previous chapter, ‘denial’ is constructed as a feature of the DSM-IV version of ‘anorexia nervosa’ (American Psychiatric Association, 1995, p. 554). The construction of a person as having ‘considerable denial’ or being ‘in denial’ positions denial as a pathology (Hewson, et al., 2004). Apparent denial may reinforce dominant understandings of the person as ‘... disordered or incapable of reliably assessing their thoughts and actions’ (Saukko, 2000, p. 300). Thus, any other account the person might give of their lived

experience can be discounted and dismissed. Kelly, Susan and Sarah were not denying that there was “something” wrong. Rather, by not readily embracing the label of anorexia, they were “denying” that their lived experience fitted with the medical construction of anorexia in terms of its reified symptom list.

Agency, moral worth and disorder.

EXTRACT 4a

Katie: *I know intellectually that it is [an illness] but (**Interviewer:** Why is it?) Because it is an unusual behaviour, an unusual obsession, but for me it's not an illness, that's denial for you (laughed). [...] It's like smoking a cigarette, I could stop if I wanted like but I'm sure I'm addicted to it. To me it's a way of life now. I can't imagine being the word normal, I can't imagine being normal, not being worried about food. [...] it's like a heroin hit, like it felt so good and if times are bad you know that you could always go back to feeling that good by doing that. [...] I was fulfilling my dream of losing weight, I was achieving something for myself and it was just for me, I wasn't doing it for anybody else, it was just for me.* (First telling, pp. 16-17)

EXTRACT 4b

Sally: *Now it's something that happened [...] that I wish people would see a lot differently. (**Interviewer:** What do you mean?) That people wouldn't think of anorexics as these skinny, poor little, you know adolescent girls who are brilliant achievers from private schools like (**Interviewer:** Mm) that pisses me off because I was none of those (**Interviewer:** How do you want?) and that people wouldn't say anorexia is an eating disorder, because it's not, it's well it's an eating disorder in that your eating is disordered but it's, well I suppose it's a mental illness in a way, I don't know if you would class it as a mental illness, but it's more about your head than your body. A lot more about your head than your body.* (First telling, pp. 18-19)

EXTRACT 4c

Lisa: *I kind of really tried to I guess get away from it being a disorder. (**Interviewer:** Yes). It's just a (pause) some people have problems with gambling, some people have - I just happened to focus, when I struggle with things, on my eating. [...] I've really tried to fight having that label and get quite resistant to anyone that wants to kind of put that label on me because I just think it hasn't been helpful for me. There is a whole lot of things that have been going on and a label almost kind of means a sickness in some way and I kind of think I function quite highly in most areas of my life. It's just one aspect of my life that's a struggle as*

opposed to someone else who is struggling with something else and having that label I think then has so many connotations. [...] I think for a long time back in the 90s I was very much seen as anorexic who wasn't well and I've really worked hard to be seen now as someone whose, I guess, competent and not helpless and because of that I am really determined not to slide down because I don't want people to be worried about me, I don't want people to interpret that I am unwell. [...] I just don't, I don't see myself as this sick patient or anything anymore. I see myself as this functional person that has a crappy eating pattern (laughed). That's how I see myself. (Interviewer: What does it mean for you to see yourself in that way? [...]) It means that I'm okay I guess. It means that I'm okay. I'm no more dysfunctional than the next person, or the next person, or the next person.

(Third telling, 10 years on, pp 1-3)

Katie, Sally and Lisa in their unique ways argued for their preference to move away from an illness and disorder perspective for both themselves and others to understand their lived experience. For Katie (extract 4a) repudiating the illness perspective signifies being in denial. However, she still rejects an illness perspective and adopts, instead, an addiction perspective. This is also problematic for her because, like illness, addiction assumes the person to be out of control as well as invoking a dualistic repertoire that separates disorder/addiction from normality. She seeks to resolve this dilemma by switching back to a control narrative and reclaiming personal agency to account for her actions as “fulfilling my dream”, “achieving something for myself” and “just for me”. Within this switch back to claiming personal agency, she negotiates a positive identity position that is derived from the understanding of herself as an autonomous agent whose actions are understood as an effort to lead a fulfilled life.

Sally rejected and felt anger that others assumed her experience to fit with stereotypical accounts of “anorexics”; these accounts are experienced as an identity violation – “I was none of those” (extract 4b). After arguing against a disorder perspective, the most available position is a mental illness position that she also then rejects. Following on from this, she finds herself in a similar position to other women in this research where there is an absence of discursive agency for her to see herself in any other way outside the terms of the dominant discourse that is, as disordered or mentally ill. She eventually settles

with the rhetorical positioning that “it’s more about your head than your body”, which is her attempt to author her experience on her own terms.

Ten years on from her first telling, Lisa viewed herself as having “worked hard” to be seen in ways other than as “anorexic” (extract 4c). She recounted how in the nineties, the identity position most available to her was the label “anorexic” that signified “sickness” and “other connotations” built on a moral repertoire that had implications for her functionality and competence as a person. She argues that this “label” was unhelpful and totalised her as a particular sort of person who “wasn’t well”. In refusing to continue to live this identity, she claims the identity as a person who is “competent and not helpless”. Holding onto this alternative identity is an active process of negotiation and renegotiation and turning away from the version of herself as sick and “unwell”. The implications of this is that she generates a different account of her identity – “It means that I am okay” (extract 4c). This does not mean, however, that her continued struggle with “my eating” is left un-authored, rather it is re-authored as only one of a number of identity narratives - “it’s just one aspect of my life”.

EXTRACT 5a

Sarah: *I think it’s what other people can do with it as well. I mean I’ve had some shocking experiences with doctors because of it. There was a time when I was supposed to be admitted to a hospital with, I have a heart problem which is possibly caused through years of this, I was supposed to be admitted to a hospital under the care of a heart specialist. I was an extremely low weight at the time and [...] this admitting officer came in and [...] began talking about my weight and being quite derogatory. Then he made some really, really horrible comments - I mean I was a very low weight, I still was having a period, there were things in which I could be classified as strictly the “A word” and other things which fell outside of that - so, I think, he was coming from the point of view, I mean he even said to me at one point “well you’re not at the Karen Carpenter stage yet”. At that point I got up and walked out, I left the hospital. He was being derogatory, but also saying well we can’t entirely classify you as this because of this, this and this. He was just obviously somebody who didn’t know what he was talking about and he was just shocking, it was abusive. [...] There’s a lot of people that I’ve come across over the years that have talked to me about eating disorders and within their bodies they mightn’t look a particular way or whatever, but they’re still sick, they’re still very sick and they have dangerous ways of thinking.*

(First telling, pp. 13-14)

EXTRACT 5b

1 **Lisa:** [...] I didn't so much see myself as it, until my doctor actually told me I
2 had anorexia. [...] I suppose I took on a whole new identity and I saw
3 myself as an anorexic pretty much and that's who I was. It's probably
4 only been in the last year or so that I'm slowly starting to let go of that. I
5 still slip into it sometimes and want to almost tell everyone that I've been
6 to hospital. When I first came out of hospital I probably spent the first
7 year or so telling everyone I'd been in hospital, almost proud of it I guess.
8 It's probably only been the last year that I think well I had an eating
9 problem, I still do have an eating problem, but then I think women do and
10 it's just some people have been given a label and some people haven't. I
11 think that was the difference, I think that in itself did me more damage
12 than anything else. (**Interviewer:** What did it mean for you to be given a
13 label?) I was sick, that I had an excuse for everything to a certain degree,
14 that everyone would understand everything now because I'm anorexic. It
15 took away a lot of responsibility from me, I found, it's hard to say, it was
16 almost something that I was proud of. I look in hindsight now and I think
17 why the hell would I be proud to? (pause) I'm moving past that a bit now.
18 I got off on being an anorexic and I'd read every book to make sure I had
19 followed all the paths of what anorexics do and just follow those patterns
20 and seem to slide into it further and further; almost thinking that I was
21 really pretending to be an anorexic, I was pretending and I'm fooling
22 everyone; but I suppose I look back in hindsight and think I was fooling
23 myself more than anyone else, but at the time I thought I was this brilliant
24 actress I was fooling all the doctors and that I wasn't really anorexic. I
25 was just thin but I could stop it any time I wanted, this was just a game. It
26 was very much like a game to me.

(First telling, pp.1- 2)

The reification of 'anorexia' assumes the category itself to be reality and to exist outside the categorical system itself. Lisa and Sarah talked about how this assumption that reified their lived experience as illness and disorder had a number of real effects. A doctor's reification of 'anorexia' to an independent reality and subsequent exclusion of her from diagnosis was experienced by Sarah as "derogatory" and "abusive" (extract 5a). Therefore the power is not only in the label but also in the way the label is used and by whom. Sarah's legitimate right to be seen as suffering was delegitimised by falling "outside" DSM-IV criteria for 'anorexia' and, later in extract 5a, she argues that a person should not have to qualify to meet these symptom lists to be acknowledged as legitimately suffering.

Diagnosis was also not neutral in its effects for Lisa. First, she took on the "identity" of an "anorexic" (extract, 5b, lines 2-3) and in doing so, her experience was

legitimised as a genuine sickness (“I was sick”, line 13). Being conferred the moral status of a person who is “sick” meant that she had the legitimate right to not continue with her responsibilities, including as a mother. Implicit in taking on the identity of a “sick” person was that she was no longer capable of acting responsibly in her life.

On the other hand, her moral status as a person who was genuinely sick was eroded by the sense of herself as an active agent in shaping herself into being “anorexic” through researching and practising “the paths of what anorexics do” (line 19). Understanding herself as an independent, autonomous agent who had actively shaped herself into being “anorexic” created a sense of fraudulency and undermined her status as a genuine “anorexic” that was revised downwards to a pretend “anorexic” (line 21). Directly following on from this, she retrospectively re-revises her position through questioning her previous assumption that she was an independent agent who “could stop it at any time” (line 25) and in doing so she reallocates agency to the illness and reclaims the status of a real ‘anorexic’ who “was fooling myself more than anyone else” (lines 22-23). I have named the repertoire that Lisa is using in extract 5b as a personal agency repertoire where her discernment as to whether or not she is genuinely ‘anorexic’ is based on whether or not she was active in choosing to be ‘anorexic’. Within professional discourse, the dominant understanding of human agency is personal agency, which is measured by an individual’s capacity for self determination, independent insight, autonomous action and responsibility that Michael White (2007) argues as ‘founded upon access to privilege’ (p. 268).

In addition to being hinged on the presence or absence of personal agency, the notion of genuine or pretend illness has moral implications. Diagnosis legitimised Lisa both having a genuine illness and her suffering. Using a moral repertoire, an “anorexic identity” conferred status through being “almost something that I was ‘proud of’” (line 16). This elevated moral status was implicit in her actions of multiple disclosures (“to almost tell everyone that I’ve been to hospital”, lines 5-6) (Charmaz, 2006). Following on from this, her shift from being a genuine “anorexic” to pretending to be ‘anorexic’ eroded her moral worth through seeing herself as fraudulent and having misled others. However, at the time Lisa prioritised an identity of someone who was in control (“I could stop it at any time I wanted”, line 25) even if this risked eroding her moral worth through viewing herself as

pretending to be ‘anorexic’. Instead she preferred to story her behaviour as a game that she was winning by “fooling everyone” (lines 21-22). In retrospect, however, she rhetorically questions this moral status linked to an anorexic identity and being sick (why the hell would I be proud to? - line 17). In this narrative reconstruction, she gives up the understanding of herself at the time as an independent agent and, through reallocating agency to the illness takes up the perspective that she really was sick and was not fraudulently misleading others.

EXTRACT 6

Katie: [...] there's a difference between pretend anorexics and real anorexics. People that think they're being trendy by being, displaying things that look anorexic but they're not [...] With me it was real because I didn't know anything about it and I went through the process naturally whereas girls now, they think oh I want to be skinny, I'd better read all the books about anorexia and all the articles about anorexia and copy what they do. So I'm going to wear my watch really loose and I'm going to eat beetroot before every meal so I know that I'm going to throw it up and they read every calorie book. So they put the symptoms on themselves, they take on the symptoms rather than them actually being the symptoms. and because it is so advertised and stuff girls will adopt the symptoms consciously.

(First telling, p. 10)

Drawing on similar repertoires of personal agency and moral worth to discern her membership of the category of ‘real anorexia’, Katie argued that not being aware that the symptoms were ‘anorexia’ signified that she was genuinely “anorexic”. Being a ‘real anorexic’ meant that the symptoms were no longer symptoms but rather formed part of an essentialised self (“being the symptoms”). She argues that ‘real anorexics’ are ‘natural’ anorexics who are being the symptoms without being aware or conscious that they are being symptoms. On the other hand, ‘pretend anorexics’ are understood as independent agents who actively impose the symptoms on top of their ‘natural self’. As for Lisa (extract 5b), the experience of having personal agency in making oneself ‘anorexic’ is construed as grounds for disqualification from the category of genuine ‘anorexics’. In addition to this, the terms real/genuine and pretend are also drawn from a moral repertoire that works to elevate the status of ‘real anorexics’ as genuinely suffering and devalues the status of ‘pretend anorexics’ who are assumed to be fraudulent.

Twenty-five years ago, Hilde Bruch marked out the distinction between ‘genuine primary anorexia nervosa’ and “‘me-too’ anorexics’ using the similar discursive resources.

The patients who were seen during the 1950s and 1960s had in common that each one was an original inventor of this effort at self-assertion. [...] At no time did I have reason to doubt the genuineness of their symptoms and reactions. [...] During the past few years several patients deliberately “tried it out” after having watched a TV program or having assembled a science project. There is no doubt in my mind that this “me-too” picture is associated with changes in the clinical – in particular the psychological – picture. Instead of the fierce search for independence, these new “me-too” anorexics compete with or cling to each other. [...] The desire to be special, unique, or extraordinary is expressed with less vigour and urgency, and I cannot suppress the suspicion that in some the symptoms are imitative or fake. [...] As it becomes more commonplace, the picture will become blurred and gradually disappear until the conditions are right again for genuine primary anorexia nervosa.

(Bruch, 1985, p. 11)

Bruch’s (1985) “me-too” anorexics are constructed as ingenuous and fake, in much the same way as Lisa and Katie’s “pretend anorexics”, while “genuine anorexics” are original inventors of their disorders rather than imitating the real thing. Negative identity claims are assigned to copycat “me too” anorexics and moral status is assigned to those who desire to be “special” and “unique”. As discussed thus far, the argument that there is such a thing as ‘real anorexia nervosa’ assigns reality to a DSM-IV category, rather than the category being understood as a human construction and one of a number of ways of looking at this particular reality. Rather than this sense of fraudulency disqualifying the person from being a ‘real anorexic’ perhaps it is within this sense of fraudulency that Lisa talked about above (extract 5b) that a person finds themselves experiencing what DSM-IV constructs as ‘anorexia nervosa’.

The distinction between “real” and “pretend anorexics”, madness/illness and badness, natural and unnatural anorexics, genuine and “me-too” anorexics” along the lines of personal agency is part of a broader distinction that is implicit in illness discourse. Not only does a person need to meet particular checklists of DSM-IV symptoms to qualify for diagnosis of ‘anorexia’, their authenticity is predicated upon the absence of personal agency. In accessing ‘anorexia’ discourse to author their lived experience, women were required to reallocate personal agency to the illness. Women were therefore required to

switch from the understanding of themselves as independent agents whose actions signify they are in control to individuals without agency that is, as individuals with an out of control illness. Personal agency may therefore be understood as a ‘discursive reference point’ (Potter, et al., 1990, p. 211) such that genuine illness and an absence of personal agency are articulated together. This relatively stable relationship between illness and absence of personal agency arises in the context of the power of medical discourse at this point in history such that these associations ‘stick’ and take on a hegemonic status through the forming of ‘nodal points’, ‘discursive clumps’ or ‘ensembles’ (Wetherell, 1998, p. 393). If the person is understood or understands themselves as an agent in making themselves ill, they are assumed to be not genuinely sick, their suffering is delegitimised and their moral status is eroded.

Although signification exists in a state of constant slippage of meaning, Laclau and Moeffe (1987) have suggested that relatively stable relationships between signifier and the signified may develop in particular historical periods. This stability arises in the context of institutional power, which supports particular articulations or discursive reference points (Potter, et al., 1990).

Agency, moral worth and madness.

EXTRACT 7a

Jane: [...] for me to go into hospital, [...] I would have been shamed more than anything with people knowing. (**Interviewer:** Why? Why would you have felt shamed?) Just people seeing what was really wrong with me and like I wasn't really sick, it was something that I'd done to myself like why should a bed be had for her? She just doesn't eat. (**First telling, p. 29**)

EXTRACT 7b

Jane: I never thought I had full blown anorexia – they were psycho and hospitalised. I was just trying to keep my figure, rather than starving myself to death. I was under control. I was sitting on top of a fence, just managing to stay on top of the fence. Kept on top of fence by studying – something else to do.

(Reflections after second telling)

Jane believed that she was not “really sick” because “it was something that I’d done to myself” with “it” being minimised as “she just doesn’t eat” (extract 7a). Is what Jane did

a simple choice to just not eat and do this to herself? Within this commentary, Jane positions herself as an independent agent, capable of making autonomous, rational choices and act on these when and how she chooses. Her experience of agency is therefore assumed to be generated within a independent context, outside of any sort of social and interpersonal context and power relations of gender and culture (White, 2007). Through drawing on a personal agency repertoire, Jane's understanding that she has somehow inflicted this upon herself disqualified her from first, having access to the 'anorexia' discourse to author her experience ("I wasn't really sick") and second, from material access to treatment services – "why should a hospital bed be had for her?" Rather than marking out her experience as illness, she would prefer to retain a sense of control and see her actions of not eating as 'self inflicted' (Hepworth, 1999, p. 44), which has profound implications for both her identity formation as well as her legitimate access to medical treatment.

The question of Jane's legitimate access to treatment services is also built on a moral repertoire where sickness and suffering are esteemed with moral worth and value only when they are viewed as genuine (Charmaz, 2006) . Sickness and suffering are not only a physical and psychological experience but also a 'profoundly moral status' (Charmaz, 2006, p. 77) that have implications for the extent through which human experience is understood as worthy and of value. Physical illness has established moral status as legitimate suffering because the illness is a bodily experience that is mainly conceived of as an uncontrollable and undesirable affliction. Mental illness does not occupy this same moral domain, although gains some moral status through being located in illness discourse. This status is, however, eroded if a person desires this illness state and/or experiences themselves as an active agent in making themselves sick. Therefore repertoires of moral worth map onto repertoires of personal agency, where claiming agency in doing this to herself is for Jane, a source of shame (extract 7a). Nevertheless she would rather be secretly shamed with knowing "what was really wrong with me" than publicly shamed with confessing that "it was something I'd done this to myself" and is therefore undeserving of treatment.

Jane also equated "full blown anorexia" with "psycho" and "hospitalised" (extract 7b). "Psycho" is an identity position of madness that is built on a personal agency

repertoire where the person is understood to be without personal agency - ‘the mad person has no control’ (Ussher, 1991, p. 146). Jane rejects the label of anorexia because she rejects the version of herself as mad and out of control. She negotiates an identity, like Anne (chapter 4, p. 65), as a safe “anorexic” who is in control and not starving herself to death. She also minimises her experience as “(me) just trying to keep my figure” or “just me”. Nevertheless, Jane also does not deny there is something wrong; instead she uses the discursive resource of metaphor to capture the complexity of her experience - “just managing to stay on top of the fence” (extract 7b). Falling off the fence signified loss of control, madness and loss of moral worth. Being able to “study” (“something else to do”) marked her out as not mad and “psycho” but as “just managing to stay on top of the fence”.

EXTRACT 8

Katie: [...] *They (health professionals in inpatient eating disorder unit) didn't give me an alternative to it, they just kept saying what you do is wrong. You've been bad and now you're going to be punished. [...] It was like you're kind of watching the movies where people are saying you're crazy and you're not and you think that's what it's like. You know in your heart that you're not crazy, but these people keep telling you that you are. In a way I guess you have to start to believe them because you're in hospital and you've got no choice than to listen to what they're saying. Things like they can brainwash you, they can tell you whatever they want.*

(First telling, pp. 15-16)

Like Jane, Katie also believed that she was not only not sick but also not “mad”. Within the context of hospitalisation in the late eighties where she experienced a punitive strict operant conditioning program for ‘anorexia nervosa’ (such as described by Bhanji & Thompson, 1974), Katie understood others’ versions of her were that she was not only “crazy” but also “bad” and deserving of punishment. Although in this stretch of text, Katie conflates the identity positions of mad/bad, the question of a person’s actions arising out of madness or badness hinges on the question of personal agency. Badness, unlike madness, assumes the person to be in control and an autonomous agent whose actions are calculated, morally reprehensible and deserving of punishment.

Outside these pathologised versions, Katie argued that “they didn’t give me an alternative to it”. Without a language to author her experience outside discourses that she

rejected, how was Katie to understand her experiences other than to either deny or “listen to” what was being told to her about the sort of person she was? First, Katie sought to preserve a “not crazy” identity for herself in a context where no other terms of speaking were available to her and protesting against the medical establishment resulted in punishment. Therefore, arguing to herself and within herself that she was “not crazy” might be understood as a form of resistance where she negated these identity definitions that were ascribed to her actions and in doing so, claimed a different subjectivity (Flaskas & Humphreys, 1993). This subjectivity, however, continued to be defined in relation to this discourse of madness, which itself is left intact.

The power of the medical establishment, however, eroded this “not crazy identity” and “brainwash(ed)” her into wondering whether she might be “crazy”. Within this context, she experienced herself as having “no choice” to see herself in any other way than through these definitions. Within this context, the foundation of Katie’s diminished agency is social and interpersonal (White, 2007) in contrast to the dominant Western concept of personal agency where a person is assumed to act independently in their lives. Within the social context of hospital the only available discursive positions were derived from the identity positions of madness or badness; in other words, hospital talk shut down opportunity for Katie to see herself in any other way than as “mad” or “bad”.

Therefore within this discursive climate Katie was denied access to other language forms and denied a voice to determine her own identity (Sampson, 1993). As discussed at the end of the last chapter, for the purposes of this thesis, I have chosen the term ‘discursive agency’ to denote this form of human agency that is related to the availability (or lack) of positions for a person to author their identities outside the terms and conditions of the dominant discourse (White, 2007). This agency is distinct from the notion of personal agency discussed thus far that assumes human beings to be autonomous agents who are capable of independently exercising their free will and choice. Despite experiencing diminished discursive agency at this time to author her identity on terms outside the dominant ‘anorexia’ discourse, Katie nevertheless refused to take on the moral status of a person who was mad or bad.

Facing death.

EXTRACT 9a

Susan: [...] it gave me more of a thing to think about than the negative things that I was thinking about, about the abuse. It actually stopped me thinking about that, and I thought about food, and that's all I had time to think about and that was good. [...] it cut off another part of my life I suppose. [...] but I remember once laying in the bath, and being above my body for a moment, and I am sure it's because I was so dehydrated and I remember thinking in my head, I wonder if I'll die? [...] I do remember that thought and thinking am I going to die? (**Interviewer:** What emotions did that thought bring up for you?) Absolutely none. (**Interviewer:** None). Maybe a flicker of fear. Which was also bizarre, because I've always, I don't so much now, but then prior to that and after that I had always feared, absolutely feared death and hated it, didn't want to talk about it, nothing and yet I didn't feel that much fear, and it wasn't that I wanted it, but I used (unclear) and it didn't affect me that much.

(First telling, p. 32)

EXTRACT 9b

Katie: I didn't think I was ever going to die, they said I was, they said I was on death row if I didn't start putting on weight. I didn't think I was, [...] I didn't feel any different.

(First telling, p. 6)

Both these women came close to death, Susan from dehydration and Katie from low weight (25kg) and neither of these women wanted to die. In questioning the possibility they could die, Susan felt a “flicker of fear” (extract 9a) and Katie “didn't feel any different” (extract 9b). Although they looked away from the reality that they might die, they still did not see themselves as sick. Even when facing death, these women also did not reach a threshold where they took on an illness classification; they continued to reject this label that did not hold relevance to them. From this analysis thus far, taking on this label for Katie meant she was mad and a refusal of ‘anorexia’ was a refusal of this identity (extract 8). For Susan this ‘thing’ helped her dissociate from past experiences of abuse and “cut off another part of my life” (extract 9a) and these positive effects of not eating could not be authored through an illness classification. Refusal of illness was a refusal to acknowledge ‘anorexia’ as negative: it helped her cut herself off from abuse memories.

In research on recovery from ‘anorexia nervosa’, Catherine Garrett (1998) constructed a theme from participant’s recovery narratives where ‘people must choose between life and death’ and that this ‘choice is not necessarily conscious’ (p. 69). Instead of choosing death, these women chose to live, whether or not this was a conscious decision at the time. At the time of these interviews, I did not enquire further into the circumstances, meanings and steps women took in their choice to live. The absence of such questions signifies my assumptions at the time, in particular my assumption that not wanting to die was a given. This assumption obscured my further enquiry into how each of these women faced death and made the choice to live, even if this choice was not conscious at the time. How did women decide to turn their lives around after they reached death’s door? What reasons might women have given as to why they decided not to die? These lines of enquiry could give clues about hope and the conditions and circumstances that gave rise to women holding onto hope as they faced death.

Recognition/Surrender to ‘anorexia’ diagnosis.

EXTRACT 10a

Susan: *I think that label, that diagnosis, that word is really important. [...] I guess I wanted some recognition that there was something wrong. [...] but for me getting that title was good for me, if I hadn’t have got that maybe it would have sent me on an even more downwards spiral to get that title. This other girl she didn’t do that, but if that had been me, I would have because I would have felt like I had failed. I hadn’t got their attention or something. (Third telling, 10 years on, pp. 26-27)*

EXTRACT 10b

Kelly: *Well see I never really knew that I had an eating disorder. It wasn’t until I hit thirty that I went to the doctor and he said to me, that turning point, that he said, you know, “You have a psychological problem. You have an eating disorder”. It wasn’t until then that I started to think, I have got an eating disorder and then I started to accept it and think okay, I surrender, I have an eating disorder. (Second telling: p. 5)*

EXTRACT 10c

Kelly: *I think it was really important for me to see that like that. Gosh, it was pounded into me, pounded into me, it’s all part of the illness, it’s all part of the illness. It was really hard to distinguish what was and what wasn’t and to be able to look beyond it. (Second telling, p. 37)*

Susan took on the “label” of ‘anorexia’ at diagnosis because this gave her legitimate status (“recognition”) through a moral repertoire as a person whose experience was genuine suffering and worthy of medical attention (extract 10a). Naming diagnosis as “getting that title” signifies the power of ‘anorexia’ discourse to legitimise (and delegitimise) suffering. Susan knew there was “something wrong” and not being recognised as genuine by the medical profession would have been understood by her as failure. She imagines that without this “title” she might have been incited into further action and been “sent” on a “downwards spiral” to be recognised by others as genuinely sick and suffering.

Kelly refused to author her experiences as ‘anorexia’ until diagnosis at which time she gave up the identity of a person who was normal and not mad or sick, an identity that she had fought to sustain for more than a decade (extract 3a). Kelly’s use of the term “surrender” (extract 10b) invokes a battle metaphor where she gave up on her own version of herself as normal and yielded to the more influential perspective. The process of yielding to the medical discourse was troubled (“pounded into me”), yet “important” because it had implications of hope “beyond it” (extract 10c) in the form of recovery. Why else was it “really important” for Kelly take up the version of her experiences as “illness”?

EXTRACT 11a

1 **Kelly:** *The turning point came one night, I’ll never forget this night. [...] I was*
2 *in the bathroom at about 11.30 and my husband came home unexpectedly*
3 *and, and caught me. I’d literally passed out on the floor. I was sitting on*
4 *the toilet, the sink was full of crap because I’d been vomiting and it was*
5 *just stinking. [...] He found me like that and thought I was dead. He tried*
6 *to wake me and clean me up and called an ambulance [...] I sort of came*
7 *to and heard him on the phone and said “no, no, no, hang up, hang up*
8 *I’m fine, I’m fine, hang up, hang up, I know what’s wrong with me”. [...] I*
9 *sort of came to and heard him on the phone and said “no, no, no, hang up, hang up*
10 *I’m fine, I’m fine, hang up, hang up, I know what’s wrong with me”. [...] I*
11 *sort of came to and heard him on the phone and said “no, no, no, hang up, hang up*
12 *I’m fine, I’m fine, hang up, hang up, I know what’s wrong with me”. [...] I*
13 *sort of came to and heard him on the phone and said “no, no, no, hang up, hang up*
14 *I’m fine, I’m fine, hang up, hang up, I know what’s wrong with me”. [...] I*
15 *sort of came to and heard him on the phone and said “no, no, no, hang up, hang up*
16 *I’m fine, I’m fine, hang up, hang up, I know what’s wrong with me”. [...] I*
17 *sort of came to and heard him on the phone and said “no, no, no, hang up, hang up*
18 *I’m fine, I’m fine, hang up, hang up, I know what’s wrong with me”. [...] I*
19 *sort of came to and heard him on the phone and said “no, no, no, hang up, hang up*

20 *I'd always been called strong and that really shook me up and tore me*
21 *apart and then I was a real total mess. I went to the doctors the next day*
22 *and said "please help me, I'm desperate I can't go on like this anymore.*
23 *I'll go and see the psychiatrist, maybe she can help me or something". So*
24 *I started to realise that I had a problem and maybe I did need to see*
25 *somebody. I couldn't keep going on the way I was going. I started to*
26 *realise I was killing myself.*

(First telling, pp. 8-10)

In the context of being “caught” by her husband whilst she was “passed out on the floor” in her bathroom (extract 11a, line 3) and with the seriousness of what was happening to her, Kelly continued to minimise the real effects, so that when her husband rang the ambulance she responded with – “I’m fine, I’m fine, hang up, hang up, I know what’s wrong with me” (line 8). She did, however, become concerned enough to see her doctor the next day. When talking to her doctor Kelly pieced together a version of her experience with a repertoire of personal agency where she saw herself as unable to “stop it” (line 10). She was also without a language to author her lived experience, having refused an ‘anorexia’ perspective for many years - “I don’t know what’s wrong with me” (lines 10-11). Her doctor’s diagnosis - “I think you have an eating disorder” (line 12) is pieced together with an internalised repertoire that locates her experience as an illness within. This disorder perspective was unacceptable to Kelly who, although open to the idea that there is something wrong, was not willing at this point to take on an ‘anorexia’ classification. Her rejection of a medical perspective to position her experience was so strong that even the evidence that she had passed out on the bathroom floor because of this experience was not enough to take her over the threshold of an ‘anorexia’ classification.

Within the discursive space of her conversation with her doctor that confined the terms of speaking to an ‘anorexia’ perspective, Kelly defended her previous position that she did not have an “eating disorder” (lines 14-15) and became disengaged. Within this context there is little room for her to reach a threshold in which change is important. Imposing an ‘anorexia’ classification onto her experience produced resistance – “I was denying it” (line 15). Following on from this, Kelly’s husband also rejected a disorder perspective and constructed an altogether different version of what was “wrong” (line 17) with her. Built on a moral repertoire, her husband argued that she was not disordered but

personally deficient (“just weak”, line 18). This identity conclusion was experienced by Kelly as a dismantling of her identity – “tore me apart” (lines 21-22). Being positioned as “weak” did not fit with her previous understanding that her actions signified strength and personal autonomy.

Implicit in this personal deficit understanding is first, the implication that if she was “strong” (line 19) she would not be experiencing this and second, that she is an autonomous agent who is free to act independently in her life. At this point, Kelly re-positions her experience as ‘anorexia’, judging this perspective as preferable. ‘Anorexia’ also accounted for her sense of a loss of personal agency to change as well giving her a language to author the real effects of what was happening in her life – “I started to realise I was killing myself” (lines 25-26). As she recognised she was killing herself she was then in a more active position to take steps to reclaim her life from what then understood as ‘anorexia’. In the following extract of text, Kelly outlines another reason why an illness classification assisted her to understand her lived experiences.

EXTRACT 11b

Kelly: *[...] There are probably not enough words to describe the guilt I felt, especially after what I did when I lost the baby. I just, like I said, there's probably just, I don't know how I could even put it into words.*

Interviewer: *[...] Why do you feel that it probably wasn't fair to hold that amount of guilt?*

Kelly: *Because I realise now that, now I realise that eating disorder is an illness. It was nothing I went out and did on purpose, although it sounds contradictory doesn't it? You know, I never did it on purpose, but I was out there bingeing and stuff, but I realise it's an illness like any other illness, it's just, well I felt I was in control and I was really out of control.*

(Second telling, p. 34)

Kelly's first child was stillborn. She had stopped purging and starving in the first trimester of her pregnancy, but as she put on weight she returned to habits of induced vomiting, self starvation and over-exercise and she believed that these actions contributed to the still birth of her child. By surrendering to an illness perspective, with its discursive reference point of an absence of personal agency, Kelly was able to reconstruct the meaning (Neimeyer, 2011) of her loss. Although she had felt in control of her “bingeing

and stuff”, realising that such behaviour “is an illness” reassigns personal agency to the illness. This shift in personal agency was not, however, sufficient to erase the guilt, a guilt that she was unable to put “into words”.

Chapter Summary

‘Anorexia nervosa’ is a hegemonic and frequently reified subject position; these women both used and were troubled by this position. As they shifted from a control narrative to seeing there was “something wrong” the most available language to them was this contested discourse. Taking on an ‘anorexia’ classification was dilemmatic and raised questions for the women around who they understood themselves to be. These women’s research interviews provided a site within which they re-negotiated their identities in relation to this dominant ‘anorexia’ perspective and in doing so both struggled to speak terms outside this dominant discourse and also refashioned alternative identity positions with the discursive resources that were available to them at the time.

Women in this research used a range of discursive tools and resources as they took up their unique positions in relation to ‘anorexia’ discourse. To qualify for an ‘anorexia’ classification, these women measured themselves against the classificatory symptom checklist approach that reifies symptoms into the category of ‘real anorexia nervosa’. The construction of lived experience as disorder creates the possibility that disorders, rather than a heuristic or common sense knowledge, become reified as natural and real entities that exist independent of human appraisal (Hyman, 2010). Diagnosis of ‘anorexia’ also marks out dualistic identity positions of either disordered/sick or normal. To take on ‘anorexia’ as relevant to their lived experience, these women were faced with giving up the identity position of ‘normal’, a position that a number of them refused. For an ‘anorexia’ classification these women were also required to reallocate agency to the illness. Personal agency might therefore be conceptualised as a ‘discursive reference point’ (Gilroy, as cited in Potter, et al., 1990, p. 211) for an illness classification such that illness and absence of personal agency are articulated together. In contexts where a woman saw herself as having personal agency in making herself sick, she was excluded from having a real illness, assumed to be fraudulent (a ‘pretend anorexic’) and her moral worth eroded. Therefore for women to be eligible to take on an ‘anorexia’ perspective as relevant to their lived

experience they were required to take a discursive leap from their actions signifying they were in control to being stripped of personal agency by the illness.

Pamela Hardin (2003a) has argued that the distinction between the subject positions of ‘‘fake’ and ‘authentic’ anorexia’ draws upon a range of social and cultural discourses related to ‘choice’, mental illness and the allocation of mental health services (p. 213). Implicit in the terms ‘real’ and ‘pretend anorexics’ is the moral status of illness. Genuine suffering was only deemed legitimate if the woman understood herself through this discursive reference point of absence of personal agency. If a woman’s application of the label to her lived experience was understood as legitimate, she was in a position to make particular moral claims around being a “real anorexic”, deserving of material access to treatment and in genuine need of assistance from others. If a woman identified herself as being in control of the illness or choosing to be ‘anorexic’, her moral rights were eroded, her actions judged as wrong, bad or fraudulent and/or her worthiness to claim to status of being genuinely sick, ill and/or suffering was contested (Charmaz, 2006).

The women’s struggles to locate their experiences as illness bears a striking resemblance to the perspectives of women reported in qualitative research by Higbed and Fox (2010) in the UK. These researchers understood women’s perspectives as evidence that there was ‘no settled view’ of what anorexia nervosa meant for women who were in eating disorder treatment and that illness was an ‘uneasy concept’ (Higbed & Fox, 2010, p. 313), particularly when women viewed these behaviours as under their direct control. The women’s struggle to see themselves as having an illness was also understood by Higbed and Fox (2010) as ‘further evidence that the perceptions of the disorder were not stable and AN (anorexia nervosa) was considered to be a facet of the self’ (p. 318). They also found that the ‘positive’ aspects of the experience (or ‘pro-anorexic beliefs’) unsettled the uni-dimensional illness model and posed questions about the applicability of physical health models of illness in ‘anorexia nervosa’. The struggle of women to take up the position of illness as relevant to their lived experience is understood as arising from the disorder itself being “illogical” and perceived by the person as “confusing and unexplainable” (Higbed & Fox, 2010, p. 320). Although critiquing an illness perspective as illogical, confusing and inexplicable, yet functional for the experiencing person, this critique leaves intact both the

‘anorexia’ discourse itself as well as the existing power arrangements that afford the medical profession privileged access to speak on behalf of the experiencing person (Sampson, 1993).

The rejection of an ‘anorexia’ diagnosis is frequently construed by the medical establishment as denial. Denial minimises the active participation of the experiencing person in the authoring of their lived experiences. Sometimes women in this research looked, sometimes they glimpsed and sometimes they turned away from an illness classification as relevant to them (Hewson, et al., 2004). Nevertheless, they were active in authoring narratives that brought into focus the real effects of this thing that contributed at times to them seeing there was “something wrong”. The women’s narratives pose a challenge to “the uncritical understandings” (Sampson, 1993, p. 1223) developed by the uni-dimensional way that the medical model constructs lived experience as illness and disorder. In the absence of a language outside the dominant ‘anorexia’ discourse, women were without agency to determine their own identity and subjectivity (Sampson, 1993). Agency within this context is discursive and a different sort of agency to the dominant Western notion of personal agency that assumes people act independently in their lives. Discursive agency relates to the availability (or lack of availability) of alternative positions that provide a platform for the re-authoring of preferred identities that are generated within a social (rather than individual) context (White, 2007).

Between the antithetical positions of control and ‘anorexia’ is an invisible and largely “uncharted land” that is far from “certainties” and interrupts the “movement of totalisations” (Foucault, 1972, p. 39) of medical discourse; this may be thought of as an apparently un-discursive space. If a discursive space is a place where statements are permitted to be made, then an un-discursive space is a place where statements outside the dominant discourse are obscured and disqualified. Women’s use of the terms “it”, “thing” and “something” were signifiers of the beginning of a language to author this apparently un-discursive space that had been obscured by the hegemonic ‘anorexia’ discourse that has been reified as the ‘truth’ of their experiences (Foucault, 1980) and assumed to exist beyond the discursive. The absence of an alternative language outside ‘anorexia’ meant that in rejecting this discourse these women were left struggling to find a language to author this

knowing that there was “something wrong”. Women were therefore left not only without a voice but also diminished discursive agency to examine and re-position themselves in relation to this thing that they sensed as “wrong”.

Taking the perspective that no one discourse may account for the multiple meanings that women ascribed to their lived experience, the following chapter seeks to generate understandings of some of the discursive processes through which the women participated in a dialogic framework that moved them beyond being positioned as individuals diagnosed with ‘anorexia nervosa’ and towards their active participation in constructing their own identities in both the public and private domain (Hepworth, 1999).

Chapter 6: Speaking outside 'anorexia'

Naomi: [...] at the end it's not anorexia and I don't think talking about anorexia is the way out.

(Third telling, 10 years on)

From the analysis thus far, women who participated in this research struggled to meaningfully structure their experience into an 'anorexia' framework. Paralleling the troubling of the socially constructed category of 'anorexia' was another struggle, that is, to find a language outside this discourse to author their experiences. These struggles brought into focus some of the limitations on the women's agency to define their identities on terms outside an 'anorexia' discourse particularly when a 'control' narrative could no longer account for their growing sense that there was "something wrong". Judith Butler (1997) has argued that discourses not only constitute 'the domains of the speakable' but also produce what is outside of this that is, 'the unspeakable, the unsignifiable' (p. 94). This chapter is interested in how this "unarticulable" became articulated by women in this research within a discursive context that was drawn from the narrative therapy paradigm and "orthogonal" to the dominant 'anorexia' discourse (A. Lock, Epston, & Maisel, 2004, p. 278).

Returning briefly to the detailed case study analysis (chapter 4) - for many years Anne's identity had been invested (Wetherell, 2007) in seeing her experiences as a signifier of control. This investment was discursive as well as material being a requirement for her to qualify in her chosen career as a dancer. With the troubling of 'anorexia' and within the context of the research interviews that were not confined to 'anorexia' talk, she re-authored her experiences between the version that this is "just me" and "an anorexic". Between these antithetical positions, she generated different ways of speaking about her experience, particularly through use of metaphor that externalised and objectified the real effects of an experience that she named "a burden to drag around with me" (Chapter 4, extract 6, p. 76). Therefore in examining the real effects of her experience in a discursive context where she

was permitted to speak on terms outside the internalised ‘anorexia’ discourse, Anne linguistically separated her identity (Tomm, 1989) using an externalised repertoire and experienced discursive agency to speak on her own terms through metaphor. This discursive agency provided Anne with opportunity to revise her relationship with this “burden” as she tapped into the imaginative dimension of her selfhood where reclaiming her life from this “burden” “would probably feel like a great freedom”.

How did other women who participated in this research navigate their way within this largely uncharted discursive space that exists between a control narrative and ‘anorexia’ discourse? This chapter analyses stretches of text where the other eight women who participated in this research over 10 years re-authored their experience within this apparently un-signifiable discursive space and some of the implications of this for their identity formation. For the remainder of this thesis, this space will be referred to an apparently un-discursive space.

Glimpsing at a dilemma

EXTRACT 1

Naomi: *[...] I suppose it came at different times- you got different glimpses of how much it controlled you. [...] I mean me looking back I can say obviously one of them was when I wanted to commit suicide, you realised how much it controlled you and you wanted out, when you lost friends – that was another thing you noticed that it was controlling you, [...] standing on a different plain to where you thought you were because you thought you were in control of your body and suddenly it's that recognition that it's a mental health – [...] I think once you realise it's in control of you, you are acknowledging the nervosa.*

(First telling, pp. 7-8)

Naomi glimpsed at how much “it controlled” her, which created a dilemma because she was faced with giving up the notion that she was in control. As discussed in the previous chapter, her use of the term “it” is a signifier of the beginning of authoring her lived experience in this apparently un-discursive space. The use of the word “glimpses” captures her choice not to focus on this loss of control (“it was controlling you”) for too long. In the context of conceptualising grief and loss, Elizabeth Kubler-Ross (1969) has used a metaphor of the sun to depict the experience of loss: ‘we cannot look at the sun all

the time' (p. 35). Borrowing this metaphor, Naomi's glimpsing might be understood as looking away from the sun because staring into the sun was facing the perspective that she was not in control when she thought she was. Glimpsing her life from this "different plain" was a difficult place to stand ("when it gets hard") because she was faced with reconsidering her relationship with this thing that signified to her that she was in control. In accounting for a sense that she was losing control, the most available subject position is a 'mental health' position. She is nevertheless unwilling to use the term 'anorexia', which she equates with an overemphasis by the medical profession on the physical illness symptoms and instead she emphasises the mental/psychological dimension of her lived experience or "the nervosa".

EXTRACT 2a

Sally: *She (mother) ended up making me go to see this psychiatrist who felt that my problems were all due to the fact that my father had left when I was ten years old and I fitted into his textbook beautifully [...] at that stage I remember feeling really, really awful. I really just, like I said I used to want to go to sleep and never wake up and my mum came down and I can just remember walking around in the cold and just being so skinny and upset and mum being upset, it was just like this big black cloud. It was awful, but nothing that I could, I can remember saying to mum it's like half of me knows that what I am doing is wrong but the other half wants to do it properly so I can't let it go. So I could get into the bath at night and I could actually sit the soap in the in the gaps here where the bones stuck out and I used to sit there and think oh wow this is great and then the next minute I would get out of the bath and look at myself in the mirror and think oh my god you look disgusting and then the next minute walk into my bedroom and think, what's the smallest thing I can get into?*
(*First telling, p. 3*)

EXTRACT 2b

Sally: *[...] I'd gone to this psychiatrist for help and all it was you fit into my textbook in this chapter [...] I remember feeling really hurt because he didn't want to know about me.*

(*First telling, p. 15*)

Like Naomi, central to Sally's narrative reconstruction is the multiple and often contradictory perspectives of her experience that she simultaneously held. These perspectives included the knowing that "what I am doing is wrong" (extract 2a), although she actively looked away from this because looking at her experience in this way for too

long meant she was faced with having to “let it go”, which she was unwilling to do at the time. Sally also saw that even though “I fitted into his textbook beautifully” (extract 2a) there was a “me” that was separate to any textbook behaviour that she displayed (extract 2b). Her hurt was that her psychiatrist focused on the textbook behaviour and not “me”. Although there was no unitary way of looking at her experience at the time, Sally, like Anne, re-authored her experience using an externalised repertoire and the discursive resource of metaphor – “it was just like this big black cloud”. Metaphor provided scope for Sally to author an identity narrative that encapsulated both this “big black cloud” and “me”.

EXTRACT 2c

Sally: *To begin with it was almost fun, it was quite fulfilling, but then I can remember it getting to a point where I actually hated it. I hated having to think I wanted to stop thinking about all these things but I just, I couldn't and (pause) I can actually remember going to bed some nights just thinking I just don't want to wake up in the morning I just, if I could just go to sleep until it was all over and wake up and everything would be fine I'd be really happy. It was like I couldn't get away from myself I wanted to get away from me and I couldn't.* (First telling, p. 2)

EXTRACT 2d

Sally: *[...] it started to lose its appeal because of the physical price that I was paying. I was physically getting tired, there were physical signs that I wasn't enjoying, that I couldn't negate by thinking about the benefits of being where I was. There was the, the continued disconnectedness, I couldn't cope, I couldn't see myself living the rest of my life on my own in order just to keep this eating disorder going. I couldn't do that, it was ruining stuff with my family. It just wasn't who I was, I wasn't a loner, but it was meaning that I had to be.*

Interviewer: *“It wasn't who I was”, that's interesting isn't it? Taking a position and seeing that it wasn't who you were.*

Sally: *I don't know if that's exactly how I thought of it at the time.*

Interviewer: *No, but that's how you've come to see it. (Sally: Mm, yeah, overall.) When you think now retrospectively what is it about who you were that, that it wasn't fitting with?*

Sally: *Well it wasn't fitting with the social person, it wasn't fitting with the person who actually liked to be a part of something and (pause) I guess the shame about it is that with anorexia you don't realise that you're there and why you're there until it's too late. [...] you're too obsessed by it, you can't put that thing down or you can't not pick that thing up or you*

can't (pause) because if you do then this whole world you've created is going to come crashing down.

(Third telling 10 years on, pp. 25-26)

Like Naomi, Sally also glimpsed a dilemma as she shifted from a control narrative. In her first telling she re-authored this as glimpsing another way of being or another “me” - “It was like **I** couldn't get away from **myself**, **I** wanted to get away from **me** and **I** couldn't” (extract 2c, my emphasis in bold). Here Sally's “I” signifies that her story about “me” is not the ‘whole story’ about who she is (Shapiro & Carlson, 2009, p. 35). Although she is positioned through her use of internalised repertoires – this is “me”, she nevertheless experienced discursive agency to take up an “I” position where she understands herself as wanting to “get away from me”.

Ten years on, she re-authored this same shift in her narrative where she started to examine the real effects (extract 2d) using an externalised repertoire where, rather than getting away from “me”, she understood that “it just wasn't who I was” that was implied in her previous argument that her psychiatrist did not see “me” outside the textbook definitions (extract 2b). This new way of looking at herself in the context of her life (“I don't know if that's exactly how I thought of it at the time”) is built not only on an externalised repertoire but also in terms of who she understood herself to be. Through seeing herself from this perspective, continuing to live her life in this way meant living an identity that did not fit with the sort of person she understood herself to be- “it wasn't fitting with the person who actually liked to be a part of something”. Sally then faced a dilemma because if she were to live in a way that resonated with the other “me” that would mean that “this whole world you've created is going to come crashing down”.

In glimpsing their experiences outside an internalised ‘control’ narrative, Naomi and Sally glimpsed at a dilemma, where they briefly faced the antithetical alternative understanding that they were not in control. Preferring not to author this glimpse as ‘anorexia’, Naomi took up ‘the nervosa’ to dualistically separate and prioritise psychological (“the nervosa”) over the physical experiences (“anorexia”) that had been prioritised by her treating doctors at the time. Sally on the other hand re-authored herself as living an identity that did not fit with the sort of person she understood herself to be.

Metaphor

Women in this research used an array of metaphors to depict their lived experience. For example, Jane drew on metaphor in the opening sentences of her first telling.

EXTRACT 3

Interviewer: *I was wondering if you think of anorexia as a name or whether you have another name for your experience?*

Jane: *Hell! I consider it more of a merry go round than anything. There was one stage where it was like – since I read the article and since I knew you'd be coming – I've really been looking back through my diaries at the time that I was actually suffering. The diaries are to me they're openly like just widened my eyes to like the hell I was going through. There's one particular bit where it's got eat diet eat diet eat diet eat diet – like it's a never ending circle and I was just so unhappy.*

(First telling, p. 1)

When asked if she had another name for her experience, Jane responded with “Hell!”, which graphically captured her memories of some of the real effects of this thing on her life. This metaphor also totalises her lived experience on negative terms. Narrative therapists Rick Maisel, David Epston & Ali Borden (2004) also select out metaphors in their therapeutic interventions that totalise the experience as negative for example, “you vampire” (p. 161), “a killer on the loose” (p. 110), “a concentration camp” (p. 110) and ‘a murderer’ (p. 114). Like an illness metaphor, these metaphors are pieced together with a moral repertoire to graphically totalise the person’s experience as bad and wrong. With the selecting out of these metaphors, the task of therapy becomes a battle or “war” (Maisel, et al., 2004, p. 110) to defeat ‘anorexia’. Within this discursive context, ‘anorexia’ becomes a profoundly moral question and therapists are faced with consideration as to the expression of their own ‘moral outrage’ and ‘moral opposition to a/b’ (Maisel, et al., 2004, p. 159) to the person and their families. The metaphors that the women in this research used, however, were not confined to such battle metaphors and analysis will now focus on these.

Metaphor of dis/appearance.

EXTRACT 4a

Susan: *I was thin and afraid and I hadn't eaten, I wanted to kind of disappear [...] I think that I couldn't stand to be touched by other people I didn't*

know, like physically close to me and so I wanted that space as well. [...] you kind of try and be as small as possible, like I mean like you walk with your head down (pause) I don't know, it was just the whole way you felt; but I think it was like more than a physical thing, it was an emotional thing. Like you felt small because you were ashamed of what you were doing or what you were or whatever, but it became physical as well. (**Interviewer:** Mm, and was the shame related to the touching? Or was that different.) Oh it was related to a lot of things. I think because I felt so small and fragile and disgusting. (pause) I don't really think it was like linked to sexual abuse or anything like that, because friends who had anorexia hadn't been abused and we had the same feelings.

(**Second telling, p. 16**)

EXTRACT 4b

Susan: I was reading the notes and stuff again the other day and I had talked a lot about wanting to disappear and all that kind of stuff and that, when I used to think that by doing that, that I wouldn't be noticed, whereas it would have the opposite effect. (**Third telling 10 years on, p. 3**)

EXTRACT 4c

Sarah: It's a very important thing not to take up too much space. I think that's what it is more than anything else, it's a state of not being, if you can shrink enough you don't exist, you don't take up space. [...] (**Interviewer:** What did taking up space mean for you?) Existing, being looked at, being noticed. People could see you or watch you or look at, it meant being invisible and of course you're not invisible, nobody's invisible, but I think you believe that you can be. That you can pass unnoticed where people just won't look at you, won't know that you exist.

(**First telling, pp.7- 8**)

EXTRACT 4d

Sarah: [...] you don't want to stay trapped like this; you don't want to be like this forever. The 'A part' was about not being visible, but, of course, it makes you more visible not less, but you believe it's (pause) you're hiding, you're not taking up space, all those things, but once you are more well and you have the mental capacity to say well, you want to be able to live and be productive and, and do things that you want to do well.

(**Third telling 10 years on, p. 3**)

Susan sought to make sense of her experience of not eating and thinness through a metaphor of disappearing from her life where being small was about taking up less "space" and in doing so, increasing the "space" between self and other. Having an appearance in her life meant she was faced with an identity where she felt "ashamed [...] of what you were"

and “fragile and disgusting” (extract 4a). Metaphor is a way that Susan re-engages with this painful topic (Erjavec & Volcic, 2010) where she seeks to make sense of her actions as both a response to and performance of a shameful presentation of self. She then makes and questions the possible link between this presentation of self and experiences of childhood sexual abuse and argues which a sexual abuse history does not necessitate such associations. Ten years on, she argued that seeking to disappear from her life had the paradoxical and unintended consequences of making herself more visible to others (extract 4b). Hence the real effects of her actions did not fit with her intentions to be less visible at the time.

Sarah also experienced a history of childhood abuse and, using this metaphor of “space”, she re-authored her experience of “the A word” as shrinking into non-existence (“a state of not being”), and also “being invisible” (extract 4c). She retrospectively qualified “being invisible” as impossible (“nobody’s invisible”), although it is in this impossibility that the discursive resource of metaphor powerfully works to mediate more complex meanings and social realities (Geertz, 1973) of Sarah’s lived experience. Not taking up space to the point of invisibility is not a state of being but rather a metaphor to depict the extent to which she sought to “pass unnoticed” (extract 4c) and hide from others (extract 4d). Research on ‘anorexia nervosa’ from a feminist post-structuralist perspective has also analysed the use of this metaphor of disappearance (Malson, 1999, 2009). Helen Malson (2009) has argued that women’s avoidance of visibility through the ‘literal erasure and destruction of the body’ might be conceptualised as ‘an insistence of corporeality’ and the ‘impossibility of living in a body whose corporeality has been denied’ (p. 141).

Marking her experience through a metaphor of ‘disappearance also enabled Sarah to re-author alternative possibilities through the opposite of this expression - “not stay trapped like this” (extract 4d). A metaphor of invisibility provides her with the discursive materials to reconstruct a narrative centred on making a re-appearance in her life (“to be able to live and be productive”) and, in doing so, brings into focus the other part of her that wanted to be known rather than invisible. Therefore Sarah’s use of a metaphor of disappearance did not merely describe her experience but opened up new possibilities for redefinition of the sort of presence she desired to have in her life. Metaphor therefore provided her with an

opening to re-author an identity in terms of the sort of person she hoped to be through the intentional states of her values, desires and intentions for her life (Bruner, 1990).

Relational metaphors.

EXTRACT 5a

Naomi: *I guess it's just that sort of accepting its presence and coming to terms with it. It's like accept, it's almost kind of Buddhist like in the sense, you accept that the tiger is in your vision but the more that you hold onto its tail, the more you're going to aggravate that tiger, but if you let go of it, it will just go and sit under a tree, but it will still be there, but it's not really aggressive. It's still there, it's not going to be aggressive at you and you've learnt to live with it in a different relationship. I think that's probably where I'm at, or constantly trying to find that, to let it go, to let go of the tail, let it just sit there. I think that's probably where I'm at. Do I want to have less fat on my thighs? Yep. Would I rather be 10 kilos lighter? Yes, but I also know that now I want to be 10 kilos lighter than what I am now for the right reasons. I don't want to be 20 kilos lighter.*

(Third telling 10 years on, pp. 4-5)

[...] if you can describe the tiger and talk about the tiger and (pause) let it sit under the tree still without grabbing its tail, the tiger will want to turn around and bite you. It's about having a new, respectful relationship and it's hard, really hard to get. [...] It's personal development, at the end it's not anorexia and I don't think talking about anorexia is the way out.

(Third telling 10 years on, p. 7)

EXTRACT 5b

Interviewer: *When you look back now, what do you think the impact of diagnosis was for you?*

Naomi: *Oh, it's probably legitimated the experience.*

Interviewer: *Okay ... so now you would look back as diagnosis helpful for you. (Naomi: Yeah). Can you tell me what part of the experience that was helpful?*

Naomi: *It gave me a medical diagnosis; it gave me a medical story, not just another story.*

Interviewer: *Not all about you and who you are? Did it bring the tiger into vision? Was it the tiger or ...?*

Naomi: *I don't see the tiger not as a friend. See you're seeing the tiger not as a friend. I'm not saying it's not a friend. When you let go of it and stop*

holding its tail, it is a friend because it's just in your vision, it's sitting there.

Interviewer: *So did you see the tiger then ... (Naomi: Yeah. As aggressive). The tiger (Naomi: Yeah) as aggressive. So the diagnosis or the label did that impact your relationship with the tiger?*

Naomi: *(pause) I don't know because that metaphor's new.*

(Third telling 10 years on, p. 15)

Arguing that “in the end it's not anorexia” and that talking about ‘anorexia’ is “not the way out” (extract 5a) Naomi generated an alternative way to depict some of the complexities of her social reality. The version of her experiences built upon a metaphor of a “tiger” places her as an active participant in her life through choosing how she relates to and seeking out “a new, respectful relationship” with the tiger (extract 5a). This relational metaphor has a number of effects. First, her actions are not guided by an intention to banish the “tiger” but rather to accept and respect it and learn to shift her relationship with it. This approach resonates with therapeutic orientations (such as Acceptance and Commitment Therapy (ACT) (Harris, 2009) and Mindfulness Based Cognitive Therapy (MBCT) (Segal, Williams, & Teasdale, 2002)) that draw on Eastern philosophies and use of mindfulness practices to assist persons to shift, rather than eliminate, their relationship with suffering and struggles. As she revises her relationship with the tiger, there is scope for alternative identities to be reclaimed and performed that is implicit in her positioning the experience as “personal development” (extract 5a). She then argued that ‘anorexia’ talk limits the opportunities to author experiences in terms of “personal development” and that confining the terms of speaking to ‘anorexia’ talk is “not [...] the way out”. In other words, confining talk to ‘anorexia’ limits discursive agency to speak using terms and meanings outside this discourse.

Within this discursive context, Naomi re-authored her journey on new terms – “that metaphor's new” (extract 5b) that is, a new way of looking at an old story (Hewson, 1991). Naomi's reconstruction of her experience imbues her with discursive agency to not only select out her terms of speaking but to use terms that position her as an active agent in revising her relationship with the tiger and negotiating her identity in the context of this relationship. Naomi's objection to my question that suggested diagnosis of disorder brought

“the tiger into vision” (extract 5b) is her rejection of the totalisation of her lived experience as a negative force in her life – “I don’t see the tiger as not a friend”. Instead she situates the “tiger” within the context of her life where it is her relationship with it (for example if she “holds onto” the tail of the tiger, extract 5a) may become problematic rather than the tiger itself being problematic. Metaphor therefore provides scope for Naomi to author complex meanings, subjectivities and social realities in a way that a uni-dimensional ‘anorexia’ perspective was unable to achieve. The question then shifts away from getting rid of something that is constructed through a moral repertoire as bad and wrong to how to negotiate her relationship with the tiger in ways that are sustaining rather than damaging.

EXTRACT 6a

Katie: [...] we were robbed and my life went into turmoil, I felt violated and out of control. The old pangs hit me and I was tempted once again to flirt with “the old friend”. What stopped me????- My breastfeeding. I felt so tempted, but I needed to stay well to feed my baby. A big step I think.

(Email reflections after Third telling 10 years on)

EXTRACT 6b

Interviewer: So where are you now in terms of your relationship with eating disorders?

Sarah: It’s good that you use the word “relationship” because (pause) I think at some stage it was described as a friend, as a friend it’s part of the secret world [...] okay so now in relationship to, it is certainly not a friend, it’s a deadly enemy.

(Third telling 10 years on, p. 5)

There has become increased recognition of what has been termed ‘the positive sides of anorexia’ (Nordbø et al., 2012, p. 64) for the experiencing person and the challenges that this may present for therapists seeking to create a therapeutic alliance whilst also assisting a person to seek out change. ‘Anorexia nervosa’ has been construed as ‘egosyntonic’ and successful treatment outcomes have been understood as ‘akin to a process of conversion, from seeing dieting as the solution to viewing it as the problem’ (Guarda, 2007, p. 114).

Katie and Sarah (like Anne in chapter 4, extract 4b, p. 71) did not convert to a perspective that totalised their experiences as problematic. Katie argued that this “friend” had been a source of assistance at times in her life when she has felt “violated and out of

control” (extract 6a). Speaking about her experience as an “old friend” meant that she did not need to defend her identity against the assumption that what she was doing was wrong, but rather she could make decisions based on possible real effects of the choices available to her. Sarah commented that my use of the term “relationship” (extract 6b) opened discursive agency for her to not only move away from negative totalisations to author her experience, but also to author the real effects of what she had termed ‘eating disorders’ through the antithesis of a “friend” that is a “deadly enemy”. What is interesting here is that Sarah’s act of looking at the real effects of this on her life (as potentially “deadly”) was generated within the context of her metaphor of a “friend”, rather than from having to convert to an ‘anorexia’ position that totalised her experience as problematic.

EXTRACT 7

Interviewer: [...] can we go over sort of the, perhaps, the meaning of control with anorexia ... when anorexia was highly dominating of your life versus the meaning of control now?

Katie: Mmm, hm. I think (pause) when I was really anorexic, (pause) how, let me think of an analogy for you (laughed). [...] I’m good with the analogies (both laughed). (**Interviewer:** Yeah). (pause) Instead of spreading control over everything, spreading ... I can control (pause) Um, hang on (laughed) this is confusing, I don’t want to confuse you. Um (pause) it starts off as a little concern with losing weight and then it (pause) does take over your whole life because (pause) oh God, how do I put it into words?(pause) It’s like a volcano that it started off really little and suddenly it’s huge and it’s a real, self-perpetuating thing that, I guess that cycle of self destruction, that once you do a little bit you want to do a little bit more, and a little bit more, and a little more and it’s the thing, like it’s getting bigger and bigger and everything is melting into the background. All you can see is this one thing that you can control. [...]

Interviewer: Yep, OK, and control now? When you were talking about control and power back or control back with you?

Katie: Because I have a different perspective on things. I think I’ve stepped back from the volcano and can see that it’s just a volcano and then there is a whole world past the volcano and there’s other mountains that I can have a look at as well (**Interviewer:** Mm) and that yes it was useful as a tool for me then and I learnt from it, but it’s still only one part of the picture and there’s whole lot of things in the world, in my life that (pause) not that we’d need to take control of, that are of interest to me and that I can put my energy into instead of just that one (pause) because anorexia I think is very selfish, it’s very self-obsessed and self-focused, but you don’t

see that when you're there because you're thinking you're doing that to be more sociable, to have more friends, to be more loved. You think you're using it as a tool, but it just takes over, it just takes over everything.

(Second telling, pp. 9-10)

In this stretch of text Katie's shift away from the dominant 'anorexia' discourse initially resulted in a struggle to find an alternative language (analogy) to depict her experiences. She then generated a metaphor of a "volcano", which provided an understanding as to how she inadvertently acclimatised to this volcano that started off as "really little", became "huge" and then obscured other versions of herself in the context of her life. Through use of metaphor, Katie moves away from the 'experience-distant concept' of the diagnostic label "anorexic" to an 'experience-near' concept (Geertz, 1975, p. 47) built on metaphor. Clifford Geertz (1975) has argued that 'experience-distant' concepts are fashioned by theorists who are seeking to depict often complex aspects of social life. Although not in 'polar opposition' (Geertz, 1975, p. 48) to 'experience-distant' concepts and existing in degrees of nearness, 'experience-near' concepts are used by people to uniquely 'represent themselves to themselves and to one another' (Geertz, 1975, p. 48). This is what Katie is doing in this stretch of text as she moved from the experience-distant label of 'anorexic' to the experience-near metaphor of a 'volcano'. Experience-near terms tend to rely on the understanding that no two experiences are identical and that experiences differ between people and over time and context. This has implications not only for a rich examination of a person's life as lived but also to bring forth their 'unique skills and knowledges' in taking actions to respond to their struggles and predicaments (White, 2007, p. 43).

In depicting her lived experience through the metaphor of a volcano, Katie faced the real effects of this volcano on her life, which she termed a "cycle of self destruction" (extract 7). Different associations are generated as Katie draws on this metaphor compared with the question of whether or not she qualified as a "real anorexic" (chapter 5, extract 6, p. 105). In addition to this, metaphor provided her with discursive tools to author her shift where although this volcano was not gone, she was living with it in a different relationship – "I've stepped back from the volcano"; "I have a different perspective on things" (extract

7). This different perspective handled the contingencies of a complex social reality where the experience, although “a useful tool” and something she “learnt from” also “takes over” and is “very self-focused”; this relational metaphor was a discursive tool that provided a thick description of her life as lived (Geertz, 1973). When a person has access to thick description of themselves in the context of their life, they have discursive agency to select out which positions they judge as preferable. For Katie this meant she was in a position to select from a complex array of meanings that which most closely resonated with her lived experience. Use of this experience-near concept also provided scope for her to reconstruct a multiply authored identity and future imagined possibilities – “there’s other mountains that I can have a look at as well”.

In scaffolding (White, 2007) between what was known (the volcano) and what was possible to be known (the “whole world” past this volcano) Katie re-authored a narrative built upon a vocabulary of values where she reconstructed a version of her experience as ‘selfish’ and ‘self-focused’. Narrative reconstruction in terms of values was an avenue for not only the broadening of some women’s terms of speaking outside the discursive field of ‘anorexia’ but also a way that women ascribed meaning to their actions and then evaluated whether or not these meanings fitted with the sort of person they were, are and hoped to be.

Values and identity

EXTRACT 8

- 1 **Katie:** *[...] some events in the world just happen and you can’t change them and*
- 2 *control them and you may as well just live your life every day, day to day*
- 3 *and make the most of everything.*
- 4 **Interviewer** *[...] what did this mean for you as a person and how it changed*
- 5 *how you see yourself in the world?*
- 6 **Katie:** *It made me look after somebody else more than myself which was a really*
- 7 *big turning point I think because I think, well most of my life I’ve been*
- 8 *fairly selfish. (Interviewer: [...] this turning point turned your life in what*
- 9 *direction?) It turned me into a nicer person I think, a more understanding*
- 10 *person and a more generous person. Also a much stronger person in that*
- 11 *I know that I can do anything, I can achieve anything and not for myself,*
- 12 *but for other people.*
- 13 **Interviewer:** *Did that have an impact on your relationship with anorexia?*

14 **Katie:** *Anorexia, I think for one of the first times ever really faded into the*
 15 *background when I suddenly saw it as being a self-indulgent pursuit*
 16 *(laughed) which is interesting because I then I listen to myself what I've*
 17 *just been saying at the beginning of the interview about perfection and*
 18 *still wanting to have the best body and the best of everything, but I think*
 19 *now I have a much broader perspective on the world. [...] Does it really*
 20 *matter if I've got two centimetres of cellulite when someone's dying? [...]*
 21 *it was a self-focused pursuit as opposed to helping other people and I've*
 22 *become quite into animal welfare and if I see something I - the fairness of*
 23 *the world has become quite important to me. We went to India and seeing*
 24 *elephants being treated badly really struck a chord with me and it*
 25 *suddenly puts everything back into perspective that starving yourself isn't*
 26 *the way to fix the world for anything other than maybe your own*
 27 *selfishness.*

(Third telling 10 years on, pp.5-7)

In the context of the traumatic and tragic death of a close family member, Katie experienced a “big turning point” (line 7) in the way she saw herself in the context of her life. In re-authoring this experience, she found herself speaking at odds to how she had been talking about her experiences earlier in the interview where seeking “perfection and still wanting to have the best body” (lines 17-18) mattered. Situating her actions within this life and death context, her actions are instead understood as the actions of a person who had “been fairly selfish” (lines 7-8). Absent but implicit in her discernment of her actions as “fairly selfish” is the presence of her own previously unstated values that she later articulated in this stretch of text as “fairness” (line 22). This shift in meaning draws on a moral repertoire where the actions of “starving yourself” (line 25) in an effort to acquire “the best body” are viewed as of lesser moral worth compared with actions that are intended to assist in “helping other people” (line 21) and “the fairness of the world” (lines 22-23).

Situating her actions in this way, Katie experienced (like Anne, chapter 4, p. 86) a values clash where she understood herself as performing the identity of a person that did not fit with the sort of person she understood herself to be. Continuing to starve herself, rather than signifying ‘control’, then becomes a ‘complex ideological dilemma’ embedded within social and discursive practices that are inescapably linked to power (Edley & Wetherell, 1999, p. 191), particularly as moral worth for women is frequently hinged upon both thinness as well as being for others where emotional fulfilment is assumed to be

achieved through ‘the nurturing and caring of others’ (White, 1986, p. 69). How Katie addresses this ideological dilemma says something to her about the sort of person she is and is in the process of becoming. Through the reconstruction of meaning of her actions in terms of values, an alternative narrative is renegotiated and performed – ‘Anorexia, I think for one of the first times ever really faded into the background’ (lines 14-15).

EXTRACT 9a

1 **Susan:** *Well I just think I’m not as egocentric and self-focused. Like I think that*
2 *the whole anorexia thing and the need for control and that cold power*
3 *play thing and everything that you did was (pause) very selfish. So I think*
4 *I’m not selfish like I used to be and I don’t want to draw attention to*
5 *myself, now and I guess back then I didn’t want to draw attention to*
6 *myself, but I did by doing that. [...] when I was around 24, 25 I started to*
7 *look back and think oh my god. I would think about things that I had done*
8 *and how childish they were and self-focused and self-absorbed and I*
9 *think that’s a good thing now because I think since I’ve had that*
10 *awareness I think that’s when I probably known that but no way would I*
11 *ever do that again because it’s just horrible.*

12 **Interviewer:** *[...] when you realised it you said, “That’s when I decided I’m*
13 *not going to go back”, what do you think that says about your values and*
14 *what matters to you?*

15 **Susan:** *(pause) I guess that because I know that my values are more caring and*
16 *more about other people and I’m kind of really open minded and I like*
17 *doing things for other people. So I guess that means that really I was*
18 *probably always that kind of person, but I had gone on this wrong path or*
19 *whatever and had ended up this certain way, but that in fact maybe, that*
20 *wasn’t me, that person and the way I am now I’m more giving, I love to*
21 *do things for other people. (Third telling 10 years on, pp. 3-4)*

EXTRACT 9b

Susan: *[...] I’ve become really aware in the last decade of how self-focused and egocentric I was during the time. I don’t blame myself for it. I don’t have a problem with that, I think it was really important to me to have that time may be I never had that. I never had focus on me when I was a child and I think that I needed that kind of attention seeking behaviour to get what I needed.*

(Third telling 10 years on, p. 50)

Susan too managed her identity through use of terms such as “egocentric”, “self-focused” (extract 9a, line 1) and “selfish” (line 3), although qualified how she took on these

terms as relevant to her identity - “maybe that wasn’t me, that person” (lines 19-20). The identity conclusion that she was “selfish” both reveals and obscures to Susan the kind of person she was and is. Marking out what she was doing as “selfish” enabled her to step back from actions that did not fit with who she understood herself to be and contributed to her decision that there is “no way would I ever do that again” (lines 10-11). This distinction provides an opening for Susan to take steps to act in ways that resonate with her preferred values identity. Susan, however, did not actively set out to act in a way that was “egocentric”, “self focused” and “selfish”. What is obscured by these identity conclusions is that this alternative understanding was previously outside her “awareness” (line 10) where the unintended consequences of her actions was a focus on herself.

For Katie, Susan and Anne (chapter 4) examining their actions from the perspective of self-reflected values provided “deeper” considerations into the kind of person they were and wanted to be. A ‘crucial feature’ of human agency, according to Charles Taylor (1985, pp. 42-43), is the capacity for the evaluation of ‘desires’ not only in relation to outcomes but also in terms of self-reflected values. Therefore, within the discursive context of the research interviews, these women reflected on themselves in the context of their lives and for each woman within these reflections her identity was ‘in question’ and previously ‘inchoate evaluations’ (Taylor, 1985, p. 42) were defined that were essential to her identity formation.

Ten years on, Susan took this evaluation of her actions as “attention seeking” and “self-focused” to another level of complexity (extract 9b). The notions of attention seeking and selfishness are built on a moral repertoire that has implications for a person’s moral status through the assumption they are somehow actively profiting from their own distress and suffering. In addressing “blame”, she reconstructed the meaning of her actions as providing her with the self-focus and attention that was absent from her life in the context of childhood experiences of physical, emotional and sexual abuse. Through this compassionate self-understanding she incorporates this period in her life into her current identity in a way that is sustaining, strengthens both the understanding that this was not “me” as well as her values identity that she was and is a “caring” person who needed for

this period of time to focus on herself and have the attention of others to “get what I needed” to heal.

Therefore, through the examination of the real effects of and values supporting their actions within a discursive context not confined to ‘anorexia’, women were faced with questions related to whether or not what they were doing fitted with the sort of person they were, are and hoped to be.

Chapter summary

Within the discursive space of the research interviews, these women re-authored their past and present experiences and actions with different meanings and on different terms that existed in the discursive space between a ‘control’ and ‘anorexia’ narrative. In doing so, they made discoveries about themselves, including what they valued. This was not, however, a seamless process. The most available language for women to draw upon continued to be the dominant ‘anorexia’ discourse and intermittently throughout the women’s narratives was the power of this discourse to repress alternative understandings, knowledge and ways of speaking. These women, however, were not passive recipients of an ‘anorexia’ discourse and this analysis has focused on analysing the discursive resources that women drew on to refashion and generate alternative positions from which they constructed and negotiated their identities through not only the troubling of ‘anorexia’ but also within a discursive field not confined to ‘anorexia’ talk.

This chapter has analysed how when women in this research spoke within a discursive context that both externalised and privileged their own terms and meanings (White, 2007; White & Epston, 1990), they re-authored their experience using language forms that were not confined to the terms and conditions of the dominant ‘anorexia’ discourse. Some women drew on metaphors that were ‘experience-near’ that provoked thoughts, feelings and images of their lived experience that were more ‘effortlessly’ (Geertz, 1975, p. 47) defined and less troubled than the ‘experience-distant’ concept of ‘anorexia nervosa’. Metaphor also provided these women with a language to mediate more complex meanings, subjectivities and social realities (Geertz, 1973). For example, through experience-near metaphors some women accounted for their experience as both a friend and an enemy, a vital yet also potentially destructive force in their lives and how they

became more visible despite seeking invisibility. Metaphor was also a vehicle for the expression of potentially painful and difficult topics that, for some women, included histories of childhood trauma.

What has frequently been left unrecognised in much that has been written about so-called ‘anorexia nervosa’ is that ‘medical definitions of anorexia are themselves metaphors’ (Garrett, 1998, p. 55). Following on from this, medical definitions of ‘anorexia’ are assumed to *be* a person’s reality rather than one of a number of possible ways of understanding a person’s reality. Confining understandings of a person’s reality to an illness metaphor has implications for not only the scope of therapeutic conversations but also for how the person understands themselves and how their modes of expression are construed by others. For example, the Maudsley family therapy approach has argued for the importance of separating ‘the illness from the patient’ (J. Lock, Le Grange, Agras, & Dare, 2001, p. 52) that fits with the intention to reduce the blame assigned to the family and/or individual themselves. However, in applying a metaphor of illness within the discursive practice of externalisation, the person is construed as sick – ‘the patient’. Knotted in with this is the discursive reference point of an absence of personal agency (chapter 5) where they are assumed to be largely out of control – ‘the patient has little control over her illness’ (J. Lock, et al., 2001, p. 52). Finally, an illness metaphor is built on a moral repertoire whereby the experience is totalised as bad and wrong.

Other metaphors that use a moral repertoire to totalise a person’s experience as negative include the externalisation practices suggested by Maisel et al. (2004) that rely on what Michael White (2007) has termed ‘contest metaphors’ (p. 32). Arguing for the significance of metaphor in externalising conversations, White (2007) has cautioned against excessive reliance on such contest metaphors in externalising conversations and highlighted that totalising the problem as an entirely negative force and subsequent seeking out its eradication may risk leaving the person with ‘an increased experience of vulnerability and, over the longer term, a sense of fatigue and reduced personal agency’ (p. 37), particularly when their efforts do not eventuate in elimination of the problem. Second, through the use of battle metaphors, the task of therapy is set up as adversarial (White, 2007), which may also risk alienating those who understand their experience as a part of them and not entirely

problematic. Metaphors that rely on a moral repertoire to totalise lived experience as negative and problematic are also unable to handle the contingencies of the complex social reality of those who experience ‘AN both as a separate entity *and* as part of their identity’ (Higbed & Fox, 2010, p. 321). This has led to the concept of externalisation itself being questioned, particularly its therapeutic utility in facilitating ‘separation of disorder and self’ (Higbed & Fox, 2010, p. 321). Rarely questioned, however, is the metaphor of disorder/illness itself, nor other metaphors that totalise a person’s experience on negative terms. Also this version of externalisation where the intention is to facilitate the separation of the self from the ‘disorder’ (separation externalisation) is built on a dualistic repertoire that limits the scope for a more relational understanding of externalisation that will be taken up further in the following chapter.

Women in this research refused to totalise their lived experience as negative and problematic and the metaphors they selected out to meaningfully depict their lived experience provided scope to handle a complex social reality. Rather than this thing being entirely problematic, instead what was problematic was their relationship to the “volcano”, “tiger”, “friend/deadly enemy” etc. and the extent to which it dominated their lives and separated them from who they understood themselves to be. Using relational metaphors addressed the complexity of a lived experience that is experienced as both separate and part of complex multi-authored (and experienced) identity. Rather than the focus of therapeutic conversations being to dualistically separate off and vanquish an experience that is totalised as bad and wrong (through illness or battle metaphors), a person’s action might be characterised as relational where the focus is on revising their relationship with this thing and in doing so, reclaim their preferred identity/ies.

Far from minimising the real effects of this thing on their lives, the metaphors women selected out also worked to scaffold them to a place of imagining what their life might be like if they revised their relationship with this thing. The women’s use of metaphors depicting their experience as a “friend”, often the dimension of the experience that is referred to as ‘egosyntonic’ (Guarda, 2007, p. 114), did not (as might be expected) result in the minimisation of the real effects of this thing on their lives. In fact when women chose the terms of their speaking and voiced their own views, their ambivalence and

defensiveness diminished, they paradoxically turned towards the examination of the real effects of this thing on their lives and relationships and made discoveries about themselves, the sort of lives they wanted to live and the kind of people they wanted to be.

One context within which these self-discoveries were authored was at the point the women traced the real effects of their actions on their lives and ascribed meanings to their actions such as “selfish” or “self-focused”. At these points these women discovered that they were living inherited cultural values that did not fit with their preferred identity/ies. Implicit in their discernment of their actions as “selfish” or “self-focused” etc. was the presence of their own unstated values of care, concern, fairness and compassion for others. On the other hand, at stake through reconstructing the meaning of their experiences on such terms was the women’s moral worth. Nevertheless, paralleling some women’s engagement with their values was a re-engagement with their histories in ways that preserved a sense of moral worth and moral status. One woman in particular re-engaged with her history with compassion, including understanding her actions to be an attempt to reclaim identity, despite the paradoxical and unintended effects of her actions in separating her from her values. Therefore, as these women reconstructed the meanings they ascribed to their past experiences, they were also in the process of re-authoring sustaining narratives that negotiated multiple meanings around their struggles to act any differently at the time.

Therefore, the power of metaphor is that complex realities and subjectivities may be accounted for and the type of metaphor that is selected out in talk is of significance. Particular metaphors provided an experience-near way (Geertz, 1975) of talking that created a number of identity positions from which some women could author aspects of their identities that were unable to be authored when their terms of speaking were confined to the experience-distant ‘anorexia’ discourse. Susan Sontag (1991) has argued that some metaphors are more useful than others.

Of course, one cannot think without metaphors. But that does not mean that there aren’t some metaphors we might well abstain from or try to retire.

(Sontag, 1991, p. 91)

Perhaps the question is not which metaphors for the experiences women have depicted in this thesis are true or untrue but rather which metaphors are most helpful or unhelpful. Some

women found the metaphor of illness to be helpful in understanding and locating their lived experience at different times in their life, other women less so and yet other women found illness to be a damaging label that was totalising of their identity and undermined their moral worth (chapter 5). Over-reliance on illness and battle metaphors may obscure other ways of looking and the generation of alternative metaphors to author a complex social reality. Women's use of their own unique metaphors and their refusal to 'submit to other's pejorative definitions of oneself' might be understood as a form of resistance (Stacey, 1997, p. 31) and discursive place. Within this discursive place, women struggled to recover themselves (hooks, 1989), to rewrite their identity narratives on their own terms and in doing so, renew a sense of alternative possibility for themselves in the context of their lives.

Women traversed a previously uncharted discursive space where their actions signified either control or an out of control illness within a particular discursive context. The research interviews and my lines of enquiry provided a range of discursive contexts within which women spoke. Women generated and clarified their experiences in discursive contexts where they both argued against my assumptions as well as contexts where I was more curious and open to the meanings they ascribed to their modes of expression. Within the discursive context of the research interviews, women claimed a voice for themselves and on their own terms (Sampson, 1993) in the negotiation of their identities. A number of women made comment about how the versions of their lived experience that were generated in the context of the research interviews were not how they would have looked at or thought of their experiences at the time. The women's narratives were re-authoring of old experiences; new and fresh ways of looking at old experiences that were generated within the discursive context of a research interview that privileged women's meanings and terms of speaking. Within this discursive context, women generated a range of identity positions and through discursive agency negotiated and re-authored identities that resonated with the sort of person they were, are and hoped to be. The implications of these alternative ways of authoring their lived experience meant that women were not only the authors of their lived experience but, following on from this, also the actors in living out narratives constructed on their own terms.

Chapter 7: Recovery or ...?

‘[...] the word (recovery) and its accompanying concepts is entrenched in our language and can serve as a useful shorthand for some of the changes I have described. [...] I have used this word because it makes some kind of sense to participants and potential readers, but I have stressed that it need not be associated with notions of linear progress; that it is not only an ongoing process, but also a cyclical one; a return to previous experience and a constant redefining of the meaning of that experience.’

(Garrett, 1998, p. 190)

An inspiration for this research has been Catherine Garrett’s (1997, 1998) work in which she provided a counter-narrative to the medical concept of “recovery” from ‘anorexia nervosa’. Although Garrett (1998) sought to re-define the term “recovery” and argued for the recursiveness of the process where experiences are continually being defined and redefined, the absence of an alternative language outside this medicalised term to depict such shifts led Garrett (and me in this research) to use and reproduce this nomenclature. In my early interviews I invited women to speak on the received terms of this medical version of “recovery” assuming that any talk about ‘recovery’ would produce entirely positive and hopeful responses. What emerged was unanticipated, informed the discursive climate of the research interviews 10 years on and is the focus of the analysis of this chapter.

As discussed in chapter 3, 17 of the 21 women in their first telling questioned the notion of recovery itself. Three of the four women who took up the notion of recovery as relevant to their lived experience in their earlier telling/s, revised their position in later tellings. The other woman was unable to be re-contacted ten years on. Thus, 20 of the 21 women argued at some points in their narratives that recovery was not relevant to their lived experience and/or impossible for them. Although the discursive context of these 21 women’s quotes (Appendix 7a) is beyond the scope of analysis for the research questions at the heart of this thesis, this is an interesting finding in itself that guided the choice of research questions at women’s third tellings, ten years on. Here are some examples.

EXTRACTS 1

Naomi: [...] I suppose maybe we need to redefine how we think of recovery. Is recovery that you never ever do that action again?
(First telling, 1997, p. 20)

Margaret: If I was to recover, I'd be giving it up, I'd be giving the control away, I'd be handing it off, it's gone, [...] Then that would mean that I would have to accept the fact that I would be an overweight person because that is the body structure and the body, the way I am, um and I'm not prepared to do that, under any circumstances. No, so, I don't know. When you look at it that way may be recovery isn't possible for me, not fully.

(First telling, 1997, p. 24)

Naomi argued that there is a need to redefine the notion of recovery itself, whereas Margaret left the notion of 'recovery' intact, instead questioning whether it was a possibility for her. Given that the majority of women experienced the notion of 'recovery' as troubled subject position (Wetherell, 1998), my interest moved to understanding alternative frameworks of meaning they drew upon to depict their changing relationship with 'anorexia' over time. As many of the women had talked about shifts in their relationship with 'anorexia' through a journey metaphor (see Appendix 7b for quotes), interviews ten years on became a site for exploration of the range of metaphors they relied on to depict the journey process.

The analysis explores firstly how the nine women who participated in this research over ten years were positioned and positioned themselves in relation to the discursively constructed category of "recovery". Following on from this, the analysis moves to stretches of text where alternative positions outside the discursive field of recovery were generated by women to reconstruct shifts in their experiences over time and some of the implications for their identity formation.

Taking up and questioning 'recovery'

EXTRACT 2a

Anne: Well, I think the word recovery to me means you had an illness (pause) so there's either illness or there's recovery. There's illness or there's death or there's illness and there's recovery or recurring illness not death perhaps. (**Interviewer:** So does that word resonate for you?) Yes because

this experience of verbalising with you and the first time we met all those years ago made me realise that I did have an illness whereas I just looked at it as being just a part of who I was. Oh, this is just the way I am, it's not an illness, but it was an illness. So therefore the word recovery is relevant to that. (Interviewer: So what does recovery mean for you?) Recovery, I guess, would mean that you, you would never fall back into that illness again. So therefore the recovery's a really strong positive word because if you keep focusing on that word and holding it then there is less likelihood of sliding back into the illness.

(Third telling 10 years on, p. 17)

Although Anne refused an illness perspective throughout her tellings (as analysed in detail in chapter 4), when she drew on the category of 'recovery', she also took up the category of illness as relevant to her lived experience. Built on a dualistic repertoire, recovery marks the antithesis and absence of illness and the return to some sort of pre-illness state or normality (Neimeyer, 2000a). Talking about recovery therefore necessitates the adoption of an illness perspective even when the latter is troubled.

EXTRACT 2b

Interviewer: *Do you believe that you could ever recover totally?*

Sally: *Well I don't know what recovery is, I don't know if recovery means never thinking about food the way you thought about it when you were anorexic. (Interviewer: Mm, mm) Does it mean that you never think about your body the way that you did about it when you were anorexic? (Interviewer: Mm) Yeh. What's the point at recovery? Is it the fact that you are maintaining a constant weight? Or is it the fact that things in your head have changed? (Interviewer: Mm. What would indicate to you that you have recovered? Or are recovering, for you as a person?) That I could get on with life and that I could function properly in terms of my marriage, my child and my job, that I wasn't a stick insect and that I wasn't obsessed with either food or exercise.*

(First telling, p. 19)

EXTRACT 2c

Sarah: *[...] maybe recovery is many different kinds of things, maybe it's (pause) I mean obviously you wouldn't have - you'd be able to eat normally. (Interviewer: Yeah.) Um (pause) I'm not sure, perhaps it's, it's not just being a healthy weight I think it's, it's a frame of mind as well. You wonder if you will always have battles with it or whether it will be totally gone, like what, what is being recovered? (Interviewer: Mmm.) You know, I suppose it's like (pause) appendicitis, you know, you've got it when you've got inflamed appendix, but once that's gone you haven't got*

it anymore (pause). With recovering from, from this, well it means I won't think it anymore; it will be like another story that's completely gone. Or will it always be well OK I maybe a healthy weight, but I still think, you know, in abnormal ways? I'm not sure. It'd be nice if, if recovery meant (pause) I don't have these wars anymore, you know, and they are wars, that's the worst thing, warring in your own mind is absolutely terrible.

(First telling, p. 12)

Sally and Sarah questioned the notion of recovery. My introduction of the concept of total recovery confined Sally's terms of speaking to a dualistic repertoire where the two available slots to author her experience were that she is either "anorexic" or that she never again thinks or acts like "an anorexic" (extract 2b). Medical discourse polarises lived experience as either illness or absence of illness. Sally and Sarah struggled to author their experiences on these terms – "I don't know if recovery means never ..." (Sally, extract 2b) and "whether it will be totally gone" (Sarah, extract 2c). Dualistically separating recovery and illness reifies recovery as a state ("the point at recovery", Sally) that a person reaches where they are assumed to be free of illness and suffering. Recovery is therefore troubled through the reification of lived experience as the elimination of disorder or in Sarah's words, "another story that's completely gone" (extract 2c). In addition to this, how recovery is defined and who defines it remains contested.

Although the notion of recovery was troubled for Sally and Sarah, this does not mean that they resigned themselves to the life and identity of "an anorexic". In seeking to define recovery on her own terms, Sally argued that recovery was not only about weight restoration (not being "a stick insect", extract 2b) or changes in thought patterns but was also related to a capacity for living and reclaiming life. Sarah hoped recovery might mean that she did not "have these wars anymore" in her mind (extract 2c). Metaphorically depicting her experiences as "warring in your own mind" is a way that she redefines and marks out her lived experience using an experience-near definition (Geertz, 1975) of recovery as "I don't have these wars anymore". Pieced together with a dualistic repertoire, this battle metaphor, like illness, confines her hopes to the terms of an absence of wars in her mind.

The question of what constitutes recovery is a thorny one. The majority of research studies on recovery from 'anorexia nervosa' have focused on physical indicators such as

weight restoration and return of regular menses (Windauer, Lennerts, Talbot, Touyz, & Beumont, 1993) and scales that measure beliefs about body weight and shape (Federici & Kaplan, 2008) as indicators of recovery. Qualitative research studies (such as Federici & Kaplan, 2008) interested in examining the perspectives of the experiencing person also tend to rely on researcher definitions of recovery based particularly on the criteria of weight restoration. Windaeur et al. (1993) have suggested that researchers and treatment teams might consider reviewing their expectations for recovery and question whether there is a need to accept that ‘complete recovery may not be achievable for many if not most of our patients’ (p. 199). Such suggestions, however, are positioned within the recovery discourse. Few have questioned the notion of recovery itself or commented upon how the reification of this discursively constructed category of recovery may itself be dilemmatic.

EXTRACT 3a

Interviewer: [...] What does recovery mean when you say, or speak of recovery?

Susan: For me that every single last bit of the eating disorder is gone [...] and eating has no bearing on my life whatsoever. I mean I always thought that it wasn't possible to get to that point. I thought that you'd always have some part of it left and you would always be paranoid about food and stuff like that but I realise now that that is not true.

(First telling, p. 37)

EXTRACT 3b

Susan: [...] where I see myself now it's a past experience, something from the past, but last time we talked I probably said that it's completely over and I've moved on from it and I have, I don't have an eating disorder, but I realise that some part of it is always with you. I wouldn't call myself anorexic at all, but I identify with some of the behaviours. Maybe for me food is often a low priority, it's not important, if I'm stressed it's the first thing to go. So I still see that it's there like its part of your personality, but I'm not really troubled by it. (**Interviewer:** So do you want to tell me a bit more about that part of it that's with you?) (pause) How do I explain this? It's just (pause) it makes me (pause) I always feel a little bit different, but I don't know if that's totally the anorexia or just other things that created that disorder I suppose, but (pause) it doesn't control my life at all and like I keep saying I don't have anorexia, but (pause) just the behaviours, and there's not many [...] I put food off, it's not important and if I'm upset I don't eat, whereas I know other friends if they're stressed they do eat, I don't. I guess that's really (pause) the only way I really identify with it. I can see that I maybe don't make choices or make

choices differently sometimes because that little bit of it is left. I probably would have said 10, 15 years ago that I'm completely better and I think I am, but I think its maybe like being an alcoholic or something, I don't think you're ever totally recovered.

(Third telling, 10 years on, p. 1)

In her first telling, Susan drew on a dualistic repertoire to author herself as recovered and “eating disorder” as “gone” (extract 3a). Ten years on, however, she rejected this notion and re-authored her experience as “some part of it is always with you” (extract 3b). This part of it that endures has implications for her relationship with food and also contributes to an identity narrative of “always” feeling “a little bit different” that she relates to both “the anorexia” and experiences of childhood abuse that “created the disorder” (extract 3b). This is a story that (drawing on Sarah’s words, extract 2c) will never be “completely gone”.

In bringing together a range of ethnographical research in the field of anthropology, Holland and Lave (2001) have coined the phrase ‘history in person’ that they define as ‘a constellation of relations between a subject’s intimate self-making and their participation in contentious local practice’ (p. 5). Identity in this context is neither reducible to autobiographical nor to cultural and political group membership; rather identity is understood as relational, produced in enduring struggles and ‘realised in’ and ‘mediated through, contentious local (i.e. situated) practice’ (Holland & Lave, 2001, p. 6). A person is understood within this framework as in an active and continual ‘state of being “addressed” and in the process of “answering”’ (Holland & Lave, 2001, p. 10) where they draw on a collective and pre-existing discursive materials to author oneself (the “I”) in the context of the world. In extract 3b, Susan breaks from the category of ‘recovery’ that lacks depth in capacity to author this “part of it” that remains with her. Within this context, she marks out a boundary where she distances herself from a colonised concept that she had taken on as her own a decade earlier (extract 3a).

Susan then draws on two subject positions to author the “part of it” that endures. First, she uses the position of “personality” (extract 3b) to justify why she is without agency for further change. She is nevertheless not “troubled” by this absence of agency to change because she has developed an adaptive capacity to sustain herself in the face of food

not being a priority particularly during times of stress. Second, she authors the “part of it” that remains using the subject position of addiction (extract 3b). “Total recovery” does not exist through an addiction framework; rather the person retains the identity of a recovered “anorexic”. A number of women used these subject positions of personality and addiction in their refusal of the term recovery as a possibility, either for them or in and of itself.

Refusing the term ‘recovery’

EXTRACTS 4

Lisa: *[...] I suppose if I'd recovered I'd probably be independent enough to be able to get on with my life and, I suppose, develop close relationships, I just can't see that ever. I can't see how whether it be through therapy or anything that you can change someone and someone's personality that much. I don't really think that will ever happen completely. I don't know, maybe it does for some people, but I've had this for so long like I don't know anything different really. It's a stage now where it's not my whole but it's there and I just can't see that ever being completely gone.*
(First telling, p. 18)

Sally: *Well it's like an ex-smoker, are they ever recovered? (laughs) Is an ex-smoker ever a non-smoker?*
(First telling, p. 19)

Sally: *[...] it's like you've (pause) maybe somebody with a mental illness that's lost the mental illness but is still doing really bizarre behaviour [...] you can analyse while you're doing it, and yet you can't stop yourself doing it. You think I'm the same person, I've lost the insanity part of it, why am I still doing it? It really annoys me. (Interviewer: Mm). It's almost like some things become innate.*
(Second telling, p. 15)

Naomi: *I still am always cautious that I could fall into the trap again. I suppose that's always still there, especially if life gets very stressful, you think well if I can't control these other things I'm going to control my body again. I mean I'm sure would be a realistic fear for many people in the same way that an alcoholic is always an alcoholic but you can't afford to have one drink because you know you could do it all again.*
(First telling, p. 14)

Jane: *[...] this gets back to you were talking about recovery, oh look, she's over anorexia she's recovered - there's always going to be warning bells, the same as an alcoholic will still get those triggers where they go I've just got to have a drink, I've just got to have a drink and everything else will be right and now I know those warning bells.*
(Third telling, 10 years on, pp.5-6)

Anne: *I don't think you ever recover. It's like a smoker. You're never ever not a smoker. I don't think you're ever not an alcoholic. (Interviewer: Mmm) It's something that's with you and you have to take it day by day I think. (Interviewer: Mm.) That's as I perceive it. I don't think, (pause) if you have something that is a part of your personality, it's a part of you, (pause) it's got to be - I'm going to say genetically imprinted but it's probably not the correct term, but it's in your blueprint somewhere. [...] Part of your genetic or whatever else is there in your make-up. It's part of you, otherwise you wouldn't have taken it on board in the first place.*
(Second telling, p. 27)

Katie: *[...] I think true anorexics never recover, you've always the potential to go back to it because it felt so good, it's like a heroin hit, like it felt so good and if times are bad you know that you could always go back to feeling that good by doing that. [...] (Interviewer: So you don't consider that you could ever recover, is that what you're saying?) Um, I'm saying it's sort of in my blood now I think.*

(First telling, p. 17)

In these stretches of text, “personality” and “addiction” are the most available subject positions for women to use to piece together their arguments as to why recovery was impossible either for themselves or in and of itself. Women used and shifted between these positions. An addiction perspective not only totalised women’s identities as “anorexic” but also constructed a version of identity using an internalised repertoire that assumes : once an anorexic, always an anorexic. Following on from this, the two slots available to the person to author their identity are that they are either an “anorexic” or a “dry anorexic” who learns to live with and manage their addiction. Here I have adapted the term “dry anorexic” from “dry drunk”, which is from alcohol/addiction discourse, as there is no equivalent language in eating disorder discourse to draw upon to depict what I mean by “dry anorexic”. A person also cannot be a completely “dry anorexic” because one cannot give up eating and survive. Second, in taking up an addiction perspective, women understood themselves as forever vulnerable to the return of addiction. The task from an addiction perspective is harm minimisation through awareness of possible triggers (named by Jane as “warning bells”) and lapses (named by Naomi falling “into the trap”), both of which are unable to be authored from a totalised medical recovery perspective that assumes the experience as “gone”.

The justification for the impossibility of recovery using the subject position of addiction is hardly new. In speaking with 13 women who had previously met diagnostic criteria for ‘anorexia nervosa’, Beresin, Gordon & Herzog (1989) found that half these women argued against the notion of full recovery using analogies of ‘alcoholism’. The remainder of the sample of women agreed that they were left with ‘remnants of the disorder’ that led these authors to conclude that ‘anorexia nervosa’ is ‘a lifelong illness that can be progressively controlled albeit with less and less effort’ (Beresin, et al., 1989, p. 125). Illness may therefore take less ‘effort’ to control over time however, is a lifelong affliction. This suggests that the notion of addiction has become a discursive tool to mark out limitations in a person’s capacity to invoke change in relation to the category of ‘anorexia nervosa’.

Women also used the subject position of “personality” to argue against a totalised recovery perspective in their justifications of the extent to which further change was possible (extracts 4). How women understood and used this position of personality had implications for the extent to which they viewed their predicaments as changeable or not. Anne, for example, used a trait position to construct the experience as “in my blueprint” and “part of your genetic make-up”, which explains why she took “it on board in the first place”. A trait understanding assumes that the person has the experience because they have longstanding stable and consistent personality tendencies that not only predispose them but also exist independent of ‘anorexia’; this forms the side of nature in the longstanding nature-nurture debate. On the other hand, a state understanding develops the idea that personality is derived and shaped by lived experience. Two women turned this state into a trait - “some things become innate” (Sally) and “it’s sort of in my blood now” (Katie). In using personality in this way, these women argue that their experiences have changed them in a way they are unable to alter. For Lisa, the absence of knowing any different because “I’ve had this for so long” built another perspective that this thing has become a habit. She also marks out a limitation on personal agency to change “personality that much”. Therefore central to the subject position of personality is the question of personal agency to invoke change.

Therefore, the women's use of both the subject positions of addiction and personality formed not only their refusal to author their experiences on the reified terms of 'recovery' but were the discursive materials they used to argue that they needed to learn to live with this experience rather than seek to eradicate it.

If not 'recovery', then what?

EXTRACT 5

Anne: [...] and I may have used the analogy last time I don't know as a recovering, say you're an alcoholic or you're a gambler or something that is now being deemed as an illness if you have those. So it's always a part of you and I guess it is one day at a time and maybe that is still overriding that feeling of being in control of your consumption of food but that's where I'm not sure if that's still the "anorexia" part of me or just me having a healthy attitude towards not overindulging in food and I think that came up last time and I sort of wondered about that - is my relationship with what I ingest now a healthy relationship or is it still a lingering anorexic mentality? and I'm pretty sure that it's a healthy connection with what I eat now. It's just a matter of not overindulging, being cautious about the quality of the food I eat and not feeling mentally tortured if I eat too much and if I do get that feeling it goes away. As an example, in the past if I'd gone out and had a really huge meal the night before, my eyes would open the next morning and I'd assess what I'd eaten before I'd gone to bed and panic and actually feel myself, feel my hip bones and if I felt fat, I felt that I would be expanded overnight and I would not eat all day to offset what I'd eaten before, but now if I go out to dinner the night before I may have that feeling fleetingly in the morning, but it's gone and it doesn't consume my day as it did before. So I think it's just about now having, I keep bringing up the word healthy now
(**Interviewer:** You said "connection), whereas it was unhealthy before and now it's a healthy ...

Interviewer: Connection with food (**Anne:** Yeah. Exactly.) With what you eat. (**Anne:** Yes). Yep. So how does seeing yourself as having a healthy connection with what you eat now, how does that affect how you see yourself as a person now?

Anne: Hand in hand I guess. Yeah. I don't feel like I have any major hang ups about anything. Yeah. I think I feel healthy and in a good place.

(**Third telling 10 years on, p. 17**)

Anne struggled to discern whether the decisions she was making in relation to her eating were "a healthy attitude" or "a lingering anorexic mentality". Within the discursive

context of the research interview, she reconstructed her relationship with food as a “healthy” (Anne’s words) “connection with food” (my words) to which she responded “exactly” (extract 5). This difficulty in defining one’s relationship with food and eating is a symptom of women’s troubled relationship with food within a cultural climate that values the thin female body. Pamela Hardin (2003b) has also researched ‘recovery’ narratives of women through a critical post-structuralist perspective and found that as women ‘stop’ self starvation the subject positions available for them to step into were not outside the disciplinary discursive space of weight, fitness and food obsession.

The recovered self is not transformed into a nondisciplinary self that no longer scrutinizes one’s thinking and behaviors. Such a position counters Westernized constructions of how selfhood is performed (Hardin, 2003b, p. 12)

As discussed, the notion of recovery restricts the terms of speaking to the dominant medical discourse whereby the person is understood as moving from the presence to the absence of disorder; the inherent problematic being how the latter is defined. Once labelled with a disorder who and how is the decision made as to when a person is un-disordered? (Gergen & McNamee, 2000) In addition to this, on diagnosis there exists the very real possibility that a person may then ‘embark on a lifetime of existence on the boundary of normalcy’ (Gergen & McNamee, 2000, p. 338). This absence of social discourse outside a disorder and disciplinary discursive space highlights this apparently non-discursive space that the women in this research found themselves in as they struggled to define their experiences and negotiate their subjectivities on their own terms. Therefore, if what the person is moving towards is not some idealised self who is free of cultural prescriptions that inform disciplinary thinking and practices, where is the person moving towards as they take steps to stop starving themselves?

Metaphor.

EXTRACT 6a

Naomi: I suppose those scars always go with you, and yeah, there are the physical scars too but there are, I suppose, the mental scars. I will always affiliate with someone with anorexia or an eating disorder, it's something that I will always relate to, because it's part of the construction of me now [...]. I suppose maybe we need to redefine how we think of recovery. Is recovery that you never ever do that action again? [...] the scar tissues

are always there. So how you - it's just making a life to live around those scar tissues. [...] it's like anorexia is always in there, it's part of who I am, it's part of my fabric, it's part of what I value, it's part of what I think of my morals, my ethics, all those type of things that flavour who I am.

(First telling, pp 21-23)

EXTRACT 6b

Kelly: *[...] there's still a lot of things of the eating disorder that linger. My personal belief is, and I'm being realistic, that you never really get over an eating disorder, I think you just push it to the background of your mind. So far in the background of your mind that it doesn't become a problem, that it doesn't interfere with your life anymore. I think that's what I've managed to do. I don't think you've ever "recovered" from an eating disorder. I think you just change your behaviour. There's so many vivid memories about it and the way I was and what I used to do, it's very difficult. I don't think that I'm ever recovered from it (Interviewer: Mm, hm) but it's pushed to the background of my mind. I'm not indulging in the self-destructive behaviours as I was doing before. [...] its part of me, always will be part of me [...] I don't feel that I can forget, I can't ever recover if I can't forget, but it's pushed in the background.*

(First telling, p. 14)

EXTRACT 6c

Kelly: *It's in the background. It's still a big thing and I know it's there, but it's in the background. When I think about it, it spurs me on. (Interviewer: Tell me how?) It was such an awful life and I never want to go back. [...] the way I was back then I could never go back to that life, I didn't have any future back then, most of the time I didn't care about the future. [...] Whereas now I look forward to next week and I am looking forward to things. I can see that all that unnecessary worrying just suppressed me. How debilitating it was and how it paralysed me most of the time. I was in this little world and I was not going anywhere and I just couldn't keep going on like that.*

(First telling: p. 20)

Naomi and Kelly used the discursive tool of metaphor to depict the complexity of their shifts where their experience, although not remaining the same, nevertheless had an ongoing dimension that they authored as “part of who I am” (Naomi) and “part of me” (Kelly). The notion of recovery does not provide scope to make meaning of this enduring dimension of an experience that continues to hold meaning for who they understand themselves to be. Implicit in Naomi’s argument that “maybe we need to redefine how we think of recovery” is that the version where a person returns to a pre-illness state of

recovery is unable to account for the complexity of self transformation through the experience – “it’s part of my fabric” (extract 6a). To mediate these complex meanings, Naomi used a trauma metaphor of “scar tissue” (extract 6a) to depict pain, healing and embodied reminders of an experience that is unable to be erased. The heart of the journey is not reclaiming life as it was, but reclaiming life having been transformed through the experience and an identity that resonates with “what I value [...] my morals, my ethics”. This identity that she has reclaimed is therefore authored as an ongoing transformation (Garrett, 1998) using a ‘vocabulary of values’ (Gill, 1995, p. 176).

If recovery means forgetting, then Kelly rejected this notion - “I can’t ever recover if I can’t forget” (extract 6b). Recovery is troubled for Kelly through the expectation that she must “forget” the experience. In her argument as to the impossibility of this, she draws on a metaphor of “the background” (extracts 6b and 6c) to capture the complexity of how, although no longer dominating or interfering with her life, “it” nevertheless maintains a presence in her life. Although she uses an externalised repertoire, this does not necessitate the understanding of the experience as completely separate from the self and Kelly maintains “it’s part of me, will always be part of me” (extract 6b).

As discussed in chapter 6, externalisation when built on a dualistic repertoire that separates the self from the illness (or in the case of contest metaphors), is unable to handle the contingencies of a complex social reality where the women continued to live in a relationship with this “thing”. Rather than authoring her experience on terms confined to the dualism of ‘anorexia’, Kelly used different discursive materials to author this dimension of her subjectivity where she continues to live with “it” in a different relationship - “it’s in the background” (extract 6c). Her refusal to author her experience in terms of recovery was also important because remembering, rather than forgetting, “spurs me on” (extract 6c). If she forgets the struggles that “paralysed me most of the time”, what is also forgotten is the processes through which she reclaimed an identity that is sustaining for her where she is “looking forward to things”. Kelly expresses a preference to remember rather than forget. Remembering also encapsulated a journey where she reached a place of resistance (“I just couldn’t keep going on like that”) and reclaimed dimensions of “me” that had been “suppressed”. Absent but implicit in remembering that “I was going nowhere” is that there

was somewhere for her to go (White, 2000). This statement signifies that this is not all there is for her life and also encapsulates the imaginative dimensions of selfhood through future possibilities.

Remembering is therefore an identity practice (Holland & Lave, 2001) that resists erasure and enables women to stay connected with an ongoing struggle that itself changes over time but also that they refuse to forget. Holding their experiences through metaphor informs and guides these women's present and future and encapsulates identity positions that are derived from both historical and imaginative dimensions of selfhood.

Remembering history.

EXTRACT 7a

Anne: *Its part of who I am, definitely, because it's in my history, it's in what happened to me.* (Third telling, 10 years on, p. 17)

EXTRACT 7b

Kelly: *Something good comes out of adversity and I think everything that I've been through with the eating disorder, something good came out of it. [...] (Interviewer: What good came out of the eating disorder for you?) (pause) Finding myself there too, realising a lot of the problem was the situation I was in. [...] I realised there is another world and I always sort of believed there was, just never thought I could ever find it. (Interviewer: Where do you think that belief that there was another world came from?) Oh, talking to other people. Being, getting out of that circle of narrow minded cultural protective.* (Third telling, 10 years on, pp. 13-14)

EXTRACT 7c

Sarah: *[...] I often think it's only just been lately that I have begun to actually grieve my losses. I'm certainly not glad for the experiences, they're horrific. Yet I know that things have developed, I think that who we are is, of course, because of where we've been regardless of whether it's been good or bad. There are things that have come out of it, out of the darkness of it, I think the compassion that you feel or empathy or being able to see or know things, the depth of spirit perhaps or the way that your mind is - I mean you may have developed some very awful things, but there's also some ways in which your mind has developed which are a direct result of what you have experienced which also can be very good and I'd been a very different person if I hadn't grown up in the family that I did and hadn't experienced what I did, but as to whether I would be a better person, I don't know; and I'm not saying that you have to*

experience terrible things to be a better person, of course not, but in grieving your losses you also, I think, have to take into account the things that you have developed, the strengths that you have developed.

(First telling, p. 16)

Anne argued that it is impossible to separate her identity from her experience (extract 7a). Kelly and Sarah made visible their losses through their experience of “adversity” (Kelly, extract 7b) and “darkness” (Sarah, extract 7c). Kelly reconstructed the meaning of her experiences (not confined to her struggles with eating) as “good comes out of adversity” (extract 7b) and Sarah as “some ways your mind has developed which [...] can be very good” (extract 7c). Using a moral repertoire Kelly and Sarah argue against negative totalisations of their experiences. Sarah argues that through loss, she strengthened her identity as a person who values “compassion” and has further developed capacity to see “things” and a “depth of spirit”. For Kelly, “finding myself” and recognising the availability of “another world” and then her struggle to “find it” was an opportunity for her to understand herself on terms other than the received terms of this “narrow-minded cultural” perspective within which she had been immersed. Therefore through the reconstruction of meaning in the context of loss (Neimeyer, 2000a) and enduring struggles, these women generated a range of identity positions to re-author their identities, particularly in terms of a clarification of their values. In these extracts, they embrace their histories rather than hiding them in shame. Their histories shape and inform important dimensions of who they understand themselves to be.

As both these women reconstructed the meanings they ascribed to their experience, their focus was not only the struggles and trauma but also the ‘strengths’ they developed through the experience. Tedeschi & Calhoun (2004) have developed the notion of ‘posttraumatic growth’ to encapsulate the many ways that persons may grow and strengthen through traumatic life events, grief and loss. Post-traumatic growth is an ongoing process of identity formation that may be linked with an increased appreciation of life, re-ascribing meaning to life and relationships, shifts in values and what matters, “life wisdom” and “a richer existential and spiritual life” (Tedeschi & Calhoun, 2004, p. 1). Women’s arguments against a recovery perspective may therefore be understood as a

refusal to give up on making meaning of historical and ongoing struggles that have formed and transformed their identities.

Sarah also argued that this does not mean that “you have to experience terrible things to be a better person” (extract 7c). Implicit in the notion of post-traumatic growth is an expectation of growth and that this develops from the trauma. Here Sarah resists totalising her experience in terms of a moral repertoire and questions whether or not she is a “better person” because of the trauma she has experienced. Although indicating a preference to take up the position that she has inevitably been shaped by traumatic experiences, she maintains that trauma is not a requirement for growth or to be a “better person”. The question here is not whether trauma is required for growth, but how a person ascribes meaning to the events of their lives and, following on from this, how helpful or otherwise these meanings are as they continue on their life as lived.

Tedeschi & Calhoun (2008), like Neimeyer (2000a), have questioned the use of the term ‘recovery’ as applied to persons who have experienced bereavement and have suggested that using the language of illness in this context may offend.

Many bereaved persons probably would be irritated or offended to have said of then they were “recovering” from their bereavement, as if they had been sick. It may connote a leaving behind of their connections to their loved ones, a connection that carries much meaning and comfort.

(Tedeschi & Calhoun, 2008, p. 28)

Feeling “irritated and offended” by the notion of recovery with the corresponding implication that the experience is gone and the person is back to so-called normality parallels women’s perspectives in this research. Emerging from the analysis of these women’s narratives thus far, the term ‘recovery’ obscured opportunity for these women to ascribe meaning to a significant lived experience and risked dishonouring experiences and struggles that were significant in their identity formation. Women’s histories gave meaning and motivation to their present lives and they refused to take up a totalised recovery perspective where their history was gone and unavailable for authoring and re-authoring. This is an anti-recovery perspective where women claimed something from the experience for themselves and held onto this as they each re-authored their identity. This stands in

contrast to a recovery perspective where the person has to overcome, move on from and/or forget the illness/disorder in order to be themselves. History, rather than something to be hidden in shame, is instead viewed as a resource that women use to inform them about not only who they are, but also who they are and in the process of becoming. Although not glorifying the experience at its worst, these women are acknowledging the valuable learning that they gained through such struggles, including implications of this learning for their identity formation.

EXTRACT 8a

Lisa: *I just don't, I don't see myself as this sick patient or anything anymore. I see myself as this functional person that has a crappy eating pattern (laughed). That's how I see myself. (Interviewer: What does it mean for you to see yourself in that way? [...]) It means that I'm okay I guess. It means that I'm okay. I'm no more dysfunctional than the next person, or the next person, or the next person. I'm just (pause) I honestly think if you sat down and really talked and I think maybe that's because I do sit down and talk to people all the time and I see people's struggles and they all have different meanings for and different ways of expressing their struggles and I just think this was mine and (pause) I kind of what to normalise it a lot more. I'm really determined to kind of normalise my experiences and just (pause) I've had some shitty things happen, sexually abused and this and all this has just been a normal reaction to some horrible things and I'm not a screwed up, unwell person. (pause) I've just tried to deal with things the best I could at that point in time in my life.*
(Third telling, 10 years on, p.17)

EXTRACT 8b

Lisa: *[...] I've gone down paths that I never thought I'd go down. I think that's where I've grown in over the years in that I never thought I'd be going down particular paths, but I have and it doesn't mean I'm not a good person, it doesn't mean I'm not a capable person, it doesn't mean my choices have always been the best ones (pause) but it's my journey.*

(Third telling, 10 years on, p. 22)

Lisa refused to see herself as a “sick patient” and over time reconstructed the meaning of her experience as a “normal reaction to some horrible things” (extract 8a). The implications of this is that she views herself as a person who is “OK” and who has responded to the events of her life in the “best” way she could. Through the lens of medical discourse, Lisa’s words might be understood as the words of an “anorexic” who is in denial

or repudiating an obvious fact. Herein lays the power of medical discourse to not only pathologise, but also to assume that any denial of the medical establishment's version of a person's reality is denial of an obvious fact. Through her argument against this version that she is disordered, Lisa shifts the shape of her identity narrative to self in context rather than on the received terms of individual disorder and pathology. Lisa also argues against the assumption that the "paths" (extract 8b) she has taken confer the moral status of a person who is "not good" and "not capable". Instead she owns her journey despite some of the decisions she has made along the way. In doing so, Lisa preserves her moral status from the pattern of erosion that follows on from disorder versions where assumptions are made that question a person's worthiness and capabilities.

EXTRACT 9a

Jane: [...] I feel that I am who I am because it happened. (pause) Sometimes I feel it would be great to be able to see, okay the path that I went down and then what would have happened if anorexia hadn't come into my life. Who would I have been now? Anorexia's helped me realise that I'm not perfect and also the empathy with other people that everybody has problems and not, very few people know how to deal with their problems [...] and just to accept, yeah, anorexia has been, I like that I've overcome something, I've fought something that had the capacity to take me down or take my life and I said no and I fought for life. So it's made me value what life is a lot more. [...] I don't think I fully appreciated what was going on because ten years ago when we first sat down I thought great I'll chat about it and it will be gone. I didn't realise that it would be something that will be with me my life, it's part of my story, it's part of what makes me up. **(Third telling, 10 years on, pp. 11-12)**

EXTRACT 9b

Susan: [...] that experience that you've had also does definitely shape you. It's so hard like I've said a few times now to separate the different experiences I've had because there's been a few, and how that shaped me, but they definitely do shape you. **(Interviewer:** Can you describe to me how) [...] - (pause) It's kind of things I think I've already said like about being more empathetic and more accepting of other people and I guess that's the main one really. **(Interviewer:** [...] and has it shaped what matters to you and what you stand for in your life do you think?) It has and it hasn't. As time goes on you kind of forget and sometimes I regret that I get too caught up and all the trials and issues in life [...] I would like to stay more in touch with it actually. I would have liked to have used that to have gone to other things and I haven't really but there's always that desire there [...] when I say I've kind of lost touch

with it a bit, I keep putting it on the back burner, but at the bottom of everything is this real well that's what I want to do [study/work as health professional] and it's specifically because of my experiences.

(Third telling, 10 years on, pp. 19-20)

Susan and Jane talked about how their struggles with food, eating and weight shaped who they understood themselves to be, particularly in terms of what they have come to value, including empathy and acceptance of others. Jane used a battle metaphor of fighting for life and through this, identifies that she has not only reclaimed life but has also developed a rich valuing and appreciation of life (extract 9a). She argued that this thing will never be “gone” because it is part of her story of who she is and therefore constitutive of her identity. Susan also did not want to forget her experiences and expressed a desire to stay “more in touch with” (extract 9b) the skill of “understanding” that she has developed through her experiences that forms the basis of hope that she may use such skills in the future. Forgetting means losing “understanding” or the insider knowledge she has developed through experiences of childhood sexual and physical abuse and enduring struggles related to eating, food and weight. In extract 9b, she expresses sadness, loss and regret related to not yet going onto “other things” in ways that fit with her knowing that “I can do these things”.

In refusing to author their experiences in terms of the notion of “recovery”, women were active in marking out boundaries in relation to the cultural forms they produced and reproduced. In particular women refused to author their experiences from the perspective of their history as gone as implicated in this was also an erasure of the identity positions that were generated within the context of enduring struggles (Holland & Lave, 2001). In rejecting recovery, the women set upon the task of establishing their own unique meanings through the generation of alternative speech forms that honoured their experience as a journey of self transformation.

“Letting go”.

EXTRACT 10a

Susan: *I suppose that at one particular stage I never made any effort to change because it was always going to be this way in fact the only thing I had was to try and get worse. I mean I wasn't like really thinking that I was on a death mission and I never really thought that I would die, but I*

suppose like for a long time I stayed in a very similar spot, because I was afraid. I didn't think there was anything for me that was different, and I was afraid to find out anyway. (First telling, p. 4)

EXTRACT 10b

Jane: *Yeah. Getting, getting better is a decision and, but also getting better - I used to be terrified, absolutely terrified that (pause) what, what will life be like if I don't control my diet? Will I become a blimp? Yeah, what is it going to be like? It's so unknown (pause) and yeah, what and, yeah, terrifying. The idea of getting better was just terrifying because I lived that way for so long. (Interviewer: So what enabled you to navigate yourself through that unknown?) Wanting to, just wanting to get better. Wanting, not wanting - the pain of where I was just had to be, was a bit worse than, than the pain of not knowing. [...] Not knowing what the future would be like because to me, and I've said in here, described anorexia as hell, it was. It was hell and to think there are people who have normal lives who are affected by this. Is that really possible? and hope, hope that it could really be true, yeah just the hope and people saying, numerous people over the years, saying, "You can do it, you're going to do it, it's going to be okay".*

(Third telling, 10 years on, p. 8)

Moving from the known and familiar was a source of fear for Susan (extract 10a) and terror for Jane (extract 10b). Central to this fear and terror was the absence of a vision of life lived differently – “I didn’t think there was anything for me that was different” (Susan) and fear of an imagined future - “what will life be like if I don’t control my diet?” (Jane). Susan argued that her struggle to “change”, rather than the position of “death mission” (extract 10a) was related to an absence of a version of herself outside an “anorexic” identity. “Death mission” is also a journey metaphor and Susan rejects the implicit implication in this perspective that she was acting as an independent, autonomous agent intending to deliberately harm herself through self starvation.

For Jane, the “decision” to get “better” (extract 10b) was less about being a free agent choosing to change and more about a question of “pain”, where the “pain” of where she was started to outweigh the “pain of not knowing” where she was going. Even though she did not know where she was going she had the courage to hold onto hope that where she was going was less painful than where she was at the time, which she depicted as “hell”. Jane’s hope for herself was built upon the hope of others for her. Hope is a position

from which Jane authors an identity that is based on the imaginative dimensions of her selfhood where she sees future possibilities in the face of fear, uncertainty and pain.

EXTRACT 11a

Naomi: *So I had to - for me to recover I had to let go of the anorexia, but what was I without anorexia? Who was I? What was left? There was nothing left, very few friends left, but who are you? (Interviewer: How did you come to that sort of process of grieving? Like do you remember when that happened and how you came to that point where you – it was like you were making a choice really when that happened, wasn't it? When you were starting to think well if give this up?) I think choice trivialises it, and makes it – makes the journey tokenistic because it was very traumatic. Letting go is huge. I mean, letting go of something that's defined you since you were eight, until you're, what, 17? Who are you?*
(First telling, p. 25)

EXTRACT 11b

Naomi: *[...]one of the hardest things was that grief of letting go, being, having the courage to let go of something that had consumed me for so long, and you know, it sort of like, I don't know, it's sort of like someone that could see and is now blind, do they only stay still or do they just try to keep walking blind? You know – you've got to work out – okay, I'm blind now, I've got to reinvent myself to work on, do you know what I mean?*

(First telling, p. 7)

When I introduced the notion of choice, Naomi sharply rejected it and argued that “letting go” is not a “choice (extract 11a). “Choice” is built on the notion of the person as an independent and autonomous agent who is making a choice between clearly marked out alternatives. Letting go meant walking “blind” (extract 11b) for a period of time as Naomi sought to redefine a life and identity that was sustaining for her. This period of walking “blind” might be conceptualised as the ‘betwixt and between’ (V. Turner, 1969, p. 95) phase of van Gennep (1960) and Turner’s (1969) rite of passage metaphor (White, 1997). This period has been conceptualised in terms of identity formation by White (1997) where in letting go of life as it was, a person is no longer who they were, nor whom they are yet to become. Naomi reconstructs the process of letting go of an “anorexic” identity as “very traumatic” because this was not only a journey of identity re-definition but also a process of letting go of something from which she had derived a sense of identity and worth for much of her adult life.

Invoking “grief” and loss as a metaphor for “letting go” (extract 11b), Naomi argued that she needed “courage” to face an inevitable loss. This grief framework invokes a different moral repertoire where letting go of an “anorexic” identity is understood as loss, rather than getting rid of something bad and wrong. Although this period of walking “blind” was characterised by fear and loss, implicit in Naomi’s use of “re” in “re-invent” is that in letting go of an “anorexic” identity, she did not enter into nothing but rather she drew on historical identity formations as well as a future vision of a life lived differently to assist her to reconstruct identity positions to move on to.

EXTRACT 12

- 1 **Sally:** *It just wasn't who I was It just wasn't who I was, I wasn't a loner, but it*
2 *was meaning that I had to be. [...] it wasn't fitting with the person*
3 *actually liked to be a part of something. [...] So you've got to be at a*
4 *point I think to give up anorexia where you are confident enough, I don't*
5 *know if confidence is the right word, that there's another life there or*
6 *enough life rafts or enough something to let it go. It's like people say why*
7 *do abused wives stay with their husbands? Why do mothers with kids with*
8 *disabilities let themselves get knocked around by this kid that might be*
9 *violent or whatever? Wherever you are in life I think you stay there*
10 *because at that time you feel you have a purpose and you're getting*
11 *something out of it or you're contributing to something. (Interviewer: Or*
12 *there isn't enough "life rafts" like you said) Yeah (Interviewer: to get out*
13 *of it. What were the life rafts that came to you to, that you could hold on*
14 *to as you let go of anorexia?) I think I knew that my mum would stick by*
15 *me no matter what. That (pause) I had another job that I actually had*
16 *another job lined up that I could go to, I found one; that I had friends*
17 *here, but I think there was also a lot more sharks than anything, as in*
18 *there were a lot more negatives that were coming to light about it the*
19 *longer that it went on that was scaring me enough to think well, maybe I*
20 *don't need 50 life boats in order to jump ship, maybe I only need two and*
21 *I found them because (pause)*
- 22 **Interviewer:** *Were any of them things about you as a person that you jumped*
23 *on to do you think? (Sally: No.) Senses of self? (Sally: No). Senses of who*
24 *you are in terms of (Sally: No), what you wanted for your life?*
- 25 **Sally:** *Maybe about what I wanted for my life, but not at a very deep level. I*
26 *think just at a very superficial (pause) (Interviewer: No. Not richly*
27 *described, very thinly described, but what that might have been that sense*
28 *that you were talking about in terms of ...) That connectedness.*
29 *(Interviewer: Connectedness.) Yeah. Just the isolation, that's one thing*
30 *that really sticks out about that, apart from your hip bones (laughed) is*
31 *the isolation. Just emotional, physical in every sense, you're disconnected*

32 *from yourself, from your real self maybe, from your community, from*
33 *your family, from everything. So I think it was more of the fact that there*
34 *were many more negative things coming to light and those life rafts were*
35 *basically offered by external things, not by you or not that you could*
36 *consciously identify at the time (**Third telling, 10 years on, p. 26**).*

“To give up anorexia” was a struggle and Sally re-authors the complexity of her lived experience at the time using the discursive tool of a metaphor of “life rafts” (extract 12, line 6) to move on to. In this stretch of text, my enquiry was intended to provide a discursive context for Sally to generate a thick description of her metaphor of “life rafts”, which is a central metaphor that she used to depict change and its associated struggles. On first enquiry, the most available subject position for Sally was built on a functionalist repertoire that constructs a version of the experience as serving a purpose where she was “getting something out of it or you’re contributing to something” (lines 10-11). What is obscured through using this functionalist repertoire is the question of power, where persons become acclimatised to their own oppression in a range of cultural and relational contexts.

In the context of my further enquiry (lines 12-14), Sally re-authored “life rafts” as “external things” (line 35) such as support by her mother and change offered to her through a new job (lines 14-16). Given her previous commentary where she talked about how her actions did not fit with who she understood herself to be (lines 1-3, analysed in detail in chapter 6, extract 2d, pp. 123-124), my enquiry shifted to questions of identity (lines 22-24). Within this context, Sally re-authored past events with alternative discursive materials that she comments as only superficially available to her at the time (lines 25-26). First, she understands her shift in terms of values where the life raft she was jumping on was “maybe about what I wanted for my life” (line 25), which was “that connectedness” (line 28). This version is pieced together with an intentional state repertoire (Bruner, 1990) where she re-authors past experiences in terms of her intentions, values and purposes for her life. In marking out “connectedness” as something she values, she is reminded of the extent to which she experienced “isolation” (line 29) through the experience and re-engages with the extent to which she disconnected from relationships, community and her “real self maybe” (line 32).

Within this alternative version, Sally re-authored her experience as ‘obstacles to being ‘me’’ (Malson et al., 2011, p. 33). This reconnection with oneself, others and the community was a dimension of the ‘recovery’ narratives analysed by Garrett (1998) who contrasted these with ‘the experience of ‘split’ self during the anorexic period’ (p. 98). For Sally, this disconnection with self was facing the real effects - “the many more negative things coming to light” (lines 34) - that became overwhelming such that she could no longer turn away from them. What was “coming to light” was that she was living a life that no longer fitted with who she understood herself to be in terms of her values; a values clash that shared similarities in form to the values clash experienced by other women in this research (for example Anne, chapter 4, p. 86 and Katie, chapter 6, pp. 134-135).

Therefore in addition to seeing the isolation more clearly, Sally develops associations that were previously unavailable to her at the time where “life rafts” included the identity position of a person who valued “connectedness”. Michael White (2007) has reinterpreted narrative practice, through drawing on the child development theories of Lev Vgotsky, as a particular form of social collaboration that provides a discursive context for persons to scaffold between what is known and familiar to what is possible to be known about their life and identities. What was known for Sally was that she let go of ‘anorexia’. What became possible to become known through this particular sort of enquiry was that letting go was about reclaiming ‘me’ in the form of an identity that resonated with her values, moving her away from isolation towards connectedness with self, others and her community.

These identity positions were unavailable to Sally at the time, such that she could not “consciously identify at the time” (line 36) this version of the sort of person she was and hoped to be. Within the discursive context of the research interview, space was opened up for Sally to experience discursive agency to reconstruct the meaning she ascribes to her past actions ‘to let it go’ (line 6). Re-authoring a past experience of a point that she gave up on “anorexia” on new and fresh terms provided scope for Sally to reconstruct her narrative in a form of an identity to move on to from which she might further align her life and relationships with the value of connection. Through metaphor, complex meanings and

social realities are not only captured but discursive materials became available to re-author past experiences into a sustaining identity narrative.

An identity to move on with.

EXTRACT 13a

Naomi: [...] I toured India and Nepal, and I had Christmas with Buddhists and Hindus and it was the most spiritual Christmas I'd ever had. [...] I think that was a very big turning point for me, in my own self-development. [...] I suppose it was that sort of self doing what I wanted to do, who I was exploring who I was through spirits, spirituality, faiths, philosophies, Eastern philosophy, finding out who I was, what makes me, me and what I value, what I want to stand for, what I don't want to stand for, those type of things. What- what's life? [...] It gave me something to move on with because if I was to let go of my anorexia well what'll I do? Who am I? and that gave me something to develop and explore, and obviously that's changed at varying times in my life since, but that gave me something to move to, something that was not destructive, something that was purposeful.

(First telling, pp. 13-14)

Naomi noted a “turning point” in her experience where she faced questions of identity in relation to the sort of person she was, is and hoped to be, in terms of values - “who am I?” and “what do I stand for?” (Extract 13a). Doing things differently and engaging in life in a different way provided a vantage point where she saw an image of life lived differently and therefore “something to move on with” and “to”. This image is retrospectively pieced together with an intentional state repertoire (Bruner, 1990) where the identity she was moving on to was defined in terms of purpose and “belonging”. Rather than her journey being confined to moving away from something that was “destructive”, Naomi negotiates the terms of her shift as an identity performance where she moved towards something she judged as preferable where her actions aligned with her values – “what I stand for”.

EXTRACT 13b

Sarah: [...] Was it Jung that said, “in order to overcome an addiction you have to have, it has to be replaced with, you’d know the quote better than I, but it was something like a stronger motivation; and it was in a private letter to a friend and remembering reading that and thinking what is more powerful than this “A thing”? and trying to find that, there was a

desperate struggle to try and find it. So within a couple of months there was a decision okay, get back into study, get back into work, etc and with that came I suppose a lesson of, if you want to go here you can't stay here and it's horrible and it's black and it's horrible and it's terrible and you desperately want to still maintain all of this because within this ball of darkness it was, is so much; and I think it's a ball of not only the secret world and a friend, but this whole ball of things that have not yet unravelled that in order to bring you into health.

(Third telling, 10 years on, pp. 3)

Sarah also reconstructed her journey as moving towards a vision for life lived differently that is “more powerful than this “A thing”” (extract 13b). As a health professional she draws on the perspective that motivation is derived from a vision of life that is “more powerful” than the person’s experience of life as presently lived.

If you want to move people, it has to be toward a vision that’s positive for them, that taps important values, that gets them something they desire, and it has to be presented in a compelling way that they feel inspired to follow.

Quote by Martin Luther King (as cited in Fuller & Taylor, 2008, p. 188).

This perspective informs the practice of motivational interviewing where the question is not “Why isn’t the person motivated?” but rather “For what is the person motivated?” (Miller & Rollnick, 2002, p. 18). From this position, change is not understood as moving away from something that is judged negatively, change is about moving towards something different that becomes judged as preferred. Implicit in this understanding is that the person has a vision for something different as they set out on their journey. Re-authoring her narrative from this vantage point, Sarah reconstructs change as relying upon this vision of life lived differently - “if you want to go here you can’t stay here”. Sarah’s struggle to locate this alternative “here” as preferable is because her lived experience is both “black” and “horrible”, yet also a “friend” and a “secret”. Through metaphor of “this ball of darkness” she has access to discursive materials to, not only depict this complex reality but also, generate a vision for life lived differently through the unravelling of this ball to reveal that which is concealed including hope for “health”. Hope is implicit in Sarah’s narrative, as with other women thus far she did not know where she was moving to, although hoped for something better. Where Sarah was moving to was ‘more than an absence of symptoms’ and, in their unique ways, other women articulated that where they

were moving to was the inhabiting of a 'more elaborated' identity (Malson, et al., 2011, p. 33).

EXTRACT 14a

Lisa: *I actually enjoyed the responsibility I had at work, like I felt like someone's actually listening to me like, someone's actually looking up to me and it was almost like I'm not a mad person, I'm actually presenting really well here and I actually liked this responsibility. [...] When I got sick and everything I've just seen myself so much as being mad and being anorexic and being a psych patient and it was almost like I had another role and I was "hey I'm not mad, I'm doing this okay".*

(First telling, p. 22)

EXTRACTS 14b

Susan: *[...] tech was a big turning point for me, doing something. I found that if I didn't eat then I couldn't sleep and if I couldn't sleep then it was hard to get to tech and being a perfectionist I had to be there and had to get the best marks and all that kind of stuff. So that sort of kept pushing me.*

(First telling, p. 6)

Susan: *[...] I didn't think I thought I would be doing it forever. [...] Well I kind of had this, just this little idea that I could do better things. Like I had these little ideas like I had things that I wanted to do with my life and some of them I still haven't done, but I thought, I knew that I couldn't achieve that. I did have the beginnings of an idea that I wanted to maybe do some study at the time and it was just going to take some time and I'd always wanted to do that, but I hadn't had any positive feedback about that in my own childhood [...] I didn't want to do that [in and out of hospital] forever, but it seemed really important at the time.*

(Third telling, 10 years on, p.5)

EXTRACT 14c

Sarah: *[...] by actually gaining a little bit [of weight], maybe it was a, perhaps it gave me a little bit more mental clarity [...] perhaps your mind starts to think well, you, you need, you desperately need to be fulfilled. [...] you don't want to stay trapped like this; you don't want to be like this forever. [...] once you are more well and you have the mental capacity to say well, you want to be able to live and be productive and, and do things that you want to do well.*

(Third telling, 10 years on, p. 3)

EXTRACT 14d

Katie: *[...] (pause) I guess it's a (pause) a waking up, a self-realisation, (pause) instead of, instead of looking at a projection on the screen, you're looking at a real person.*

(Third telling, 10 years on, p. 22)

Each of these women in their unique ways and at some point in their narratives had a vision for life lived differently. For Susan, Sarah and Lisa this vision was in the context of roles in work/study and experiencing themselves differently as they engaged in these pursuits. In taking on “another role” in her life, Lisa’s vision of an alternative identity from that of a “mad person” (conferred through an ‘anorexia’ diagnosis) became realised (extract 14a). Within this different role she was allowed to express herself and speak out without the identity label of “anorexic” or “psych patient”. In other words, she was allowed to be ‘me’ and she enjoyed the responsibility linked to this alternative presentation of self. Betwixt and between was therefore not entering into nothingness. Rather a feature of this phase between what was known and what was possible to be known was the realisation of alternative and preferred identities through *living* a different ‘me’.

Susan lived this different ‘me’ through her commitment to her studies (extracts 14b). She retrospectively re-authors this commitment as being built upon a “little idea that I could do better things” and questions whether she would have been able to “verbalise that at that time”. The imaginative dimension of Susan’s selfhood was in the form of this “little idea” about who she was that was eroded in her childhood. Through doing other things and juxtaposing this with being in an inpatient eating disorder unit, what was made clearer to Susan was that there was more to who she was and what she hoped to be than the course mapped out for an “anorexic” whose life was consumed by repeated admissions to an eating disorder unit – “I didn’t want to do that forever, but it seemed really important at the time”. Within this discursive context, imagination may be understood as a discursive resource that Susan used to piece together an identity on her own terms, yet it also provided scope for re-engagement of her history from a compassionate standpoint.

Seeing that there was more to her and her life after unintentionally gaining some weight, which led to “a little bit more mental clarity” allowed Sarah to see the “trap” she was in and how this was getting in the way of an imagined future possibility of living a “fulfilled” and “productive” life (extract 14c). Katie, on the other hand, re-authored her journey as waking up to a sense of herself as a person who had previously been obscured whilst she slept. She depicts this journey as waking up, seeing and realising who she is when she is not defined by the identity of an “anorexic”. She positions this as “looking at a

real person” and, following on from this; implicit in her journey is the negotiation of an identity that sustains her that is “real”.

For each of these women, acting differently in their lives was an entry point into the betwixt and between phase of change where they were sustained by an implicit hope and knowing that there is more to me and my life than life as presently lived. This construction of self is a ‘more promising position from which to begin to imagine a ‘recovered’ future self (Malson, et al., 2011, p. 33). Rather than change being limited to contexts of substantive turning points, these were moments of acting differently in their lives that women re-authored many years later on different terms in relation to the development of their preferred values identities. Baumeister (1994) has argued that a major mechanism of personality change is insight developed in the context of ‘identity change through the crystallization of discontent’ (p. 282). Implicit in a person’s discontent is what they accord value and this informs their commitments around change.

EXTRACT 15

1 **Jane:** *At the time (pause) when I first said to my mum sort of 17 or 18, listen*
2 *something’s wrong I need to get some help she sent me to a psychologist*
3 *who immediately said “you feel guilty for your grandfather’s death or for*
4 *what you did stealing from your grandfather” and at the time I*
5 *completely said, “No, you’re wrong”, can’t think of the word, like threw*
6 *it away, “that can’t possibly, can’t possibly be that simple” and I can see*
7 *through reading that (transcripts) it was that, that it was so close to the*
8 *bone that I just didn’t want to hear about that. Didn’t want to (pause)*
9 *didn’t know how to deal with those feelings [...] (when her mother found*
10 *out) They (Jane’s parents) were dealing with him (Jane’s grandfather)*
11 *going into a nursing home and him dying as well and mum said to me at*
12 *some stage before his death she just couldn’t deal with it, with the*
13 *betrayal, she felt betrayed and she said, “You’re a no person to me”.*

14 *[...] it wasn’t until most probably 16 or 17, [...] I’d lost five kilos or*
15 *something and they both (her parents) said, “Wow you look fantastic”*
16 *and to me it was oh praise (pause) and that I believe is when I associated*
17 *oh if I’m thin then they’ll love me more, I’ll be perfect. [...] So that’s*
18 *when anorexia stuck, started to get a stranglehold and so to be able to*
19 ***identify** that and go wow I can picture when the, I suppose, the emotional*
20 *need for approval happened and then I found a way that, oh, if I’m thin*
21 *they (pause) I’m, it’s okay, they love me. [...] and through finding a*
22 *counsellor (psychologist) who fitted me and he said, “I think this is*
23 *what’s going on” and he just said, “You need to go ask your father”, and*

24 *asking dad. Yeah, I was a mess. I can still remember the day he just*
 25 *looked at me and went, “Yeah, I forgave you ages ago”. What? (pause)*
 26 *and from that healing started happening (pause) and from then the last*
 27 *two years [...] there’s been that lessening of that need for approval.*

(Third telling, 10 years on, pp. 2-3)

In her third telling, 10 years on, Jane reconstructed her experience into a coherent narrative where she understood how seeking her parents’ approval through being thin was a way of reclaiming a sense of identity and moral worth after stealing from her grandfather and being told she was a “no person” by her mother (line 13). This loss of identity through her mother’s eyes was followed by a desperate attempt by Jane to be seen as a person by her parents. Jane’s experience of losing weight was one way that she noticed herself as moving from being a “no person” to being elevated in moral status as a person worthy of their approval. Although she was not ready to accept the psychologist’s interpretation, she recognised that his approach “fitted me” (line 22) and she acted from his recommendations to ask her father for forgiveness. From this she recognised two things. First, that her father had already forgiven her and second, that she could have an identity for herself that was less defined by her parent’s opinions of her, a “lessening of that need for approval” (line 27). Central in her journey was a redefinition of identity where she reclaimed a version of herself that I am not a “no person”. Rather than a narrative saturated by accusations, guilt and an impoverished sense of moral worth, in this stretch of text Jane re-authors a sustaining narrative that traces her reclaiming of identity as a person of worth.

A journey of healing.

EXTRACT 16a

Naomi: I think if anyone thinks they’re going to recover from anorexia and think there’ll never be a tiger in their vision, they’re setting themselves up for failure; and I think the clinician thinks that’s the aim of recovery, they’ll never have one person to leave their room recovered from anorexia. [...] There’s no full stop, there’s no full stop. It’s a lived experience that keeps continuously fluctuating. *(Third telling, 10 years on, p. 5)*

EXTRACT 16b

Naomi: [...] and you know, it’s probably healing not recovery. [...] Healing is more gentle, it’s more compassionate, it’s more spiritual, it’s more of a journey, it’s not totally logical in the sense that there’s an ending, there’s

no full stop at the end. [...] healing is more important than recovery. From the recovery perspective, I'm dead and gone. (Interviewer: Can you tell me what resonates with that meaning in?) It becomes part, it's the tiger, it's moved in, it's part of my image, it's still there, it sits there. It's a part of my (pause) it's constantly part, it infiltrates who I am. It's the oozing, it's still there. If life moves on it would be a box and you've gone past it. It's like a river, it keeps going you take all the water with you, you don't leave it, you don't leave some of the water up there. It all goes down the river. [...] You might move on from the clinical aspect, the medical story, but you don't move on from the experience. [...] and I think that's where people get caught is that yes, you've moved on from maybe the clinical experience of cancer. My friend's moved on from cervical cancer. Has she moved on from having cervical cancer? It infiltrates exactly, absolutely who she is.

(Third telling, 10 years on, pp. 11- 13)

Ten years on, in rejecting the dualism of recovery as an absence of illness or a “full stop”, Naomi invoked the metaphor of a “tiger” (extract 16a) that was analysed in chapter 6 (extracts 5, pp. 128-129). This metaphor provides scope to author a complex social reality where there is “no full stop”; this expectation of achievement of a reified end state sets the person “up for failure”. Through use of the discursive tool of metaphor (“tiger” and “river”), Naomi captures the complex reality of a multi-authored identity that is constituted by a past “medical story” and the “clinical experience” that has infiltrated, yet no longer dominates, “who I am”.

Higbed and Fox's (2010) enquiry into women's struggles with the perception of their experiences as illness found that women both externalised ‘anorexia’ as well as experienced ‘anorexia’ as part of them. From this they conclude that therapy should aim to assist the person to ‘maintain life with AN’ (Higbed & Fox, 2010, p. 321), thereby making allowances within a dualistic framework for the person to live with a little bit of ‘anorexia’. The dualistic repertoire on which ‘anorexia’ is built confines not only ways of speaking about this thing but also ways of conceptualising shifts in women's relationship with this thing and, following on from this, restricts the possibility of engaging the person in ‘transformative dialogue’ (Gergen & McNamee, 2000, p. 342) about their experiences over time. Naomi externalised and depicted her lived experience as a ‘tiger’ in her life. She argued against my assumption that totalised the tiger as problematic. The tiger for Naomi, in and of itself, was not a problematic force in her life. What was potentially problematic

was when she pulled the tail of tiger and it bit her, in other words, her relationship with the “tiger”.

The ‘tiger’ had also resulted in metaphorical and physical scars that she continued to live with that were the embodiment of her lived experience and shaped the sort of person she had become. The ‘tiger’ was not going to somehow be gone from her life and consciousness and it was not so separate from her as to not be part of her. Nevertheless the tiger was not a dominant force in her life and she experienced herself as an active agent to the extent by which the tiger influenced her life. Rather than a dualistic concept where the tiger was either present or gone, she had made a life and identity for herself to live around the tiger. The question that follows on from this is: was Naomi learning to ‘maintain a life with AN’ (Higbed & Fox, 2010, p. 321) or is she reclaiming her life and an active agent in negotiating the terms of her relationship with the tiger? The implication being, does language matter?

Rather than taking on the dualistic category of ‘recovery’ to depict her lived experience, Naomi argued for the alternative position of “healing” that captured the “spiritual” dimension of her experience as an identity journey (extract 16b). “Healing” is built upon a recursive rather than a dualistic repertoire where the experience is construed as an ongoing journey of transformation through definition and redefinition. Michael White has also developed a particular perspective on “spirituality” that is pieced together in terms of identity.

The spiritualities of the surface have to do with material existence. These are the spiritualities that can be read in the shape of people’s identity projects, in the steps people take in the knowing formation of the self. [...] This is a transformative spirituality, in that it so often has to do with becoming other than the received version of who one is.

(Hoyt & Combs, 1996, p. 36)

Perhaps what Naomi is referring to when she talks about “healing” being “more spiritual” is the dimension whereby she was transformed by the experience that Michael White names an “identity project”. This identity project is living and working within, ‘complying, resisting and transforming’ (Reynolds & Wetherell, 2003, p. 493) possibilities both within and outside particular cultural categories. Thus in marking out the boundaries

of self and other, the women refused to be colonised by the other of the dominant ‘anorexia’ discourse. Instead they resisted, argued and reconstructed versions of their lived experience using their own terms, meanings and discursive tools to re-author their experiences as journeys of transformation of self. Garrett (1998) has argued that such journeys of self-transformation are not a great deal different to other contexts of human suffering to which persons respond through searching for ‘better ways to be, in all its manifestations’ (p. 188). In this research the women also responded through searching for different ways of reconstructing the meanings of their lived experience into narratives that were personally meaningful, sustaining and compassionate.

Chapter summary

“Recovery” is the antithesis to illness and the marker of its endpoint. Implicit in “recovery” is the understanding that this is a state that a person reaches where there is an absence of illness, an endpoint where the illness has “gone”. “Recovery” was a troubled, socially constructed category that the women used, qualified, sought to re-define and rejected as a subject position from which to author their identity narratives. In their refusal of the category of ‘recovery’, they took up alternative subject positions to define their experiences. The most available positions for the women to author enduring struggles was that this was “an addiction” or as an internal personality trait (“just me”). The troubling of “recovery”, however, also gave way to alternative positions that were built on alternative metaphors outside the dominant metaphor of illness.

Relational metaphors provided some women with a discursive tool to mediate complex meanings and social realities and therefore an alternative context to author their narratives from the dualism of ‘anorexia’ discourse where the experience is either present or gone with a return to a pre-anorexia state. These metaphors enabled these women to both linguistically separate their identity from this thing (Tomm, 1989), yet to also author their experiences as an enduring struggle that had implications for their identity formation. Metaphor also gave rise to new insights through overturning categories of self-definition and imaginatively resituating women in the context of their lives (Kerby, 1991). The women therefore used metaphor to position and construct their identities and experiences as dynamic, relational and contextual in ways that encapsulated personal agency, reclamation and

journey and in doing so, expanded “the horizon of possibilities” (Bruner, 1990, pp. 59-60) for themselves in the context of their lives. The women’s use of metaphor resonated with Catherine Garrett’s (1998) argument for the significance of metaphor in self transformation.

Because our experience in the world is embodied experience, our bodies are always reflected in the metaphors we use in language.

(Garrett, 1997, p. 269)

The women in this research argued in many different ways and within different discursive contexts that their experience shaped them, was part of their story and constitutive of their identities. Although some of the women reconstructed their narratives in terms of growth through connection with alternative and preferred identities (frequently constructed through a vocabulary of values), not all women understood their experiences on these terms. The women did not have to re-engage with their histories on growth terms, such as articulated through theories of post-traumatic growth (Tedeschi & Calhoun, 2004), to narrate sustaining narratives. What sustained the women was their remembered history that was an active process of re-engagement with their historical struggles through understanding and self-compassion.

The stories of women’s lives did not only describe to them who they are, they were the discursive materials that constituted their identities; therefore the idea that these stories could somehow be gone or erased through a “recovery” perspective was implausible. Women could not forget their experiences, nor did they choose to. Their refusal to confine their identity narratives to the terms of “recovery” signifies their refusal to give up and erase their history. Instead their identity narratives may be read as what Holland and Lave (2001) have termed ‘history in person’, which was honoured by their refusal to take on the colonised discourse of recovery. The women did not see themselves as moving past their history or leaving their history behind. Their history was an identity position from which they authored and re-authored a narrative that was acceptable to them (Wetherell, 2005). Through their journeys, the women reclaimed themselves, re-engaged in life in ways that mattered and formed a richer connection with their values as well as their hopes that constituted the imaginative dimensions of their selfhood. Their refusal to take up the

position “recovered” may therefore be understood as a refusal to give up identity positions that are derived from both historical and imaginative dimensions of selfhood.

Shifting from their known ‘anorexic’ identity was imbued with fear; this shift may be conceptualised using a rite of passage metaphor (van Gennep, 1960; White, 1997) as the ‘betwixt and between’ (V. Turner, 1969, p. 95) what was known towards what was possible to be known about their lives and identities. As discussed in chapter 2, Catherine Garrett (1998) has conceptualised recovery from ‘anorexia nervosa’ using this rite of passage metaphor where ‘anorexia nervosa’ itself is understood as a ritual that is betwixt and between and the experiencing person viewed as a ‘ghost-like ‘liminal being’ (Kessler in Garrett, 1998, p. 127) not who they were and not who they are yet to become. In this present analysis, ‘anorexia nervosa’ is itself understood as an identity position and central to this betwixt and between period is the migration of identity from this known dominant ‘anorexic’ identity position into the unknown. Letting go of an “anorexic” identity not only lead to uncertainty and fear for these women but was experienced by one woman as traumatic. The conceptualisation of recovery from ‘anorexia’ as traumatic through the consequent questioning of whom am I now, has been reported elsewhere (Halse, Honey, & Boughtwood, 2008); central in this trauma is an identity crisis. In this present study, as the women re-authored this movement from their known identity as an ‘anorexic’ into the unknown, they were clear that this was not a choice; the notion of choice that assumes the person to be an individual autonomous agent making change in their lives was argued to be too simplistic, minimising and trivialising the significance of their journeys. These women’s journeys were entangled with their identities (Halse, et al., 2008) and central to their journeys was self-redefinition through the recognition and (re)claiming of preferred identities.

Malson has argued that where a vision for something different is ‘unimaginable’, change is ‘unattainable’ (Malson, et al., 2011, p. 29). The women’s reconstruction of their narratives of change was that as they departed from their lives as known, they did not enter unassisted or into nothing. Within some contexts, the women’s entry into the unknown (or the ‘betwixt and between’) was through acting differently in their lives and reconstructing alternative and preferred identities within these alternative contexts of living. Within other

contexts, women's actions were supported by historical narratives of self where they drew upon a sense of knowing that this is not all there is to 'me'. This was a 'more promising position from which to imagine' future selves (Malson, et al., 2011, p. 33) and to inhabit this imagined space. This vision of alternative identities therefore relied on both historical and imaginative dimensions of selfhood and informed women's hopes for future possibilities.

Within the discursive context of the research interviews that drew on lines of enquiry inspired by narrative therapy (White, 2007), what was previously available to be known by these women about their journeys was scaffolded towards what was possible to be known about their journeys in terms of their life and identity formation. Michael White (2007) has aligned the discursive space of narrative enquiry with Vygotsky's (1986) 'zone of proximal development' (p. 187) where children's concept development (that has implication for their abilities and intellectual development) is understood as contingent upon their social context to provide a scaffold between what they know independently and what is possible for them to know through collaboration with adults (White, 2007). White (2007) has argued for the transporting of this notion beyond the context of child development to any form of social collaboration that provides a discursive context for persons to be assisted to traverse between what is known to what is possible to be known about their life and identity. Women's re-authoring of their journeys in terms of what was possible to be known about their life and identities was frequently built on metaphors that carved out not only versions that could handle the complex contingencies of their social realities but also versions that tapped into the imaginative dimensions of their selfhood. Rather than coming from nowhere, these versions built upon already established narratives of the sort of person they were, are and hoped to be.

These women's identity journeys may also be understood as a form of "transformative spirituality" (White, 2000, p. 132) whereby they knowingly reshaped their self understandings from self as individual pathology to self in context and on their own terms. Enduring senses of self that had emerged in the context of the women's struggles were therefore located and attributed to the interpersonal contexts of their development rather than with an individual self deficit repertoire that produces the version of a

disordered self who is “anorexic”. These women’s visions for life lived differently were frequently developed through the processes of working out what mattered and was of value in their lives, the lives of others and the society in which they lived. Only then were women in a position to ‘choose’ whether or not they were able to live these values fully if their lives remained unchanged.

Throughout this analysis, I have sought to rethink theories of ‘anorexia nervosa’ in much the same way that theories of grief have been reconceptualised (Attig, 1996; Klass, Silverman, & Nickman, 1996; Moules, 1998; Moules & Amundson, 1997; Moules, Simonson, Prins, Angus, & Bell, 2004; White, 1989) that is, from a pathologised state from which recovery and an ‘end’ to grief and return to some sort of pre-morbid state is possible towards the understanding of anorexia, like grief, as a ‘life-changing experience’ (Moules, 1998, p. 143) that renders a person’s world ‘forever transformed’ (Neimeyer, 2000a, p. 86). Similar to the normative discourses that underpin stage models of grief theories (Attig, 1996), a medical recovery model for ‘anorexia’ with the expectation that a person returns to some sort of pre-morbid state may obscure and thereby fail to resonate with the unique experiences of a person. In conclusion, women rejected the received version of medical discourse of “recovery” to construct their journeys over time. This I did not anticipate. Rather than forgetting, women wanted to remember. Rather than being gone, the experience shaped their self understanding. Rather than returning to some pre-morbid state defined as ‘recovery’, women honoured their experience as a journey of self-transformation that provided them with opportunity for growth and rich connection to their values. The heart of this journey included, but was not limited to, growth meanings. Women spoke about their journeys on their own terms, used their own metaphors and derived unique meanings, rather than being confined to the terms of an illness metaphor. This was a journey of women claiming their voice.

Chapter 8: Discussion and Conclusions

To have voice is to be human. To have something to say is to be a person. But speaking depends on listening and being heard; it is an intensely relational act.

(Gilligan, 1982, 1993, p. xvi)

Central in this research study is the women's voices. These women had something to say that had significance to their personhood as well as more broadly, to how so-called 'anorexia nervosa' is understood at this point in history. These women's voices were also generated within the dialogical space of the research interviews and over time. This research has sought to capture the shifts for women (and myself as researcher) both within the research interviews as well as over time. The uniqueness of this research is in its attempts to capture both women's voices and what they had to say over ten years as well as how their voices have depended on what I have heard and understood as researcher. This 'relational act' of speaking and listening or the dialogical space between researcher and research participant is frequently neglected in critical discursive/discourse research and more broadly the field of psychology itself. Therefore, this research study has implications for not only how so-called 'anorexia nervosa' is understood but also, more broadly, for understanding psychology research as an inescapably relational act that has implications for practices that include but are not limited to critical discursive/discourse analysis.

Contributions to 'anorexia nervosa' research

The majority of 'anorexia' research has inadvertently reified the category itself to *be* a person's reality rather than one of a number of possible *versions* of their reality (Potter & Wetherell, 1987). Within such contexts, 'anorexia' has become an uncontested way of speaking about the lived experience of a person who has a troubled relationship with their body and engages in particular body shaping and food refusal practices. From a critical discursive and discourse perspective, 'anorexia' is a 'discursive object' (Allen & Hardin, 2001, p. 167) and a 'discursively constructed social category' (Reynolds & Wetherell,

2003, p. 490) that, rather than merely being descriptive, marks out and confines the terms of speaking to a specific discursive field. Drawing from dominant medical and psychiatric discourse, this discursive field constructs lived experience as illness and disorder where, to qualify for diagnosis, a person is required to meet a symptom checklist and, from this and other research (for example, Hardin, 2003a) to reallocate personal agency to the illness.

Diagnosis marks out two pathways - the person either continues on to develop a chronic illness or they return to a pre-illness state or recovery. Therefore a large body of research has been concerned with discovering causes and a cure for an illness that is argued to be difficult to treat. Although at the heart of 'anorexia' research is the intention to alleviate suffering and provide hope for a pathway towards 'recovery', confining the terms of speaking to the dominant medical discourse shapes the experience of the person, with a dualistic repertoire into the identity positions of sick, that is, 'anorexic' or disordered, or the antithetical position of recovered and a return to 'normality' where the illness is assumed to be gone. Whether intentional or not, confining the terms of speaking to the dominant discourse is inevitably an act of power (Foucault, 1980) that has real effects on the lives and identities on an individual person and groups of people. One of the effects is that those 'inside' this discursive construction are confined and silenced in 'the ways and means they have of storying their experience' (A. Lock, et al., 2004, p. 277).

This research study has sought to analyse how a group of women who came to identify their experience as 'anorexia nervosa' authored their narratives within a context not confined to 'anorexia' talk. This discursive context, derived from a narrative therapy paradigm (White, 2007; White & Epston, 1990), provided scope for these women to speak in their own experience-near terms (Geertz, 1975) using an externalised repertoire with particular interest in how they themselves ascribed meaning to their experiences and ways they had shifted their relationship with so-called 'anorexia' within and between interviews. Within this discursive context, subject positions were refashioned and alternative positions generated that allowed these women to re-author their identity narratives, which had implications for their life as lived.

The women in this research used, were troubled by, and negotiated their identities in relation to the category 'anorexia nervosa'. Where understanding their lived experiences as

‘anorexia’ had become an unquestionable ‘fact’, the options for these women to speak about their experiences on their own terms appeared to disappear. This diminished discursive agency had implications for how these women defined their subjectivity in terms of the sort of person they were, are and could be. At other points in the interviews, where some women argued against the ‘fact’ that they were ‘anorexic’ on the terms of the dominant discourse, they refashioned alternative subject positions from the discursive materials available to them at the time. At these points, they were not denying there was something wrong, rather they were refusing to author their experiences on the terms of the dominant ‘anorexia’ discourse that positioned them as sick and disordered. A dilemma in authoring lived experience as ‘anorexia’ was that in order to claim the status of a ‘real anorexic’ these women were invited to, on the terms of medical discourse, reallocate personal agency to the illness. This question of personal agency became both a discursive reference point for an ‘anorexia’ classification as well as a discursive knot that entangled women in argument, justification and negotiation as they sought to meaningfully author their lived experiences.

Another dilemma for the women was a totalisation of the experience of ‘anorexia’ as an entirely negative force in a person’s life. Built on a moral repertoire, ‘anorexia’ within this context is assumed to be bad and recovery to be good. The women in this research argued against this simplification of their lived experience as entirely negative. The moral status of a person both is preserved and eroded with an ‘anorexia’ classification. Previously contentious actions become understandable and the person is construed as less culpable because they have an illness and, by implication, their actions are out of their control. Their experiences are understood as genuine suffering by their immediate social networks and the wider community. On the other hand, the authenticity of their experience as genuine suffering is eroded when the person experiences themselves as being active in shaping themselves to be ‘anorexic’. This personal agency in making oneself ‘anorexic’ disqualified these women from the status of a ‘real’ or ‘genuine anorexic’ and they took up a fraudulent identity position of a ‘fake’ or ‘pretend anorexic’. Suffering is deemed legitimate if arising from influences that exist outside the realm of control of the individual (for example, an out of control illness). Outside this context the person is not only assumed to be fraudulent and

untrustworthy (by themselves and others), their material access to treatment services also becomes questionable.

This moral discourse permeates treatment approaches and it has become commonplace for health professionals to engage in prolonged debates centred upon seeking to convince the person that what they are doing is wrong. A moral repertoire is also frequently invoked in a number of therapeutic contexts where externalisation is used as a therapeutic tool, ranging from the construction of ‘anorexia’ as a ‘terrible illness’ (J. Lock, et al., 2001, p. 53) to metaphors such as “the prison” (Maisel, et al., 2004, p. 29). I was influenced by this assumption that constituted women’s experiences as entirely negative to the extent that it shaped some of my lines of questioning. Many women responded to such questions with argument, debate and justifications, including positioning of their experiences as a “friend”. Illness is a metaphor (Sontag, 1991) that totalises lived experience as negative and problematic. This establishes a context where the task of therapy/intervention becomes adversarial, to eliminate the problem from a person’s life (White, 2007). Although for some people and within some contexts these adversarial metaphors may be helpful, when they dominate there is a risk that alternative metaphors are obscured. Although most women in this research found ‘anorexia’ to be troubled, the helpfulness of an illness classification was nevertheless significant for one woman in this research who found comfort in understanding her lived experience as illness/disorder over which she had no control because the illness discourse enabled her to live with the grief and loss of the death of her first baby, which she attributed to the unintentional real effects of starvation and purging whilst pregnant.

Recent research that sought not to impose an illness perspective on women’s accounts (Higbed & Fox, 2010) found strikingly similar commentaries to those of the women in this present research study. Women’s struggles to locate their experiences in relation to an illness classification were understood by these researchers as signifying of the nature of a disorder that is “functional and illogical” and “confusing and unexplainable” for women (Higbed & Fox, 2010, p. 320). Ascribing such meanings to women’s accounts gives women permission to speak about their perceptions of ‘anorexia’ as illness but their expressions are confined to the terms of the dominant ‘anorexia’ discourse that is itself left

intact and ‘shielded from transformation’ (Sampson, 1993, p. 1220). In the absence of critical reflection on behalf of both research participants and researchers themselves, the body of research into so-called ‘anorexia’ will continue to be articulated in the terms of the dominant and privileged ‘anorexia’ discourse. The experiencing person will continue to be primarily understood as disordered with an out of control illness that is illogical, confusing and inexplicable. They will continue to be constituted as “other” (Halse & Honey, 2005, p. 2144), incapable of making decisions and speaking for themselves and stripped of rights and responsibilities to speak on their own behalf and on their own terms (Saukko, 2000).

Another implication of these women’s refusal to take on an ‘anorexic’ identity was that they were caught in what seemed like an un-discursive space that existed outside discourses that construe the thin body as either signifying control/achievement or illness/disorder. These discourses mark out a range of subject positions and identity claims that have implications for the moral status of the experiencing person. These moral claims on a person’s identity are regularly played out in magazines and newspapers that intermittently accuse various models and celebrities for being ‘anorexic’, thereby stripping them of the status that arises from their embodiment as the ideal woman. Nevertheless, in their refusal to position their experiences as control or ‘anorexia’, the women in this research found themselves struggling to find words, terms and concepts to author their narratives. Following on from this struggle, some women shifted from re-authoring their experience on the dominant illness metaphor to alternative metaphors that used experience-near concepts (Geertz, 1975) and were relational (for example the “burden”, “tiger” and “volcano”) rather than built on negative totalisations.

These relational metaphors enabled the women who used them to tap into the imaginative dimensions of their selfhood and, through the marking out of both the inside and the outside of their experience, they generated the possibility of a life lived differently. These women were then in a clearer position to “choose” whether or not they wanted to continue to live the life dominated by this “thing” (for example the “burden”, “tiger” and “volcano”) and whether or not they wanted to revise their relationship with “this thing”. Rather than externalisation with the intention of complete separation of the person from this “thing”, use of these metaphors provided scope for more of a relational externalisation.

Within this discursive context of relational externalisation, the women were freed to talk how their relationship with this “thing” had shifted over time and the implications of these shifts for their life, relationships and identity formation.

Therefore, within the particular social context of the research interview, the women experienced discursive agency or ‘choice’ to speak about their experiences outside an ‘anorexia’ discourse, to negotiate alternative identity positions and, following on from this, to generate experiences that fitted with the kind person they wanted to be. Some women commented that these different ways of looking at their experience were not previously available to them prior to the research interview - these became new ways of looking at old experiences (Hewson, 1991) or the re-authoring of new narratives from old stories (White, 1995).

Values were central to the women’s discernment of the kind of person they wanted to be. Reflecting on their actions in terms of the real effects and impacts on their lives and identities, some of the women in this research began to wonder if what they were doing fitted with the sort of person they were and hoped to be. These women started to look at their actions as clashing with their self-reflected values and their preferred identities. Values are built on a moral repertoire that is pieced together to produce accounts where a person understands objects and actions as desirable, worthy, useful, important, favourable etc. (Sadler, 2005). The human capacity to evaluate self-reflected values has been argued as an integral feature of human agency (Taylor, 1985) and identity formation (Calder, 2009). At different points in their narratives, different women evaluated their actions and the meaning of their lived experiences in terms of values. Within the context of connecting with what mattered, alternative discursive resources became available to women that provided the materials for them to reconstruct their identities and provided a foundation for them to commit to act differently in their lives and in doing so, shift their relationship with so-called ‘anorexia’.

Talking in a discursive space outside the dominant ‘anorexia’ discourse therefore produced shifts for a number of these women. Significant in this process was speaking on their own terms and the identification of what mattered that contributed to their shifts towards a new life and a different relationship with this “thing”. Through argument, debate

and justification, these women preserved their own meanings as they defined their subjectivities. Implicit in their arguments was that their journeys were significant and meaningful and they therefore struggled with the expectations marked out by medical notions of recovery that they would one day return to some previous pre-illness state. Recovery both provided and undermined hope; providing hope of something different but undermining hope when the achievement of this state proved questionable, if not impossible. Authoring lived experience through the medical notion of recovery also risked a meaningful journey being rendered hollow.

On the other hand, the understanding of their lived experiences as an identity journey provided scope to author ways that the women were transformed through their experiences and suffering in a range of different ways that were not always limited to growth narratives. There is little doubt that women were transformed through their experiences, although not necessarily in the ways that have been previously proposed as a through a rite of passage metaphor with the negative rite signifying their period of suffering and loss of identity to a positive rite where they engage in rituals of healing whereby they reconnect the self with body, nature and reintegrate into society (Garrett, 1993, 1997, 1998). Through drawing on a range of religious metaphors, Garrett (1998) has depicted the journey as a spiritual journey, often aligning this journey as a religious conversion experience, that ‘almost always involved some kind of descent into an ‘underworld’ of chaos and suffering, the a return to a fuller life, almost as a new person’ (p. 186). Rather than elevating the status of the journey with metaphors that draw on moral repertoires to justify the worthiness of the journey, the women in this study drew on metaphors that captured the complexity of a journey that did not always make sense, was not always associated with growth through suffering although nevertheless had implications for their identity formation.

Women’s experiences were in a constant process of definition and redefinition, change and flux over time and within different discursive contexts. No one metaphor was able to capture the complexity of all these women’s journeys but their journeys were nevertheless significant such that they could not and would not forget their experiences. The relational metaphors used by these women captured the active and ongoing process

that constitutes identity formation through not only richly depicting life as presently lived but also through tapping into the imaginative dimensions of selfhood, provoking images for what might be possible for their lives and identities. The common thread for these women's experiences was not a particular researcher selected metaphor but rather the notion of identity journey that provided coherence and meaning to these women's experiences and a richer understanding of themselves in terms of both their struggles and capacities.

Looming behind this analysis, as well as behind therapies that have sought to apply post-structuralist ideas to therapeutic practice, is the question of whether or not engagement in critical reflection necessitates the rejection of human intentional states, such as values, hopes and desires. Implicit in this question is another question that is, what is the site of critical reflection? Foucault's critique of humanism implied that assumptions informing modern therapeutic practices, particularly those borne from particular understandings of identity, were not only questionable but potentially 'dangerous' (Sawicki, 1991, p. 98). Although Foucault's efforts were future-orientated with a focus on making less familiar and necessary traditional ways of thinking, categorising and living, Jana Sawicki (1991) has argued that this does not 'necessarily invalidate the efforts of those who continue to struggle with the constraints of the old ones' and that 'we are free in being able to question and re-evaluate our inherited identities and values, and to challenge received interpretations of them' (p. 101).

The research interviews generated a context for this 'freedom' through engaging these women in conversations whereby they questioned not only what they valued but also what they were relying on in their discernments as they ascribed meanings to their experiences as identities or what Michael White (2000) has termed engagement with 'the absent but implicit' (p. 35). Through the generation of multi-storied accounts over time, what became available to the women was an array of discursive materials that were previously unavailable to them when they sustained an un-storied or single storied account of their lives. These discursive materials became available within a relational context, where reflection from one person to another (in the research interview) with a focus on meaning making, meaning reconstruction and thick description provided a context for rich

story-making and the generation of multiple narratives. Alternative discursive materials also frequently became available to women through argument, negotiation and seeking to explain the complexities of their lived experiences. Within the dialogical space of the research interview, the women took up and latched into alternative discursive materials, particularly when they were used to reconstruct meaningful accounts of their lived experiences that resonated with the sort of person they were and could be.

The women in this research challenged the inherited identity of ‘anorexic’; this identity was more troublesome than helpful for most women. In their re-evaluation of this identity, they generated alternative metaphors that required less effort, resistance, argument and debate to both depict and make meaningful their lived experiences and identity journeys over time.

Contributions to critical discursive/discourse research

This study has wider implications for the study of discourse, particularly the possibility of addressing issues related to identity and personhood over time. These implications pose a challenge to research that focuses uni-dimensionally on analysing participant’s narratives with little consideration for the influence of researchers on the subjects they choose to research.

Few, if any, discourse/discursive studies have interviewed participants over many years. Interviewing women over ten years provided a unique opportunity to explore potentially sensitive complex and evolving processes (Murray et al., 2009) that were facilitated by a relationship between the researcher and these women. Few researchers address the significance of the relationship between the researcher and those they engage. This longitudinal study also enabled not only the researcher but also the women to compare themselves with their earlier selves. This had profound implications for the women in not only storying their experiences and identities but also in renegotiating their preferences for their lives and identities in the presence of another. This longitudinal focus also provided scope for the researcher to reflect upon her own assumptions that might have both limited and facilitated the women in the active negotiation of their identity narratives.

This research takes into consideration the intersubjectivity that is at play between the researcher and the person whose experience they seek to research. Within this relational context, both participants and researchers experience opportunity to renegotiate their positioning. It is within this process or renegotiation by both researcher and participant that scope is provided for the development of rich identity narratives that may be witnessed by the other. This process of witnessing to an alternative story-line that resonates with who the person understands themselves to be also provides a context whereby these identity narratives constructed with alternative discursive resources may be latched into by the person and elaborated upon (White, 1995).

Few qualitative discourse studies turn their focus towards how researchers are positioned by the discursive materials available to them and how a researcher's positioning (whether or not examined at the time) might shape the narratives of the person whose experiences they seek to understand. This absence of focus on the researcher and how their lines of enquiry are also influenced by their positioning in discourse means that the analysis of what is a dialogical encounter between two human beings becomes a uni-dimensional or one-way account that is understood as existing outside this relational context.

For example, one of the few discourse studies into 'anorexia' that included the researcher questions in the data by Helen Malson (1999), neglected to address the shaping effect of the researcher's line of enquiry.

Tricia: I started thinking: but I am the anorexia. /HM: mm/ This is my identity ... it had become my identity ... that's a problem with it ... it can become an all consuming identity.

HM: Right (.) that that you feel you're, you're nothing else outside of it?

Tricia: Nothing else but anorexia ... it's like if I give up that name what else is there? / HM: right/ I'm still this shell inside. (Malson, 1999, p. 147)

The researcher's question "... you feel you're, you're nothing else outside of it?" had the effect of shaping this participant into constructing her self-understanding as 'Nothing else but anorexia' (Malson, 1999, p. 147). Analysis of this and other extracts contributed to Malson's (1999) theory of '... women's 'anorexic' bodies as disappearing bodies that signify a (feminine) 'anorexic' identity constructed as an identity-put-under-

erasure' (p. 137). The construction of an 'anorexic' identity as 'identity-put-under-erasure' is an interesting, albeit troubled conceptualisation that re-allocates agency from the person to 'anorexia'. This construct may also obscure other identity accounts that might be generated through conversations enquiring into how the person has responded to the impacts of 'anorexia' on their identity that Michael White (2000) refers to as the absent but implicit second story. My argument here is not that researchers seek the impossible task of dualistically separating themselves from the human experience they seek to research, rather that researchers address that inevitability that reality is co-constructed between the researcher and those who participate in their research.

This research study provides clues as to some of the processes by which alternative discursive resources might be generated through talk drawn from the paradigm of narrative therapy (White, 2007) and the utility of these lines of enquiry for qualitative discourse/discursive analysis. These lines of enquiry provided a context for the generation of narratives that were built upon alternative discursive resources included (but were not limited to) the multiple meanings a person ascribes to their experiences (thick description), the discursive resources they are relying upon to construct their accounts (absent but implicit) (White, 2000), their experiences and their responses to their experiences (double listening) and enquiry into intentional states (values, intentions and purposes that their actions speak to).

In addition to this, the importance of the relationship between the researcher and research participants that is often unacknowledged in qualitative research was highlighted in this study. Within this context, what became clear was the possibility of generating discursive space for participants to argue with the researcher's often unexamined assumptions that were shaping the research conversations. It was within the context of these arguments and debate that a number of participants generated, latched into and renegotiated meaningful accounts of their lived experiences and they authored this apparently un-discursive space with alternative discursive materials that existed outside the dominant 'anorexia' discourse.

This research is built on a position that challenges the dualistic separation that distinguishes the knower and the known and bears some resemblance to Karen Barad's

(2003) agential realist understanding of reality as existing in the “*intra-action*” (p. 815) between the inseparable subject and object/observer and observed.

It is through specific agential intra-actions that the boundaries and properties of the “components” of phenomena become determinate and that particular embodied concepts become meaningful [...] *relata* do not preexist relations; rather, *relata*-within-phenomena emerge through specific intra-actions. Crucially then, intra-actions enact *agential separability* – the local condition of *exteriority-within-phenomena*. (Barad, 2003, p. 815)

This notion of “intra-action” or ‘performativity’ (Barad, 2003, p. 823), distinguished from the notion of “interaction” that assumes an independent reality prior to relationship, captures how reality is understood as “‘things’-in phenomena’ (p. 817). In the absence of exteriority between observer and observed, the possibility of ‘objectivity’ is realised within ‘a local, situated, or functional objectivity in a moment when it is needed, when it matters, our utterances as *real* units only within the speech flow’ (Shotter, 2011, p. 7).

Phenomena are situated as existing in a continual process of intra-action in being and becoming, and are therefore doing, and take into consideration material-discursive forms of agency where meaning is ‘an ongoing performance of the world in its differential intelligibility’ (Barad, 2003, p. 821). Future research would benefit from a deeper consideration as to how Barad’s (2003) insights might have further implications for the practice of research and ways researchers conduct their inquiries (Shotter, 2011), including in the field of discourse and discursive research.

Implications of the findings

This research poses a challenge to therapeutic approaches that confine treatment to the domain of medicine, which has reduced treatment to a common set of practices (Hepworth, 1999) that frequently set out to correct what is assumed to be the many ‘misconceptions’ on which the person’s life is based (Bruch, 1994, p. 6). These therapeutic approaches seek for a person to face what is assumed to be the reality that they are sick/disordered, with a primary focus on overcoming denial, challenging cognitions that are assumed to be faulty and taking steps to restructure their eating patterns and gain weight.

Much of the research interest into treatments for ‘anorexia nervosa’ has been concerned with analysing the clinical evidence (based on researcher selected variables and outcomes) for the efficaciousness of one treatment intervention over another. Christopher Fairburn has asked “Is evidence-based treatment for anorexia nervosa possible?” and responded after reviewing the research evidence that ‘the answer must be “*Barely*”’ (Fairburn, 2005, p. S29). Evidence-based practice (EBP) has become the catchcry of many professions, including psychology, and evidence based treatments that have been ‘proven’ to be most effective in clinical trials and treatment comparison studies have become the basis upon which health professionals are expected to practice. In the absence of this sort of evidence, the picture is assumed to be bleak or ‘a disquieting conclusion given the seriousness of the disorder’ (Fairburn, 2005, p. S29). The women’s stories in this research, however, were far from bleak.

This research did not seek to provide treatment for the women who participated, although within the discursive context of the research interview that explored how women themselves ascribe meaning to their experiences, these women experienced discursive agency to speak on their own terms. The effects were not merely descriptive. When speaking about their experiences within this discursive context, these women were freed not only from having to defend their identity from an ‘anorexic’ identity but also to speak more effortlessly about their experiences using metaphor and other experience-near concepts (Geertz, 1975). For some of the women, this included speaking on their own terms about the depth of their suffering, the extent to which their lives had been impacted upon both positively and negatively and for some, the extent to which they had been living a life that did not fit with who they understood themselves to be. Speaking about their experience in these ways led the women to seek out new and fresh ways of understanding their lived experiences as well as generating different options for living in ways that resonated with the sort of person they were, are and hoped to be. In parts of the interview where opportunity to speak on their own terms was diminished, these women resisted, argued, qualified and justified why their experience did not fit with what I had assumed to be their reality.

The evidence-based approach has been misinterpreted by many as meaning simply that practice should be based on the best available research evidence. However, in the seminal paper on which most definitions of EBP have been based, the medical researchers stated:

Evidence based medicine [...] integrates the best external evidence with individual clinical expertise and patients' choice [...] Without clinical expertise, practice risks becoming tyrannised by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient.

(Sackett, Rosenberg, Muir Gray, Haynes, & Richardson, 1996, p. 72)

This three-pronged definition (evidence, clinical expertise and patient choice) of EBP has been adopted across the health professions. For example:

Effective evidence-based psychological practice requires more than a mechanistic adherence to well-researched intervention strategies [...] The best-researched treatments will not work unless clinicians apply them effectively and clients accept them.

(Australian Psychological Society, 2010, p. 3)

This research highlights that the “patient’s choice” component of EBP is often not addressed in treatment models for “anorexia”. In most instances the women in this study ‘chose’ to speak on terms outside the dominant medical discourse. They would not, or could not, accept the illness discourse. Having ‘choice’ to speak on one’s own terms and express preferences about what sorts of therapeutic conversations are helpful or unhelpful for an individual and their family is not just an issue of humans rights, but also a bottom line requirement for evidence-based practice.

Whilst analysing the women’s narratives, I sought to transport what I had heard these women saying in this research study to my work as a clinical psychologist. I continued committed to the creation of therapeutic space for clients to speak on their own terms, using their images and metaphors. What I became increasingly confronted with was how to extend this commitment outside of the therapy room. I initially started to avoid using the term ‘anorexia nervosa’ in my conversations with other health care practitioners. I started to notice that my choice not to use this term created the appearance that I lacked the required skills and expertise for diagnosis. I too experienced myself in this apparently un-

discursive space outside ‘anorexia’ discourse and felt a sense of disempowerment when seeking to speak within this different discursive space. In reflecting on how to make my position transparent I experimented with forms of therapeutic documentation. The following is an example of one such document.

“Margaret” (pseudonym) said that the term ‘anorexia nervosa’ does not resonate with her experiences and contributes further to the view of herself as disordered and “a girl with problems”. Nevertheless, she recognises the seriousness if she continues to restrict her eating and sustain a low weight. She does not want her life to continue to be dominated by what she terms a “cycle” of restrictive eating, low weight and body image concerns. (De-identified extract from client’s initial assessment report to GP)

My struggle to find a language outside the dominant medical discourse has been similarly reported by Christine Halse and Anne Honey (2005) who have identified ‘profound intellectual and moral implications’ (p. 2145) of speaking about young women’s experiences of self-starvation on the terms the dominant ‘anorexia’ discourse in the construction of their research ethics application and information form for participants.

Which words should we use to address a girl whom clinicians classified as anorexic but who rejected the assignation of any medical or psychological problem and saw the label of anorexic as a (mis)representation by others? Could we invite her to share her experience of living with anorexia if she did not believe that she was anorexic? We were anxious to adhere to the principle of respect for human subjects, but we worried about how to name those who volunteered to participate in our study. To brand a girl anorexic without consent was to deny her selfhood—one of the very issues the study aimed to address.

(Halse & Honey, 2005, pp. 2145-2146)

Seeking to use alternative terms outside medical discourse was met with resistance from the ethics committee who privileged the doctor’s diagnosis - “The girls are anorexic. The fact that some girls don’t agree with their diagnosis doesn’t mean they’re not anorexic’ (Halse & Honey, 2005, p. 2147). These researchers saw no other way out of this quandary than to compromise and adopted ‘the broadest, most inclusive category available: “girls who have received a medical diagnosis of anorexia nervosa”’ (Halse & Honey, 2005, p. 2147). They remained, along with a growing number of researchers and health professionals concerned about the real/material effects and ethical/moral implications of using a category that privileges medical diagnosis over the young women’s perspectives

and the consequential marginalisation of them and their actions as “other” (Halse & Honey, 2005, p. 2147).

The values informing DSM diagnosis have increasingly embraced the importance of objectivity, precision and have been part of a move to elevate psychiatry from a marginalised pseudoscience into mainstream medicine (Sadler, 2005). In recent years there has been a shift towards examining not only the values implicit in DSM but also towards how values ‘*should*’ guide action in DSM (Sadler, 2005, p. 448). Sadler (2005) for example, has argued for a shift away from defining disorder to defining health to defining what constitutes a ‘good life’ (p. 451). These are the sorts of questions that the women in this research grappled with. For example, did their actions constitute the sort of life they wanted to live and were they acting in ways that fitted with the sort of person they wanted to be? Within a discursive context where there was space to critically reflect on what mattered, these women experienced a gap between the values they believed they held and the values that motivated their actions. Critical reflection to highlight such gaps in what a person or group of people believe themselves to value and the values underlying their actions is an integral first step to ‘values-based practice’ (Fulford, 2011, p. 977). Values-based practice is becoming increasingly recognised as important and a central component to a number of therapeutic approaches including acceptance and commitment therapy (Harris, 2009), motivational interviewing (Miller & Rollnick, 2002) and narrative therapy (White, 1995).

Interest in the dimension of evidence-based practice that encompasses a practitioner’s individual clinical expertise, not only in understanding, interpreting and applying the findings of research studies, has generated efforts to integrate evidence-based medicine with narrative medicine (Meza & Passerman, 2011). This includes practitioners paying particular attention to and asking appropriate questions that address the concerns of their patients as well as accessing and applying clinical information related to these concerns and assisting the person in their own decision making. The significance of including narrative in this person-centred approach is the understanding of stories as a meaningful form of human interaction that are co-constructed in a relationship, and a way of structuring and accounting for dilemmas that exist within the complex fabric of a

person's life. Close analysis of narratives of human distress provide a framework for psychotherapy, where narrative rather than a method is a metaphor (Neimeyer, 2000b). Through analysis of the women's narratives, this research has sought to develop insights into some of the processes that these women used to formulate and reformulate their sense of identity, or self concept, through the stories of their lives, which were continually authored and re-authored. This study has been interested in not only understanding how women negotiate their identities in relation to how they act in their lives and with the discursive materials available to them at the time, but also what they were doing and trying to do in the context of their lives (Bruner, 1990).

This study highlights the importance of interpersonal context, between researcher and research participant, between practitioner and client, between doctor and patient in shaping processes of meaning making and identity construction. What might be possible when the official version of the identity of a person struggling with so called 'anorexia nervosa' is understood as just one version rather than the only version? What might be possible when persons are permitted to speak on their own terms? What implications might there be for a person to have a voice to narrate their own experiences rather than their experiences being narrated by powerful others?

These questions have been generated by and are the outcome of this thesis, therefore to answer them goes beyond the scope of this thesis. In this study, what became possible to these women when they were given opportunity to speak on their own terms was that they neither minimised their struggles nor glorified their experiences. Instead they engaged in a moment to moment process of seeking to understand themselves in the context of their lives and within the interpersonal context of the research interview. In their understandings, they traversed between what was known and what was possible to be known about themselves and their identities; the materiality of their existence was less as a thing and more of a doing. There was also ongoing exteriority whereby these women's identities were 'inherently unstable, differentiated, dispersed, and yet strangely coherent' (Barad, 2003, p. 828).

This research has highlighted that change is possible for an individual under these different conditions. Creating discursive space where the women in this research

experienced agency to speak on their own terms had therapeutic effects, even though this research did not set out to evaluate possible therapeutic effects of engaging women in talk through the paradigm of narrative therapy. Some women commented that speaking about their experiences in the research in helped them look at their experiences in a different way. The implications of this for some women included not only imagining what their life might be like if they shifted their relationship with so called ‘anorexia nervosa’ (or whatever metaphor they used) but also taking steps to live a life that they had imagined and hoped for in their earlier tellings.

Scope of the study

As a researcher who has worked in the medical field as both a registered dietitian and clinical psychologist, I have had many years of privileged access to and use of the dominant ‘anorexia’ discourse. Although my intention at the outset of this research was to provide space for women to talk about their experiences on their own terms, I was initially unfamiliar as to how to translate this intention into practice, particularly in advertising for interviewees for this research and as a researcher facilitating the earlier research interviews. In the news stories (Appendix 2) and consent forms (Appendix 1a &b), there was an absence of positioning around my use of the term ‘anorexia nervosa’, apart from my interest in hearing the meanings the participants’ ascribed to their experience of ‘anorexia nervosa’. Taking on the term ‘anorexia nervosa’ is a reproduction of medical discourse that implicitly privileges clinical diagnoses over women’s terms and reproduces the construction of ‘self-starvation as different, deviant and other’ (Halse & Honey, 2005, p. 2155). Therefore at the start of this research that intended to hear women’s voices, my unqualified use of term ‘anorexia nervosa’ is likely to have excluded some participants and reproduced the already established power relations bestowed upon researcher to speak on behalf of the researched ‘other’. One woman (Naomi) commented she would not have volunteered to participate in this research if she had not been medically diagnosed with ‘anorexia nervosa’. Therefore my use of this term implicitly reproduced the power of medical diagnosis to confirm to a person the nature of their reality and their eligibility to participate in this research, it also disqualified those who may engage in practices and experience similar “symptoms”, but did not engage with the term “anorexia”.

Through interviews and analysis of the women's narratives, some of my familiar and unexamined perspectives came to light, mainly through the women's protests and anger at some of my assumptions, which were embedded in an 'anorexia' perspective, as well as through critical reflective practice through supervision. Nevertheless there are undoubtedly other assumptions that are embedded in an 'anorexia' perspective that continue unexamined that worked to inform the discursive climate of interview, the analysis and conclusions of this research. Therefore my intention to privilege women's voices may have inadvertently worked to privilege the dominant voice that confines the terms of speaking to the dominant 'anorexia' discourse. In addition to this, the focus of this analysis of the women's narratives may have obscured and neglected aspects of their experiences that had formed the basis of their commitment to participate in this research over 10 years.

Concluding remarks

This research study has sought to develop a richer understanding into how these women were positioned by the dominant 'anorexia' discourse and how, within a specific discursive context that embedded narrative principles into the interviewer's questioning, they traversed into a previously un-discursive space and experienced discursive agency to 'choose' the positions from which they re-authored their identities. These lines of questioning initially enquired into the unique ways these women's ascribed meaning to their experiences of so-called 'anorexia' and then moved to explore some of the implications of their experiences for their identity formation, including what was 'absent but implicit' in their second interviews. The interviews 10 years on focused on these women's identity shifts over 10 years that were based on values and were re-authored outside the dominant 'recovery' discourse. The latter provided new knowledge about the role values in processes of change as well as an alternative understanding of the so-called recovery process that highlighted ways in which remembering (rather than forgetting or erasing) is an identity practice.

The methodology of this research has sought to develop innovative ways to address the inescapable question of recursivity in any research process. Through critically reflecting on my own positioning as researcher (often through my supervision and peer consultation), my shifts over time and addressing the effects of asking particular questions at particular

points in time, I have sought to understand these women's experiences and identity formation as a process of doing rather than being, where the location of this doing was on boundary between myself and each woman.

It is hardly a surprising finding that most women in this research found speaking on their own terms to be less troublesome and more meaningful than speaking on the terms of the medical discourse. What is surprising is that this simple fact is not more widely recognised in the world of eating disorders, which assumes the person to be disordered, sick and incapable of making decisions for themselves. When these women were presented with an opportunity to talk on their own terms about the real effects of their experiences on their lives and relationships, something happened. Instead of defending their identities against a disorder construction, some women drew on alternative relational metaphors that provided scope to author a complex social reality and, through tapping into the imaginative dimensions of their selfhood, provoked images of a life lived differently. Through critically reflecting on the real effects of their actions on their lives, some women also recognised a gap between their actions and who they understood themselves to be. This gap presented for some women as a values clash and the performance of an identity that was incompatible with the sort of person they were and hoped to be. In their narratives over 10 years, rather than seeking for their experiences to be erased, these women sought out understandings of their experiences as meaningful rather than meaningless, of value rather than valueless and important in their understanding of who they were, are and hoped to be.

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APPENDICES

APPENDIX 1: Research information and consent forms and ethics approval

a) Information and Consent form, 1997

MACQUARIE UNIVERSITY

School of Behavioural Sciences (Room C3A422)

Balaclava Road, North Ryde, Sydney 2109

Dear _____,

Thank you for agreeing to join this research project which I am conducting as part of a doctoral thesis program at Macquarie University. The purpose of the study is to develop ideas and themes which appear to explain experiences and meanings people have of anorexia. I hope that sharing your experiences of anorexia in this study will provide valuable insight not only for this research but also for you as a person.

The ideas and themes about people's experiences of anorexia will be developed from interviews which will need to be audio-taped so that they may then be carefully analysed. In order to more fully explore your experiences of anorexia as an individual this interview will be unstructured. This means that the questions asked will be partly determined by your responses. Therefore with me as a guide and you as the researcher you will explore the meanings that anorexia has had in your life. After the unstructured interview you will be asked some questions about your medical history in relation to anorexia.

My role will be to write about the experiences that you explain and try to link these with other participants' experiences and then to current psychological literature on anorexia nervosa. This research is being supervised by Dr Daphne Hewson (School of Behavioural Sciences, Ph:).

Only Dr Hewson and I will have access to the taped interviews. Any of your personal details gathered in the course of the study are strictly confidential. My written work will not contain your actual name and before we meet I would like you to choose a pseudonym (another name) for yourself. Then if my work contains quotes from our interviews, your confidentiality will be ensured. If a report of this study is submitted for publication you will therefore not be identifiable in such a report. After I have completed my thesis if you would like me to return the tape-recordings to you or erase them please indicate this on your consent form. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without having to give a reason and without penalty. Please sign the attached consent forms and return them to me on our meeting. If you have any questions please don't hesitate to contact me or my supervisor.

I look forward to our meeting on ____ Kind regards, JANET CONTI (Ph: ***)

CONSENT FORM (PARTICIPANT'S/INVESTIGATOR'S COPY)

I, _____ have read and understood the attached information and any questions I have asked have been answered to my satisfaction. I agree to participate in this research and have been given a copy of this form to keep.

I understand that this research will involve an interview for about 1 hour, and that this interview will be audio-taped. I am also aware that I do not have to disclose anything which I choose not to and that I can withdraw from the study at any time. If I become distressed during the interview, we will stop and support will be provided.

I understand that in all written work associated with this research that I (and anyone I name in the interview) will be identified by a pseudonym to ensure confidentiality. I give my permission for Janet Conti or her supervisor to listen to and transcribe the audio-tapes, on the understanding that I have the right to read the transcripts and to request that details be deleted if I believe that they would identify me, or for any other reasons. I have the right to request that the tapes be erased at the completion of the research (indicated below). I have been informed that my requests will be met.

I know that the aim of the study is to explore persons experiences and meanings of anorexia nervosa. I know that I can contact the researcher Janet Conti on (phone) or her supervisor Daphne Hewson (phone) during working hours with any queries I may have. I understand that this project forms part of Janet Conti's requirements to complete a PhD, within the School of Behavioural Sciences at Macquarie University.

Participant's Name: _____ (block letters)

Participant's Signature: _____ Date: _____

Investigator's Name: _____ (block letters)

Investigator's Signature: _____ Date: _____

On completion of the thesis I request that (please tick one of the following boxes):

☐ My taped interview remain in the care of the above researchers

☐ My taped interview be erased

☐ My taped interview be returned to me at the end of the research

The ethical aspects of this study have been approved by the Macquarie University Ethics Review Committee (Human Subjects). If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Ethics Review Committee through

its Secretary (telephone 9850 7448). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

b) Information and Consent form, 2007

MACQUARIE UNIVERSITY

School of Psychology

Balaclava Road, North Ryde, Sydney 2109

Experience and meanings of anorexia over ten years and reflections on past conversations and interpretative accounts

Many thanks for your continued interest in this research. You are invited to participate in a study with the purpose of giving you feedback on the analysis of your transcript and gaining further insight and understanding into our previous interviews and my analyses.

The study is being conducted by Janet Conti (Ph:) and forms part of her requirements to complete a Ph.D. within the School of Psychology at Macquarie University. This research is supervised by Dr. Daphne Hewson (School of Psychology, Ph:).

If you decide to participate you will be asked to be involved in an unstructured interview for about 45 minutes with the aim of exploring whether my interpretative accounts of our past conversations fit with your experience of anorexia. Prior to this interview I will send you a copy of the transcripts, my interpretative accounts of our previous conversations and some questions that I will ask you to reflect on as you read these papers. You may also be asked some medical questions if your medical safety is at risk. Opportunity to have feedback from this interview will be provided with your consent. You do not have to disclose anything, which you choose not to. My role will be to reflect on your feedback and alter my analyses of your transcripts with the aim of more richly understanding your experience. I hope that

reflecting on our past conversations will provide valuable insight not only for this research but also for you as a person.

The interviews will need to be taped so that they may be transcribed and carefully analysed. You have the right to read the transcripts and to request that details be deleted if you believe that they would have the potential to identify you, or for any other reasons. The tapes will be erased at the completion of this research. If you become distressed at any time during the interview we will stop and support will be provided.

Any of your personal details gathered in the course of the study will continue to be strictly confidential. My written work will not contain your actual name but the pseudonym that you chose for our previous conversations. Then if my work contains quotes from our interviews your confidentiality will be ensured. If a report is submitted for publication you therefore will not be identifiable in such a report. Only Dr. Hewson, the person transcribing the interview and myself will have access to the taped interviews.

If you decide to participate, you are free to withdraw from further participation in the research at any time without having to give a reason and without consequence.

I, (participant's name) have read and understand the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this research, knowing that I can withdraw at any time without consequence. I have been given a copy of this form to keep.

Participant's Name: _____ (block letters)

Participant's Signature: _____ Date: _____

Investigator's Name: _____ (block letters)

Investigator's Signature: _____ Date: _____

The ethical aspects of this study have been approved by the Macquarie University Ethics Review Committee (Human Research). If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Ethics Review Committee through its Secretary (telephone 9850 7854, email ethics@mq.edu.au). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

(INVESTIGATOR'S [OR PARTICIPANT'S] COPY)

c) Ethics approval from Macquarie University Ethics Committee, 1997



27 May 1997

Ms Janet Conti
SCHOOL OF BEHAVIOURAL SCIENCES

Dear Ms Conti

"Experiences and meanings of anorexia nervosa in an Australian context"

This application was approved by the Ethics Review Committee (Human Research). Approval will be for a period of twelve months, commencing **23 May 1997**. At the end of this period you will be required to submit an application for renewal of the approval if the project is still current.

Please remember that if your project aims change in a manner which results in alteration of the protocol, the Ethics Review Committee (Human Research) must be notified. At all times you are responsible for the ethical aspects of your research.

Yours sincerely


Dr J Ungerer
Chair, Ethics Review Committee (Human Research)

MACQUARIE UNIVERSITY
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Ethics approval from Macquarie University Ethics Committee, 2007

22 May 2007

Ms Janet Conti
112 Benelong Road
Cremorne NSW 2090

Reference: HE27APR2007-D05196

Dear Ms Conti

FINAL APPROVAL

Title of project: *The interweaving of women's discourse on the experience of 'anorexia' with their narrative identity and embodied subjectivity - transitions and shifts in meaning over ten years*

Thank you for your recent correspondence. Your responses have satisfactorily addressed the outstanding issues raised by the Committee. You may now proceed with your research.

Please note the following standard requirements of approval:

1. Approval will be for a period of twelve months. At the end of this period, if the project has been completed, abandoned, discontinued or not commenced for any reason, you are required to submit a Final Report on the project. If you complete the work earlier than you had planned you must submit a Final Report as soon as the work is completed. The Final Report is available at <http://www.ro.mq.edu.au/ethics/human/forms>
2. However, at the end of the 12 month period if the project is still current you should instead submit an application for renewal of the approval if the project has run for less than five (5) years. This form is available at <http://www.ro.mq.edu.au/ethics/human/forms>. If the project has run for more than five (5) years you cannot renew approval for the project. You will need to complete and submit a Final Report (see Point 1 above) and submit a new application for the project. (The five year limit on renewal of approvals allows the Committee to fully re-review research in an environment where legislation, guidelines and requirements are continually changing, for example, new child protection and privacy laws).
3. Please remember the Committee must be notified of any alteration to the project.
4. You must notify the Committee immediately in the event of any adverse effects on participants or of any unforeseen events that might affect continued ethical acceptability of the project.
5. At all times you are responsible for the ethical conduct of your research in accordance with the guidelines established by the University (<http://www.ro.mq.edu.au/ethics/human>).

If you will be applying for or have applied for internal or external funding for the above project **it is your responsibility** to provide Macquarie University's Research Grants Officer with a copy of this letter as soon as possible. The Research Grants Officer will not inform external funding agencies that you have final approval for your project and funds will not be released until the Research Grants Officer has received a copy of this final approval letter.

Yours sincerely



Dr Margaret Stuart
Director of Research Ethics
Chair, Ethics Review Committee [Human Research]
cc. Dr Daphne Hewson

Ethics Secretariat (sent by bhawna.gursahani@mq.edu.au)

9:57 AM (4
hours ago)

to me

Dear Sir/Madam,

This email is to confirm that the following ethics application/s cited below received final approval from the Macquarie University Human Research Ethics Committee:

Chief Investigator: Ms Janet Elizabeth Conti

Ref: HE27APR2007-D05196

Date Approved: 22/05/2007

Title: "The interweaving of women's discourse on the experience of 'anorexia' with their narrative identity and embodied subjectivity - transitions and shifts in meaning over ten years"

Please do not hesitate to contact me if you have any questions.

Yours sincerely,

Dr Karolyn White
Director, Research Ethics
Chair, Macquarie University Human Research Ethics Committee

On Mon, Nov 11, 2013 at 9:53 AM, Ethics Secretariat

APPENDIX 2: News stories to advertise this research study

a) The Sunday Telegraph, July 27 1997

(See text on page 221 that was reproduced with permission from the author)

Text of news story “Diets under new scrutiny” (Sheather, 1997)

(Reproduced with permission from the author)

HISTORICALLY anorexia nervosa has been portrayed as the disease of girls from “nice families” in the middle to upper classes.

The stereotypical sufferer was little Miss Perfect – before she became anorexic. That perception is changing.

According to Janet Conti, a researcher into eating disorders, anorexia in the 90’s penetrates all strata of society.

“It’s really spread right through; not everyone fits the classic category,” she says.

As a former nutritionist at the Royal Prince Alfred Hospital, Janet was involved in the treatment of anorexics from all over the State.

“I saw a whole range of people from different socio-economic groups and cultural backgrounds,” she says.

The changing demographics of anorexia has become the focus of Janet’s doctorate in psychology.

She says there is a need to understand what anorexia means to people in the 90’s – which might explain why it is affecting a far more diverse group.

Ultimately she hopes her research will give an insight into more diverse treatments.

Therapists in the 60’s though low self esteem and a sense of ineffectiveness was central to anorexia.

Janet wants to examine these issues as they are experienced in the 90’s.

“Things do change over time and the meaning of anorexia in the 60’s and 70’s may be different to the meaning of it in the 90’s,” Conti says.

Culturally and socially the environment is changing. There’s much more pressure on women in western society to perform in the workplace, the home, and at university.

There is also more pressure from magazines and fashion icons heralding thin goddesses as the pinnacles of desirability.

Subsequently food has become an obsession rather than a pleasurable necessity of life for many women.

A recent study of schoolgirls by Jenny O’Day at Sydney University revealed 27 per cent were dieting at the time and 40 per cent wanted to lose some or a substantial amount of weight. The increasing incidence of anorexia may, in part, be the manifestation of any number of new pressures.

The only certain factor about anorexia now is that it still affects women predominantly.

Janet hopes to provide valuable insight for treating the disease by studying people’s experiences with anorexia with particular emphasis on their stories of recovery.

She believes it’s more beneficial to look at recovery than cause when you’re refining treatment.

“When you’re looking for a cause, there’s always a lot of blame around anorexia. Most people in the field will say

nobody knows the cause. There are only theories,” she says.

Treatment programs for anorexia nervosa vary throughout the world and studies have found that after four years a quarter of sufferers still had significant problems, a quarter had improved and half had recovered.

Longer term studies have found that after 12 years, three quarters of sufferers have recovered from anorexia.

In Sydney the main treatment centres are at Royal Prince Alfred Hospital, Northside Clinic in North Sydney, and Concord and Westmead hospitals in the west.

Treatment is through either outpatient, inpatient or by group therapy. Only severe cases of anorexia or bulimia, when patients are in a medically dangerous situation, are admitted to hospital.

Outpatient programs use a multi-disciplinary approach combining sessions with nutritionist, counselling with a clinical psychologist, psychiatrist or family therapist.

Are you interested in talking about your experiences of anorexia nervosa for research purposes? It will involve about an hour-long interview. Phone Janet Conti on Ph:.

Press release sent to local newspaper (The Northern District Times) outlining this research study

TALKING OF ANOREXIA

How do people experience anorexia nervosa? This question is the focus of a research study at Macquarie University into the experience of anorexia nervosa. By developing ideas and themes about people's experiences of anorexia this research has potential to provide valuable insights in the search for effective treatments for anorexia.

Treatments for anorexia nervosa vary throughout the world and studies have found that after 4 years a quarter of those treated for anorexia still had significant problems, a quarter had improved and a half had recovered. Longer-term studies have found that after 12 years, three-quarters of people have recovered from anorexia. What constitutes recovery varies between studies, and people's experiences of recovery are often not evident. There has, however, been some interesting research in Australia by Dr. Catherine Garrett into people's stories of recovery which has relevance for the treatment and prevention of eating disorders.

In treatment programs for anorexia nervosa there is a tension between focusing on peoples' eating behaviours and weight - which is essential when someone is in a life-threatening situation - and focusing on what anorexia means to the person. In Sydney, treatments are moving towards greater flexibility in their approaches. There is a multiplicity of aspects which are important in treatment - including psychological, medical, social and cultural issues. There is, however, potential danger when focusing on all these aspects of treatment that the meaning of the individual's experience is lost.

PhD student Janet Conti, under the supervision of Dr Daphne Hewson, will be interviewing people who have experienced anorexia nervosa. "I have talked to many people with eating disorders and have been inspired by their stories and experiences. I have also been fortunate to hear people's experiences of recovery" Janet said. "I believe that meanings and experiences of anorexia, including recovery stories, should be central in any treatment program."

The interviews will be open-ended with the aim to explore the meaning of anorexia in each participant's life. People interested in taking part in this study or those who would like further information can contact Janet Conti on **Ph:.**

b) Advertorials published in the Northern District Times, June 25 & July 16, 1997

Talking of anorexia⁴

A STUDY into the experience of anorexia nervosa is about to start at Macquarie University.

PhD student Janet Conti, under the supervision of Dr Daphne Hewson, will be interviewing people who have experienced anorexia nervosa.

Janet has worked as a dietitian dealing with eating disorders for six years before starting her doctoral thesis in psychology.

“I have talked to many people with eating disorders and have been inspired by their stories and experiences. I have also been fortunate to hear people’s experiences of recovery”, Janet said.

The interviews will be open-ended with the aim to explore the meaning of anorexia in each participant’s life.

People interested in taking part in this study or those who would like further information can contact Janet Conti on (incorrect mobile number)

Study to look at anorexia⁵

A study into people’s experiences of anorexia nervosa is about to start at Macquarie University.

PhD student Janet Conti will be interviewing over the next few weeks people who have experienced anorexia to explore the meanings and effects of the condition in people’s lives.

It is the first phase of the study and the findings will determine subsequent phases. Janet has worked as a dietitian for six years before starting her doctoral thesis in psychology.

She has particular experience in talking to people with eating disorders.

“I have talked to many people with eating disorders and have been inspired by their stories and experiences,” Janet said.

“I have also been fortunate to hear people’s experiences of recovery.”

Her PhD study is something she found lacking in research available on the condition.

All interviews will be conducted under the supervision of Dr Daphne Hewson.

Anyone interested in taking part in the study or simply wanting more information can contact Janet Conti on (mobile number).

⁴ Northern District Times, June 25, 1997.

⁵ Northern District Times republished article, July 16, 1997, due to misprint of my contact phone number.

APPENDIX 3: Participant medical diagnoses, treatment histories and demographics

Table A: Participant medical diagnoses and treatment histories

Pseudonym	Age identified experience as AN -yrs	Age identified problems with eating	Eating disorder diagnosis (and age at diagnosis)	Treatment for eating problems	Treatment for other problems
1. Sally	23	23	AN (at 23 years)	Psychiatrist (for AN); psychologist/dietitian (for BN)	Fertility counsellor (IVF) Postnatal counsellor
2. Anne	recently	15	Nil medical diagnosis	No	Psychiatrist for anxiety/depression
3. Kelly	17	12	BN (at age 30)	Psychiatrist, inpatient admission and day program for BN.	Grief counselling.
4. Katie	13	13	AN (at age 13 years)	Inpatient admission for 6 months for AN, outpatient treatment for 4 weeks	Nil
5. Darcy	14	14	AN (at age 14 years)	Inpatient admission and psychologist/dietitian for AN	Psychologist for depression.
6. Lisa	26	15	AN (at age 26 years)	2 admissions for AN; CBT for BN; 2 psychiatrists for ED	Depression and sexual abuse
7. Mary	21	21	Nil medical diagnosis	Nil	Counsellor for sexual abuse
8. Chelsea	16	16	AN (at age 21 years)	Inpatient admission, outpatient psychiatrist/dietitian for AN	Social worker – for other issues
9. Naomi	15	9	Eating disorder (at age 15)	Outpatient Psychiatrist, Psychologist and dietitian, then another psychologist	Counselling for depression
10. Fluff	18 & 28-30 reoccur	18	AN (at 18 and 28 years)	3 Psychiatrists, dietitian & psychologist	Psychiatrist and psychologist for OCD

Pseudonym	Age identified experience as AN (years)	Age identified problems with eating	Eating disorder diagnosis (and age at diagnosis)	Treatment for eating problems	Treatment for other problems
11. Avalon	11	11	AN (at 14 years)	Inpatient admission and outpatient psychologist for AN	Inpatient admission for depression, Psychologist & social worker for depression & childhood sexual abuse (CSA)
12. Sarah	Early teens	From young age	AN (in 30s)	Therapist, counsellor and doctor for AN	Therapist, counsellor and doctor for CSA
13. Nicole	15	15	AN (at age 15 years)	2 inpatient admissions and outpatient psychiatrist for AN	Psychiatrist for schizophrenia
14. Chloe	15	15	AN (at age 15 years)	2 inpatient admissions, outpatient psychiatrist and psychologist for AN	Psychiatrist for depression – individual & family therapy
15. Margaret	21	13	Nil medical diagnosis	GP; psychologists	Nil
16. Beverley	15	15	Nil medical diagnosis	Nil	Nil
17. Lorraine	15	15	Nil medical diagnosis	Nil	Nil
18. Sara	10	10	AN (at age 10 years)	3 inpatient admissions and family therapy for AN. Also natural/alternative therapies.	Marriage counsellor
19. Catherine	21	21	AN (at age 21 years)	Hospitalisation, psychiatrists, paediatrician for AN	Nil
20. Jane	16	16	AN (at age 19 years)	Psychiatrist and counsellor for AN, overeaters anonymous.	Nil
21. Susan	19	12	AN (at age 19 years)	Psychologists, psychiatrist, dietitians and hospitalization for AN	Psychologist for CSA

AN= 'anorexia nervosa', BN= 'bulimia nervosa'

Table B: Participant demographics

Pseudonym	Number of research interviews	Age (years)	Occupation	Education Level	Marital status	Children
1. Sally	3	33	Health professional	College degree	Married	1
2. Anne	3	43	Health professional	Year 10; now diploma	Separated	2
3. Kelly	3	33	Receptionist	SC, TAFE certificate	Married	3
4. Katie	3	24	Creative arts and health professional	Undergraduate university degree	Single	Nil
5. Lisa	3	31	University student	Undergraduate university degree- final year	Married	1
6. Naomi	3	21	University student	Currently postgraduate university degree	Single	Nil
7. Sarah	3	44	Health professional	SC, health professional training	Married	3
8. Jane	3	25	Engineer	Undergraduate university Degree	Single	Nil
9. Susan	3	26	Childcare	TAFE qualification	Married	Nil
10. Darcy	2	21	Presently looking for work	HSC + 1 st year University	Single	Nil

Pseudonym	Number of research interviews	Age (years)	Occupation	Education Level	Marital status	Children
11. Mary	2	26	Artist and musician, administrative work	Undergraduate university degree	Single	Nil
12. Chelsea	2	21	Health professional assistant	HSC	Single	Nil
13. Fluff	2	40	Business	HSC and TAFE	Single.	Nil
14. Avalon	2	24	Writer, previously spiritual healer	HSC (incomplete)	De-facto	Nil
15. Chloe	2	19	Sales assistant, exercise trainer	HSC	Single	Nil
16. Beverley	2	35	Undergraduate university student	Undergraduate university degree – currently 2 nd year	Married	2
17. Lorraine	2	38	Sales assistant	Undergraduate university degree (3 rd year), TAFE	Married	Nil
18. Sara	2	34	Admin assistant	SC + TAFE	Separated	Nil
19. Catherine	1	29	Teacher	Uni. Degree	Single	Nil
20. Nicole	1	25	Not working	Undergraduate university degree (until 3 rd year)	Single	Nil
21. Margaret	1	28	Shop assistant	SC	Married	2

APPENDIX 4: Interview questions – First, second and third tellings

a) Interview questions for first telling

Do you think of anorexia* as a name or do you have another name? (Zimmerman & Dickerson, 1994) (Another name*:_____)

Story / experience of anorexia

1. When has/did anorexia* had the greatest effect on your life? (White & Epston, 1990)
2. Tell me your story of anorexia*
3. How do/did you experience anorexia*?
(prompt: as you look back on your experiences of anorexia*, which events stand out in your mind?)

How do/did you live with anorexia*?

How does/did anorexia* affect you? your life? your relationships? (White & Epston, 1990)

4. Do/did you consider anorexia* to be a problem. If so, how? If not, why?
5. What was life like before you experienced anorexia*?
(prompt: as you look even further back before anorexia*, which events stand out in your mind?)

Recovery

6. Do you consider you have recovered from anorexia? if so why? if not why not? (Garrett, 1993)
7. Tell me your story of recovery
8. How do you know/would you know that you had recovered? (Garrett, 1998, p. 199)
9. As you look at your experiences after anorexia* which events stand out in your mind? (Charmaz, 1995)
10. Do you feel now like the same person you were when you were experiencing anorexia? Before anorexia? (Garrett, 1998, p. 199)

Meanings

11. What do/did your experiences of anorexia* mean to you? What meanings do you attach to your experiences of anorexia*? (White & Epston, 1990)
12. Tell me about your views of anorexia*.

13. How do/did you identify your experiences with anorexia*?

14. How has your life changed with your experience of anorexia*?

Would your life be different if you did not experience anorexia*. If so, how?

15. How do you describe yourself to yourself? (Gilligan, 1982, 1993)

16. What is a typical weekday like for you? (Charmaz, 1995)

- **Use prompts such as always? sometimes? when?**

With responses such as “never”, “always”, “it couldn’t possibly be that way”, “there’s no need for discussion” (Strauss & Corbin, 1990, p. 93)

What do you mean never? or always?

Why is this so?

Never, under what conditions?

How is the state of never maintained?

What are its consequences?

What happens if never is not maintained?

Are there certain strategies to get around that never?

b) Medical safety and diagnostic questions asked at the end of the first interview

Do you mind if I now ask you some medical questions?

WEIGHT HISTORY

Has your weight changed over the past 6 months? -decreased

-increased

-maintained

- fluctuating between ____kg & ____kg

What is the least you have ever weighed?____kg For how long?_____

What is the most you have ever weighed?_____kg For how long?_____

What was your weight before you developed an eating problem?_____kg

What is your preferred weight? _____kg (BMI:_____)

PAST TREATMENT

Have you had counselling or other treatment in the past for an eating disorder?

Have you had counselling or other treatment in the past for any other problems?

MEDICATIONS (current)

MENSTRUATION

Current menstrual status/ OCP:_____

Past history amenorrhoea: Yes/No. If yes, when?_____

CURRENT WEIGHT LOSS BEHAVIOURS

Behaviour	Type	Quantity	Frequency	Age of Onset
Binge eating	Objective/ subjective	Time:_____		
Vomiting				
Laxatives				
Diuretics				
“Diet” pills				
Food restriction				
Exercise: (circle) -weight /				

shape			
-fitness			
-other			

c) **Questions asked at second telling to explore themes arising from first telling**

Themes to be further questioned at the end of the interview

The following questions were generated themes identified when interviewing women between 1997-1998.

1. Control and power

From the interviews so far, some people have talked of how anorexia for them is about **control**. Does this match your experience? Others talk of anorexia being about **power**, what about for you? Do **control and power** have the same or different meanings for you?

2. Thinness/ body image

Some people say anorexia is about **thinness**, is this the case for you?

3. Sexuality and Sexual Abuse

Others say anorexia is about **fear of maturity including sexual maturity**, does this match your experience?

Some people have talked about **experiences of sexual abuse** - have you experienced sexual abuse?

4. Self esteem

Some say anorexia is about **self esteem**, what about for you?

5. Isolation

Some have described how during their experience of anorexia they distance themselves from others and this has a **profound effect** on themselves. Can you relate to this from your experiences?

6. Emotions

Some of the people I have interviewed describe difficulty **expressing emotions**, especially **anger**. Is this the case for you? Has this always been the case for you? How was anger expressed in anorexia?

7. Death/suicide/depression

Anorexia has been described by some as a **death wish**. Can you relate to this description from your experiences?

8. Discourses

Some people say that anorexia is an **illness**, do you relate to this description of anorexia?

It has been said that **the media** has a role to play in the development and maintenance of anorexia. Has this been the case for you?

9. Reward/punishment

Some people I have interviewed have described how anorexia is a way of **punishing** themselves. Do you relate to this?

Others describe aspects of anorexia they consider to be **rewarding**. Do you relate to this?

10. Guilt/deception/selfish

Themes of **guilt** associated with anorexia have also been described. Can you relate to this in your experience?

Others describe feeling **selfish** in their experience of anorexia. What about for you?

11. Perfectionism

Anorexia has been described by some as the **pursuit of perfection**. Does this match your experience?

12. Protection/escape

Anorexia has been described by others as a way of **protecting themselves**. Can you relate to this in your experience?

Others say anorexia is an **escape** - what about for you? (What about responsibility?)

13. Body/mind paradigm

Some have described how during their experience of anorexia they have an **internal battle** going on, sometimes like two voices, sometimes like their mind is fighting with their body. Can you relate to this?

14. Recovery

Some people consider recovery is possible, others are less optimistic. What about your experience?

d) Letter sent with transcripts from interviews conducted between 1997-1998 (first telling)



Dear _____

Many thanks for your continued participation in this research that I have named Experiences and meanings of 'anorexia'. As discussed I have attached your transcripts and my analyses of your transcripts. As you will see there are a number of focal points in my analyses. In my current research I am particularly interested in –

1. The processes through which you came to identify your experiences as a problem, which you may or may not have named 'anorexia',
2. Your changing relationship with 'anorexia' over time, particularly how this affects how you see yourself as a person (or your identity),
3. How you position yourself in relation to societal taken-for-granted assumptions or discourses (for example, people who experience anorexia are “starving for attention” or “selfish”) and how this positioning affects your view of yourself as a person,
4. Your journey in moving from anorexia and how this has influenced your view of yourself as a person or identity.

As you read through the transcripts and my interpretations could you note down and/or highlight any of the following for us to discuss when we meet.

- Parts of the transcript or interpretations that stand out for you and/or are most interesting in your journey and relationship with 'anorexia', and why?
- Any aspects of the transcript or interpretations that continue to hold meaning and are relevant for you now. Why?
- Aspects of the transcript that you feel have the potential to identify you and how this could be modified or removed to ensure your confidentiality.

- Any parts of my interpretations that do not fit with your experience and how I could change them to more closely fit your experience.

I look forward to exploring these questions with you at our meeting

Yours sincerely JANET CONTI

e) Questions for 10 year follow up interview

When I last saw you, your name for anorexia* was _____. Do you still have this name for anorexia*, or has the name for your experiences changed?

(i) Relationship with “anorexia” questions – reviewing life in relation to “anorexia” (MI to explore ambivalence, change talk) and where moved in relationship with “anorexia”

First I wanted to catch up with you in terms of where you are up to now in relation to anorexia*.

I was wondering what you *like* about your relationship with anorexia*? Is this different to what you liked about anorexia 10 years ago? How?

What *concerns* you have about your relationship with anorexia*? Are these concerns different to your concerns 10 years ago?

What else do you want me to know about your relationship with anorexia*?

What would you tell other people about it?

What may you have told other people 10 years ago?

(ii) Identity questions

Can you tell me a bit about who you are now and if this has changed over the past 10 years?

How would you describe yourself to yourself now in terms of what you stand for and what matters to you?

How would you have described yourself to yourself 10 years ago in terms of what you stand for and what matters to you?

What does it mean for you as a person that you have experienced anorexia*? Is this positive, negative, both and why?

Any life experience has the capacity to shape our sense of ourselves, often in multiple ways that may seem conflicting and that change over time.

I was wondering how your experience of anorexia* invites you to see yourself as a person now?

How did anorexia* invite you to see yourself as a person 10 years ago?

(iii) “Moved *on*” (or “moved *in*” questions)

What made the difference ... to move from anorexia*?

Would you describe changes in your relationship with anorexia* as having moved ***on*** from anorexia* (Or, does anorexia* feel like it is behind you?) If so, how has moving ***on*** from anorexia affected how you see yourself as a person?

Read quotes from Tim Winton –

Life moves on, people say, but I doubt that. Moves in, more like it. (Winton, 2004, p. 37)

... the past is in us, and not behind us. Things are never over. (Winton, 2004, p. 53)

Would you describe changes in your relationship with anorexia* as anorexia* moving ***in***? If so, how has anorexia moving ***in*** affected your view of yourself as a person?

Have **other life experiences** moved *in* and shifted your relationship with anorexia*? If so, can you tell me about these experiences?

How have these experiences affected how you see yourself as a person?

What meanings have you drawn from these experiences that have contributed to a shift in your relationship with anorexia*?

Has your relationship with yourself changed through your experience of anorexia*? How?

Follow-up letter

When reading transcripts think about how the person's talk is now compared to 10 years ago. Send the transcript for their approval and a letter after quick analysis (within two months) and invite person to write a letter back.

For example, This time I noticed ... when you were talking about your relationship with anorexia, last time (10 years ago) Does this stand out for you?

(iv) Questions for feedback interview to explore past transcripts and my analyses

First, ask about person's reflections on the following questions included in the letter sent.

Parts of the transcript or interpretations that stand out for you and/or are most interesting in your journey and relationship with 'anorexia', and why?

Any aspects of the transcript or interpretations that continue to hold meaning and are relevant for you now. Why?

Aspects of the transcript that you feel have the potential to identify you and how this could be modified or removed to ensure your confidentiality.

Any parts of my interpretations that do not fit with your experience and how I could change them to more closely fit your experience.

Second explore questions related to the focal points of my research as also outlined in the letter.

Processes through which as person comes to identify their experiences as a problem

I was wondering if there was anything you wanted to add about your journey to identifying your experience as a problem ('anorexia' or another name), such as

The meaning of this for you,

If this process was important for you as a person and why?

If this process influenced your view of yourself as a person and how?

Another aspect of interest for me is the section in my analysis on **"identity descriptions"**. In my analysis what stood out for me in your transcript was _____ (description of a unique aspect of person's account). Does this stand out for you as well or were there other aspects of your transcripts in relation to your identity that are more important? If so, can you describe this for me?

Are there **societal discourses or taken for granted assumptions** about anorexia that stand out for you? Why? What do you think is important for me to know about these assumptions about anorexia?

I am also interested in your **journey of moving from anorexia**. Some people call this recovery, what would you name your experience of moving from anorexia? Aspects of your journey that stood out for me from your transcripts were _____ (unique aspects of person's journey). Do you consider these aspects were important or are there other aspects that you consider to be important for me not to forget and/or to emphasise more strongly?

APPENDIX 5: Transcription notation

(pause): long pause

[...]: material deliberately omitted

[text]: information to clarify statement or account

***text**: word(s) emphasized by person in bold*

(Janet: text): interviewer's question

(Drawn from Edley, 2001, p. 228)

APPENDIX 6: Summaries of women's narratives

(Disc attached to end of thesis for marking purposes only)

**APPENDIX 7: Quotes relevant to the women's positionings on 'recovery' and
"moving" from 'anorexia'**

a) Quotes relating to the women's positionings on 'recovery' in their first and second tellings

Recovery - troubled

Sally: *(Interviewer: So where would you say that you are in terms of recovery? Would you say?) Well it's like an ex-smoker, are they ever recovered? Is an ex-smoker ever a non-smoker? (Interviewer: Do you believe that you could ever recover totally?) Well I don't know what recovery is, I don't know if recovery means never thinking about food the way you thought about it when you were anorexic. Does it mean that you never think about your body the way that you did about it when you were anorexic?. What's the point at recovery? Is it the fact that you are maintaining a constant weight? Or is it the fact that things in your head have changed? [...] I think until to the day I die I will basically be the same way as I am now, which is a hell of a lot better than I was. (First telling, p. 19)*

Anne: *(Interviewer: [...] and recovery (pause), tell me about your idea, we've talked a bit about recovery [...]). I don't think you ever recover. It's like a smoker. You're never ever not a smoker. I don't think you're ever not an alcoholic. You know. It's something that's with you and you have to take it day by day I think. Um that's as I perceive it. I don't think, um if you have something that's a that is a part of your personality, it's part of you um it's got to be I'm going to say genetically imprinted but probably not the correct term, but its, it's in your blue print somewhere. (Second telling, p. 27)*

Kelly: *There's still a lot of things of the eating disorder that still linger, but there's something that I remember too about that you never really, I don't. my personal belief is and I'm being realistic, that you never really get over an eating disorder, I think you just push it to the background of your mind, so far in the background of your mind that it doesn't become a problem, that it doesn't sort of interfere with your life anymore and I think that's what I've managed to do. You know I don't think you've ever "recovered" from an eating disorder so to speak. I think you just change*

your behaviour, but I don't think essentially, it's like it's there. Like and there's just, there's so many vivid memories about it and the way I was and what I used to do and everything like that, so I don't think that I'm ever recovered from it (Interviewer: mm, hm) but it's pushed to the background of my mind where it doesn't, it's not, I'm not indulging in the self destructive behaviours as I was doing before.

(First telling, p. 14)

Katie: *(Interviewer: Do you consider that you've recovered now?) No I think true anorexics never recover, you've always the potential to go back to it because it felt so good, it's like a heroin hit, like it felt so good.*

(First telling, p. 14)

Darcy: *I feel that there's a few loose ends but initially maybe this is me, maybe I've recovered and this is me and how it's affected me, like what it's left, this is the person that's shaped me. Maybe I am a person who doesn't feel confident in tight clothes, but does that mean I'm not recovered. I don't know I'm in the process of working that out at the moment.*

(First telling, p. 16)

Darcy: *So, in terms of recovery I am thinking that maybe that that might be how it is. Maybe there is no time you get to when you just never ever worry about your weight. Maybe that's just probably normal but for me. I am probably a little bit more sensitive to that because I have been sick.*

(Second telling, p.1)

Lisa: *(Interviewer: [...] and do you feel if you woke up and you said I have recovered that you would feel that need still to be looked after?) Well I suppose if I'd recovered I'd probably be far enough- independent enough to be able to get on with my life and just, I suppose develop close relationships, but I just, I just can't see that ever. I can't see how whether it be through therapy or anything that you can change someone and someone's personality that much, I don't really think that will ever happen completely, I don't know, maybe it does for some people, but I just, I've had this for so long like I don't know anything different really, and it's just it's a stage now where it's not my whole but it's there and I just can't see that ever being completely gone. (First telling, p.16)*

Mary: *(Interviewer: So do you feel that you have recovered from anorexia?) Sort of. I still get the feeling it's lurking and, if I ever get depressed, I have to really watch and make sure I do eat because it would be too easy to slip back into it and I'm dead scared that if I did slip back into it I wouldn't get out of it this time.*

(First telling, p. 20)

Nicole: *(Interviewer: Mmm. So do you feel that you have recovered from anorexia) I don't think I'll ever get rid of it. I think always a bit of it will be there, but I feel that I have control of it rather than it controlling me.*

(First telling, p. 12)

Naomi: [...] So I do think I'm recovered but I'm always cautious to think it would never ever happen again. You see alcoholics that go off the rails 20 years later, they're still always an alcoholic, even in the 20 years when they're sober and I suppose maybe we need to redefine how we think of recovery. Is recovery that you never ever do that action again? So I mean, are you a failed giving up smoking person if you have one cigarette when your mum dies, I mean, no of course you're not, you know, you haven't failed, you've still recovered. I mean maybe our notions of recovery need to b. [...] I do call myself a recovered anorexic, purging anorexic, yeah the scar tissues are always there. So how you it's just making a life to live around those scar tissues. *(First telling, p. 21)*

Fluff: (Interviewer: Tell me about that recovery, was there sort of phases of that recovery or do things stand out in your mind, particular things during that time...)?[...] I'd like to think that I'm cured, as I say, I think you'll always be wary, but then you've forgotten how everyone else is with certain things. So you've probably just come back to a normal level but you just feel that you always going to be a bit wary, but no the attitudes are healthy though, that's the difference. *(First telling, p. 13)*

Fluff: (Interviewer: I wonder what recovery means for you? When you think about recovery, (pause) you have talked a bit about addictions or that sort of stuff. Some people have said well do you ever get over an alcohol addiction? Do you ever get over this?) No, I think you learn how to live within the limitation or you learn how to control it and, to um yeah, you just replace one sort of behaviour with a more healthy, um normal.

(Second telling, p. 49)

Catherine: I think it might finally make it – the complete eating disorder – go away. I sort of come to my conclusions that I'm well as I'm ever going to be and I don't think I can ever get rid of it. I think I don't know if I can ever get rid of it because I don't know if it is me, still my mind hanging onto that certain element that's like a security thing, it makes just that little bit different too, to everybody else, you're not exactly the same. It's the you're special but it's something that's yours and no one else can take it away from you and I often wonder what is it about me- what's the insecurity? and yet I just can't completely get rid of it, or is it just the way that the mind works that's always going to be there.

(First telling, p. 5)

Avalon: (Interviewer: So at this stage do you consider that you've recovered from anorexia?) I've recovered from it as a disease, but I think like once you're an alcoholic, always an alcoholic. I feel like you've just got to watch yourself. It's still there, it – you think about it sometimes, you're tempted by it, it's alluring, when situations in your life cause your self

esteem to plummet or you feel a little bit disempowered, that's a very hard thing and you've got to find other ways to deal with it.

(First telling, p. 12)

Avalon: (Interviewer: What is the meaning of recovery for you?) Recovery isn't so much about the disease process, or recovering from it, it's about recovering yourself, it's about reclaiming your place in the world, understanding that there is a choice, of thought processes now. [...] So I don't consider that you um, ever get over this disease, because I don't think that it is something to be gotten over. Um, they were actions, the physicality of starving and bingeing, they were just actions. The real disease was the thoughts that started it that convinced you that this was a good way to go. Got to deal with that and I think it's a day to day process.

(Second telling, p. 40)

Sarah: (Interviewer: [...] but in the experience of recovery or of being, sort of, things being different from that, your body and your mind were like a whole? Is that what you're saying?) [...] I mean, I don't know, may be recovery is many different kinds of things, may be its um, I mean obviously you wouldn't have, you'd be able to eat normally. (Interviewer: Yeah). Um, I'm not sure, perhaps it's not just being a healthy weight I think it's a frame of mind as well. You wonder if you will always have battles with it or whether it will be totally gone, like what, what is being recovered?(Interviewer: Mmm). You know, I suppose it's like, um appendicitis, you know, you've got it when you've got inflamed appendix, but once that's gone you haven't got it anymore. Um with recovering from this, will it mean I won't think it anymore? It will be like another story that's completely gone or will it always be well OK I maybe a healthy weight, but I still think, you know, in abnormal ways? I'm not sure. It'd be nice f, recovery meant I don't have these wars anymore, you know, and they are wars that's, that's the worst thing, war in your own mind is absolutely terrible.

(First telling, p. 15)

Chloe: (Interviewer: Do you consider you've recovered from anorexia?) Yep. As much as I'm going to, I think I have (recovered). (Interviewer: And tell me about that process of recovery. Tell me what happened during your recovery and was there any stages or turning points or (pause)?) I don't know, it's difficult. [...] When I got sick again and then I got better for the last time, that was when I had confided in a friend and opened up and when I got better then I knew that was the last time. Because I had got rid of what it was behind the eating disorder. I got rid of the problem behind it.

(First telling, p. 11)

[...] (Interviewer: Now just the last think with recovery, you were saying before that you are as recovered as you'll ever be. Can you tell me what you mean by that?) I just think that I don't think I'd ever go back to the way I was. I mean, I'm not going to lie, there's days where it's hard to make myself eat or I have to force myself to eat but it's very infrequent

now. Like most days I'm as normal as you get in regards to that. I mean at first it was more common that I'd have to force myself to eat than not, but now it's 90 to 95% of the days I'm fine. On a bad day where I have to force myself to eat I usually try and avoid mirrors, that's usually my biggest trick. Most of those days I'll make myself eat. I know I don't want to but I know I have to, but every other day's just like I was before, before I ever got sick. (First telling, p. 17)

Chloe: [...] they say you never recover 100% and I mean that's true, you still have, you know, I still have days now where I think oh, you know, look at yourself, but those days are very few, it's not all that often; but up until that point I sort of was having them really regularly, until I said something. (Second telling, p. 18)

Beverley: (Interviewer: [...] Do you feel that you've recovered now?) I think I've recovered from that portion, but I still think I've got some work to go with my, probably overeating and the bad relationship I have with food, but that part I think I've recovered from because I think well that's, I've closed the book so to speak. It's still there, I still know about it, I still think about it sometimes, but I've closed the book coz I thought I could never go back there and I think that's half the battle, to me, in my view, that's half the battle. That if I can say well no I'm never going to revisit that time of my life again, (Interviewer: Yep). I'm not, not going to go back that. (First telling, p. 16)

Margaret: (Interviewer: Because I think perhaps when you look through the eyes of anorexia recovery means you lose control. If you take off the glasses of anorexia then maybe you see recovery in a different way). Yeah. I think, I think if I stop seeing things through the, the eyes of anorexia if, as you put it, yeah you recover and that means you don't lose control, you give it up. There's a difference. (Interviewer: Mmm, can you tell me about that?) If I was to recover, I'd be giving it up, I'd be giving the control away, I'd be handing it off, it's gone, um, I wouldn't be losing control. (Interviewer: You'd be making the choice to give it up?) Yeah, that's where I would make the choice, I don't want to make that choice. (Interviewer: Hmm). I know that. (Interviewer: Hmm. What would that choice mean for you to, to actually make the choice to give the control over or) Then that would mean that I would have to accept the fact that I would be an overweight person because that it the body structure and the body, the way I am, um and I'm not prepared to do that, under any circumstances. No, so, I don't know. When you look at it that way may be recovery isn't possible for me, not fully. (First telling, p. 24)

Sara: (Interviewer: [...] and do you see all those things as part of your recovery? Mm, I get really frustrated because I'm one of these that – it's got to be done like that, and because it's not I sometimes think I'm not getting anywhere, but then if I look back and see how far I have come I think yeah I have; but only the other day I was, actually I was only

walking, I was thinking about something and I thought, god it's so slow then I thought, well it didn't happen overnight did it? So it's going to take time, but even though sometimes that physical eating part – it's still a fair way to go - in a lot of other things I've come a long way too, so.

(First telling, p. 12)

‘Recovery’ – untroubled at first telling, troubled at second telling and third telling 10 years on

Jane: *(Interviewer [...] you were just saying that you've – that you consider you've recovered. Can you tell me how?) Okay. Because I feel so good but I'm still wary of like falling back into that pattern, that's why I won't go on diets now, I won't take laxatives [...] yet I realise it's just so easy to get back on that pattern, and so I won't do it again.*

(First telling, p. 32)

Jane: *When we last spoke, I lied about my experience with eating. I wanted to appear normal. I lied to you, I felt really bad. Saying this is a relief and there is no shame. I was trying to have that persona that things were OK. No shame. I did what I thought was necessary at that time to keep the façade going.*

(Conversation after Jane contacted me in 2002)

Chelsea: *(Interviewer: So do you consider that you've recovered from anorexia?) Yeh. (Do you want to tell me why you think you've recovered?) Because I don't feel the need to have my bones sticking out anymore. Sometimes I feel like I want to be thin, but I wouldn't start dieting again. I wouldn't think I want to be thin again so I miss out on meals because I don't want bones sticking out. I'm the way I am and I'm eating a lot of foods now, because I was just mainly eating fruit and vegetables and now I can eat proper things.*

(First telling, p.15)

Chelsea: *(Interviewer: In terms of recovery, um some people talk about that they see recovery as possible and others don't. What's your view) Um, I think a full recovery, I don't know if that exists, because I would say that I am probably 90% recovered, and I have come a long way, but I still have the battle every day, every meal and I sometimes get a bit overwhelmed thinking is this ever going to go away? So I know that you can recover to a certain extent.*

(Second telling, p. 21)

Susan: *(Interviewer: [...] What does recovery mean when you say, or speak of recovery?) For me that every single last bit of the eating disorder is gone. I mean, it doesn't mean I don't still have struggles because I do. Like I said before I have one with anger and you know I still have this problem with family and stuff but every single eating disorder is gone and any things that are there are really not eating disorder things, like when I am weighed at hospital, you know, those kinds of things are really not a problem with me and don't affect my life at all. Whatever number I*

am on the scales doesn't affect me, and what I eat doesn't affect me and all that kind of thing. Eating has no bearing on my life whatsoever. I mean I always thought that it wasn't possible to get to that point. I thought that you would always have some part of it left and you would always be paranoid about food and stuff like that but I realise now that that is not true. That's what I used to say and that's what I used to think. (First telling, p. 37)

Susan: [...] where I see myself now it's a past experience, something from the past, but I maybe would have said, you know last time we talked I probably said that its, its completely over and I've moved on from it and I have, I don't have an eating disorder, but I realise that some part of it has kind of always with you. I wouldn't call myself anorexic at all, but I kind of identify with some of the behaviours. Maybe, you know, like, for me food is often a low priority, it's not important, if I'm stressed it's the first thing to go. So I still see that it's kind of there like it's part of your personality, but I'm not really troubled by it. (Interviewer: So do you want to tell me a bit more about that part of it that's with you?) (pause) How do I explain this? It's just, it kind of makes me, I always feel a little bit different, but I don't know if that's totally the anorexia or just other things, you know, that kind of created that disorder I suppose, but, it just, it doesn't control my life at all and like I keep saying I, I don't have anorexia, but just, just the behaviours. (Third telling 10 years on, p. 1)

'Recovery' – remained untroubled

Lorraine: (Interviewer: Do you consider now that you've recovered from anorexia?) Oh, for sure. Absolutely. Like I'm like everybody else, I wouldn't mind losing a bit of weight, but I haven't got the wear-with-all to go on a diet or do, do some exercise or whatever. (Interviewer: Yeah. So can you tell me about that process, like ... the process of recovery?) Mmm, no. (Interviewer: No?) Yeah. (Interviewer: They're, are they things that, like anything that, any experiences after anorexia that stand out in your mind?) No. I, it's all very hazy. I think what might have helped is going to stay with my sisters for my school holidays while they were at uni, you know and, um, just being a normal person there. Like as soon as I came back home I'd very quickly, shrouded by my parents, got back into the habit. (Interviewer: What, what, what do you mean shrouded by your parents?) Um, come on we've got to get you home and um, brush your teeth and, mmm, yes, but I, I don't know because it seemed like after that, yeah, I just got back to normal. I've got six form photos where I was back to normal.

(First telling, p. 11)

b) Quotes related to the women repositioning their experiences as ‘moving’ from ‘anorexia’

A phrase that emerged from my earlier conversations with fourteen of the twenty one women was that of “moving on from (or out of) anorexia” (journey metaphor).

Lisa: *(Interviewer: What did it mean for you to be given a label?) That I was sick, that I had an excuse for everything to a certain degree, that I could understand everything now because I was anorexic. It took away a lot of responsibility from me and, I don't know it's hard to say, I just, it was almost something that I was proud to have I look behind now and think why the hell (pause) I'm kind of moving past that a bit now.*

(First telling, p. 1)

Lisa: *[...] I mean last year I kind of, I think when I spoke to you I said that, um I, you know, I don't want to get any better than where I'm at right now, but then I look to last year and look to now and I think I've moved a bit. I, I think I would have said last year I can't image ever not having it to some degree and I still can't ever image not having it to some degree, but at the same time I have moved from last year and may be next year I'll move a bit further and a bit further. Who knows? But at this point in time I've seen a big move in myself, but at the same time I can't, it would still, like it still, as this week's been a real battle for me it's still in there, in there and I don't know if it will completely go.*

(Second telling, p. 17)

Anne: *[...] I seem to need that judge, mental side to keep myself in that little, tight square that I create, I had created for me in my formative years and I guess that it's probably frightening to move out of that because in my formative years it was so ingrained in me to behave that way and to live up to others expectations of me.*

(Second telling, p. 2)

Catherine: *(Interviewer: [...] and was it like a release from anorexia? or it was a release of anorexia? Could you tell me what you mean by “release”?) I don't know if it's a release from it because I believe that it never goes away, I just don't think it will completely go away, but I think you're moving away from it, you're taking steps away from it, you're controlling it, it's not controlling you. I think for me, the only way I can stay well in my life is to control it and not let it control me the way it was. I think*

you've got to turn it around, you got to be able to say "I'm doing this so leave me alone". I think you have to be able to talk to it in your mind – not like talk out aloud or anything but you've got to know or you need someone around you that's very close to you that can see it for you and just gently help you. I think that's it, but I don't think it ever goes away, I don't think it's – I think it's always going to be there. (First telling, p. 17)

Chelsea: *I feel sad that it overtook my spirituality, because, um, yeh, I have been a Christian for like eight years or whatever, and I have always been blessed with a lot of things that I took for granted and then I experienced the eating disorder. Yeh, but um, you know, it's done and I can move on and stuff. (Second telling, p. 16)*

Darcy: *I think the main difference between now and twelve months ago is I have moved forward in other areas of my life. I feel happier in myself. (Second telling, p. 4)*

Chloe: *Understanding why you're the way you are or when you're sick why you're sick, what's behind the problem and sorting yourself out and getting all that straightened out. I guess most anorexics are the way they are because of things that have happened in the past and getting over the past, leaving the past and moving on. I think that's what it was really. (First telling, p. 3)*

Chloe: *(Interviewer: So when you think about your experiences of anorexia, what are some of the meanings of anorexia for you.? [...] Would you attach certain meanings to your experiences?) Not really, just that it was I mean a long process, but it was a way for me to learn how to deal with things, and how to move on from things that had happened in the past. I guess more than anything it taught me how to deal with problems and things that had built up over years. (First telling, p. 13)*

Fluff: *I like to think that you've moved ahead, you haven't just gone back to where you were. You know. Ten, 15 years ago before it all started, so – (Interviewer: How do you think you've moved ahead? What's – can you identify parts of you –) I think you just understand yourself a bit better. Perhaps you know what your weaknesses are, so therefore, well you've acknowledged what your weaknesses might be. So therefore, kind of do your best to steer away from those sorts of situations. (First telling, p. 17)*

Katie: *[...] it means that I'm moving on from it I guess. It's like an alcoholic that can admit they're an alcoholic I guess, but I don't know, it's I think it's me growing up. (Second telling, p. 4)*

Kelly: *(Interviewer: When you think about the good things in anorexia and then the bad things?) Well the good things I tried to build on the good things to get over it. The bad things, you just don't want it. You just don't to build on anything. You want to try to forget, to push that into the*

background, but hang on to the good things and I think that's what the most difficult part is to sort out what's good and what's bad, and to let go of those things and move on with the good things.

(Second telling, p. 1)

Kelly: *I feel like I have moved on since doing it*

(Reflections on second telling, p. 23)

Mary: *(Interviewer: [...] what does it mean for you that it's always a part of you?) Its part of my experience, there's nothing I can do to get rid of it or I don't want to get rid of it, it's there, it happened. I can move forward and it's my life, it's a deep dark part of my soul, it's just there. I always get a bit worried when people think about things, like they put that aside, and it's not a part of them anymore. Its like, isn't it just denying that it happened? It is part of you, really it is. What you make of it is your choice, like how you move on from there or backwards from there is your choice, but it's there. It's sort of a bit like your pancreas, it's there, you don't really think about it that often, but you don't really want to have it removed.*

(First telling, p. 24)

Naomi: *(Interviewer: [...] and you say that you developed this – what you feel is a higher state of being. What does that mean for you, to feel that you sort of-) It gave me something to move on with, because if I was to let go of my anorexia well what'll I do? Who am I? and that gave me something to develop and explore, and obviously that's changed at varying times in my life, since – but, it gave me something to move to, to something that was not destructive, something that was purposeful, that provided some element of happiness, sense of being, a sense of belonging, without being destructive anymore and getting my life on track. It's hard to get your life back on track, because you waste a lot of years, don't you think?*

(First telling, p. 7)

Naomi: *(Interviewer: [...] is that how you define grief in your experience?) In my experience from anorexia, the grief was how do I move on, how do I go on without bringing it with me completely? How do I (go on?) so it doesn't suffocate me but yet I don't forget it? How do I keep on growing without losing all the experience that I got from it? [...] and it is hard work to recover, it really is, and that grief is so touch and go because as I say you don't want to lose the experience if you can get growth out of it, and you only grow because of that experience and where do you – where do you move on? What do you leave behind?*

(First telling, p. 23)

Sarah: *(When talking about her leap in trust in her relationship with her therapist)*

[...] I've had periods of times where I've just stepped enormously in a, made a big leap in trust. I mean trust is something you build up over a

long period of time. When people prove themselves to be trust, trustworthy which they have, the struggle of trust lies within myself, not with them definitely, but I felt like I'd moved closer and I was thinking I have no idea what's happened, but it just felt as though you know, I'd taken a step closer and then I had this picture in my mind and there often, they just flood and there often so clear, you know, it's like actually looking at something and I, I saw this picture of this rushing river and the therapist standing on a big stepping stone in the river and a part of me was on another rock with still this flood, this rush in between, not daring to move; and I could see that part of me had jumped on to the same rock and, um, it was very interesting. **(First telling, p. 13)**

Susan: *(Interviewer: So understanding more enabled you to be able to do more, accepting more and why you needed to do those things. How did this understanding or greater acceptance of those abnormal things and how you came to do them, do you think that that sort of enabled you to move from this abnormal person view of yourself to a normal person view of yourself?) Yeh, I suppose so because as I accepted more about my past and the things I had done, I attempted more - like I a few years ago I was in such a kind of depressed state that I thought I was dumb and I didn't ever think that I could achieve anything and so I didn't. I was on a sickness benefit and I did nothing except control my weight and when I started to move out of that I started to want to challenge things.* **(First telling, p. 6)**

APPENDIX 8: Original interview transcripts.

(Disc attached to end of thesis for marking purposes only)

APPENDIX 9: Retention of original research data



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RETENTION OF ORIGINAL RESEARCH DATA

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Course: Doctor of Philosophy (Psychology)

Title of Dissertation:

“It’s part of what makes me”. Women’s constructions of ‘anorexia nervosa’ in their identity journeys over ten years

Date of submission: _____

I, Janet Conti, undertake to retain original data associated with the above dissertation for five years until

(day, month and year – five years from submission date)

Signed: _____

Witness: _____

Witness name: _____

Date:

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