Anorexia Nervosa Stories

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ABSTRACT

The wind, the seas, the storms
unpredictability their nature
howling, raging, destroying
some soul structure hopelessly enveloped
within an unknown grip
a grip that tenses, strangles.

(Diary extract, 1972)

These words take me back 35 years ago to my lived experience of anorexia nervosa. It is this history that enabled me to question the relational narratives of anorexia – my own history and that of the women who participated in this research.

This thesis is a study of the way women, who were once diagnosed as 'anorexic' story their lives. I wanted to find out what relationships and what cultural knowledges constituted their stories. I believe 'anorexic' stories are the starting point for understanding the meaning given to experiences of anorexia because it is the stories we live by which enable us to make sense of our lives.

My study of these stories and their cultural knowledges has been informed by social constructionist and post-structuralist theories. These theories have enabled me to understand that the meanings we ascribe to our identities are mediated through power relations embedded in cultural discourses.

Using Brown & Gilligan's (1992) voice-centered relational method for doing psychological research I have listened to three women's stories to understand how meaning was inscribed on their experiences of anorexia nervosa.

My analysis of the women's stories focussed on the relational actions and events they experienced whilst growing up. I found it was the dominant relationships the women encountered which gave meaning to their lives and spoke to them of their thin identities. These were very thin identities, framed by our dominant cultural knowledges, and which, for women in our society specify a highly individual and gender specific way of being in the world.

The possibilities for re-authoring our thin anorexia stories are also discussed.

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(Diary extract, 1972)

Despite its power to terrorize and shame me within its stranglehold, 'anorexia' was unable to silence me completely and so my diary became my refuge. My diary voice was a subjugated voice and has become for me a starting point to understand the way this disorder the medical profession call 'anorexia nervosa' was able to completely take over and almost destroy my life.

Today I write in a very different voice - a voice that attempts to resurrect subjugated knowledges that might enable a space for healing. It has been informed by social constructionist and post-structuralist knowledges which have enabled me a different understanding of 'anorexia' and has inspired me to explore anorexia nervosa, not as an eating problem, but as a meaning problem. Understanding meaning as embedded in powerful cultural knowledges which have been given 'truth' status and which continue to permeate and constitute women's lives, enables ways of re-storying our lives.

My intention is not to try to prove any particular theory about anorexia of which there is a proliferation but rather I am attempting to come to an understanding of how and why as subjugated bodies, we women who experienced anorexia nervosa were not able to acknowledge in any other way, than by self-starvation, our very thin life stories that had been constituted through personal, interpersonal and cultural relationships.

Chapter 1

INTRODUCTION

I'm riddled with hate for me. I hate what I am which is me, a useless load of junk. Thus if that's what I am in my eyes what must others think. Why won't I eat? I'm too ashamed. I'm not worth feeding, well it's true.

(Diary Extract, 1972)

This is not the language the medical profession use to describe anorexia nervosa. They use the language of the medical diagnosis to describe and give meaning to the person who self-starves. This diagnosis is found in the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is now in its fourth version (DSM-IV). In DSM-IV, anorexia nervosa is defined as an eating disorder and is included as a distinct diagnostic category within the DSM classification of disorders. When I was diagnosed DSM II was in use and anorexia nervosa came under a category of eating disturbance. It first appeared as a specific disorder in DSM III (APA, 1980) with its essential features being intense fear of becoming fat, self-induced weight loss, and a disturbance of body image. Bruch (1973) described the disorder as the relentless pursuit of thinness. These features have remained stable over time with the inclusion of amenorrhea as essential in DSM IV (APA, 1994). The course and outcome of anorexia however, is highly variable and there remains no known etiology. Predisposing risk factors generally fall into four broad categories: developmental (identity, autonomy), familial (rigid boundaries, high conflict), biological (onset at puberty, gender) and sociocultural (ideal body shape) which lead to the initiation and persistence of anorexia nervosa (APA,

1994). DSM III reports the disorder occurs predominately in women (95%) but this rate is reported as 90% in DSM IV.

From my perspective as a diagnosed anorexic some 35 years ago my understanding of anorexia had very little to do with a distorted body image or a fear of weight gain. Rather, it was all to do with being too ashamed to eat because *'I'm not worth feeding'* as highlighted in my diary extract above. When I was diagnosed back in the late 1960s I remember feeling silently relieved because I no longer felt like a hypochondriac. There was really something wrong with me, even if I did not understand what it was all about. But still I felt very ashamed and alone, as I was unable to make sense of my experience of anorexia. Neither friends nor family talked about it because they had never heard of, or known anyone with this disorder. They were also afraid to talk to me about it for fear of upsetting me.

Although anorexia nervosa was first named in 1874 it has become increasingly prevalent since the 1960s. It was during this time that anorexia was usually attributed to cultural norms regarding desirable body shape and weight (APA, 1994). The increased prevalence of anorexia nervosa has manifested itself in a variety of meanings ranging from the institutional discourses in which anorexia is constituted as a clinical entity to the popular discourses surrounding anorexia, femininity, subjectivity and the body (Malson, 1998). These discourses have become alternative meanings for anorexia nervosa, which were not available when I was diagnosed.

The only sense I could make out of my diagnosis was the following:

I'm sick, sick, sick
to the very core or what you might call a hopeless case,
rotten, putrid through.
(Diary Extract, 1972)

While I identified with this diagnosis at the time I now realise the power it had over me in being able to make me believe I was sick to the core. I offered no resistance and I succumbed to the diagnosis and treatment.

Having read Foucault's (1980) post-structuralist theories relating to power and knowledge and the constitution of subjects, I have now come to understand how I became objectified as a subject of power through knowledge, through the normalizing effect of the diagnosis. Foucault (1991) has described how this

practice of medical diagnosis and scientific classification coincided with the practice of objectivisation. Such practices constitute the body as an object. Foucault (1980) has described how this objectivisation of the subject is caused by "technologies of power which determine the conduct of individuals and submit them to certain ends or domination" (p.146). He has proposed that once people are treated as objects they see themselves as objects, and evaluate themselves, and structure their bodies to fit instructions and specifications. In this way, people are constituted and they become either 'docile bodies' or 'rebellious bodies'. A 'docile body' of the medical gaze resonates with Foucault's body "that may be subjected, used, transformed and improved" (p.180). From this notion of power, I can account for my becoming a 'docile body' once I was diagnosed.

Foucault (1980, p.176) has argued that the development of this objectivisation process is mixed with, and essential to the operation of power in the modern state. He has traced its beginnings to the objectivisation of bodies to Paris in 1656 when the insane were institutionalised. It was from this time that the idea of treating individuals as objects was developed for the purposes of social control. In understanding power this way I can see how this form of power rather than being restrictive is constitutive of people's lives. According to Foucault (1980) the practices of this constitutive power filter through all aspects of people's lives, right down to their feelings, desires and behaviours. In this way it pervades our whole existence, constituting our whole image of self, and in my case, my anorexia.

Because these practices of power constitute our very self-identity through processes of objectivisation we become the subjects of our own subjection without even knowing it. And it is exactly this insidious nature of its operations that Foucault (1980) was intent on exposing. Therefore he has highlighted how these operations of power operate not from on high but right down in the workings of everyday society. That is, in our everyday institutions, the hospitals, the schools, the prisons, the churches and in our families. Foucault (1980) has also argued that it is in these everyday places that the workings of this power are most evident. For this reason I propose to start with uncovering the workings of this power in our medical institutions and specifically in the anorexia diagnosis as I have come to understand it.

In tracing the history of these institutions through which these practices were practised Foucault (1980) has used Bentham's Panopticon as the perfect model for this form of power which constitutes people's behaviours through objectivisation of the subject.

This design is made up of a windowed circular structure divided up into cells. Each cell could be observed from a central control tower. This ability to be constantly watched meant the cells' inmates never knew when they were under scrutiny so they could only feel secure if they assumed they were under constant surveillance. This made the inmates forever on their guard, becoming more and more self-surveillant just in case. Here we have a model which describes the invisibility of power and how when people are isolated in their experience of processes of normalisation they become their own judges and perform disciplinary practices on their own bodies. "Bentham had invented a technology of power designed to solve the problems of surveillance" (Foucault, 1980, p.148). This technology of power was able to recruit people into participating in the objectification of their own bodies and subjugation of their own lives.

We see the effects of this model in the practices that use behaviour modification treatment to treat anorexics. Central to this type of treatment process is the Panopticon concept of surveillance and the production of 'docile bodies' (Gremillion, 2003). These treatment programmes constantly monitor the self-starver's weight, which in turn makes the self-starver even more self-surveillant, which is exactly the problem for which the person is being treated. Foucault (1980) has also explained how we become willing participants in our subjection because this working of power is disguised. It becomes disguised because it operates in relation to certain norms that come to be given truth status. The power of this truth status to constitute lives can be seen in the medical diagnosis for anorexia. This diagnosis describes anorexic behaviour and "the doctor becomes the great advisor and expert" (Foucault, 1980, p.177).

This diagnosis incited me into my own subjection, which included moulding my behaviour according to the medical profession's specifications for anorexia, which I believed to be true. I did not see or understand how this medical diagnosis was a technique of power that constituted my anorexia because I believed the medical profession knew the truth about anorexia and if I

followed the prescribed treatment I would be cured of the anorexia. The disguised workings of the power of this diagnosis were effective as they incited me to co-operate in my own subjugation. Foucault (1980) believes criticism can help to reveal the power relations that constitute knowledge.

The primary effect of this power through truth for me was in the specification of my anorexia individuality that constituted me as anorexic and told me the problem was in me. It enabled me my sick anorexic identity. So I became objectified for the purposes of subjugation and shaped into a 'docile body' and inscribed with the anorexia symptoms of the diagnosis. As a subject of the medical profession's power I was judged and classified as anorexic and recruited into an active role in my subjugation as illustrated by my treatment.

The prescribed treatment for anorexics like me back in the late 60s and early 70s involved anti-depressant medication, psychotherapy, behaviour modification treatment, insulin treatment and when all that did not appear to be working some ECT. Even that proved ineffective and I was left more anxious and guilt ridden. The only way I had of reducing the guilt burden was to become more self-surveillant and food avoidant.

I understand the process of myself becoming a 'docile body' and not a 'rebellious body', which Foucault (1980) has proffered as an alternative way of being, was because I had no way of resisting this diagnosis. I offered no resistance because there were no alternative meanings for anorexia back in the 1960s unlike today where there are various cultural meanings now attached to anorexia. There also exist pro-anorexia communities that make available opportunities for resistance. Since I was isolated from other diagnosed anorexics, separate and alone like the Panopticon inmate, I could not compare experiences or generate or find alternative meanings that would have enabled me to protest this subjugation and offer forms of resistance. For me, with no other available meanings for anorexia the medical diagnosis further added to my worthlessness because I had medical 'proof' there was really something drastically wrong with me.

Rereading my diary has uncovered for me a subjugated voice, which described anorexia very differently to the medical definition, and yet it was a voice, which offered no resistance but rather reiterated the sickness discourse. It has sadly reminded me of the long forgotten anguish and despair caused by

my experience of anorexia so many years ago – a time when the medical profession and family and friends did all they could to help me but the only understanding I had of anorexia was the diagnosis. It made very little sense to me and only served to reinforce my guilty and negative feelings about myself.

As a woman who was once subjugated and diagnosed as a psychiatric patient I am interested in subjugated knowledges - knowledges that (Foucault, 1980, p.82) described as "disqualified and marginal". He argued that it is through the emergence of these non-qualified knowledges from such persons as the psychiatric patient and the ill person, that criticism performs its work. To meet this challenge, an aim of this project is to listen to, and represent other women's voices and the meaning they give to their cultural experiences.

From my first-hand experience, (my insider narrative) of anorexia I believe, as Robertson (1992) has argued, that anorexia discourses lead girls and women to understand and interpret their self-starvation practices and feelings in terms of the language of the diagnostic category. The legitimacy of the mainstream medical diagnosis for anorexia continues to dominate our understanding of anorexia today just as it did back in the late 1960s for me. Not only was it able to make me believe I was the cause of the problem but the medical profession and family and friends came to view me as the problem as well. I became the focus for treatment with no understanding of the origins of my behaviour except that I was sick and in need of psychological services.

The tendency to shift clinical attention away from the various cultural experiences that place women at risk through locating that risk within the individual, pathologises women's experience (Malson, 1998). This within-individual deficit model of anorexia nervosa attributes anorexia to deficits in the individual and fails to account for the larger context within which the person and especially women live. It tells us nothing about the person diagnosed with anorexia but rather tells us only about the diagnosis. This means questions and answers will be related to the diagnostic understanding of anorexia, which places the burden of change on the anorexic and frees the larger society of taking responsibility for addressing gender issues. When one considers that most diagnosed anorexics are girls and young women, it seems that a gender analysis is necessary. Working from a notion of deficit also tends to diminish the value placed on the anorexic's own understandings which is demonstrated

by the absence of the voices of anorexics themselves from quantitative studies on anorexia (Brown, 1998).

Reading social constructionist and post-structuralist understandings of the social construction of anorexia has enabled me to revisit my experiences which I now understand as social and changeable, and I no longer believe as the diagnosis made me believe that anorexia nervosa is a person problem. Rather I now understand it as a meaning problem bound up with knowledge and power. The reason why anorexia nervosa is a meaning problem is because we will never find one true meaning for anorexia because as post-structuralist theory informs us meaning is plural and unable to be fixed and is subject to interpretation.

Believing that there is no one true meaning for anorexia Malson (1998) has listened to a number of self-starvers constructions of anorexia and has discovered the self-starved body is representative of not just one meaning but sustains a multiplicity of meanings that are both self-productive and self-destructive. Therefore, writing from a feminist post-structuralist perspective, Malson (1998) suggests self-starvation is expressive of a multiplicity of societal concerns that are specific to the socio-economic, cultural and political dynamics of contemporary western culture.

Considering anorexia nervosa as a meaning problem because of differing interpretations ranging from the medical to the post-structural to the anorexic's own differing meanings, has helped me to understand why my diary meaning is so different to the DSM meaning. The DSM meaning is the medical profession's interpretation of anorexia constituted from medical language which has been legitimated through scientific knowledge, whereas my diary meaning is a sufferer's interpretation of anorexia constituted from my own non-powerful, non-medical language. Hepworth (1999) has highlighted this plurality and flexibility of meaning constituted in specific language in her historical account of the problem of anorexia. Her account discusses the historical emergence of anorexia as an object of medical discourse and has shown how meanings change with shifts in the range of language or discursive fields, which constitute them.

Hepworth's overview of these shifting meanings over time starts in the twelfth century when the first documented cases of self-starvation were

recorded with descriptions of starving Catholic saints. These women were living at a time when their Italian culture held holiness in the highest regard and the religious system had religious power. At this time the main interpretation drew on religion and it has been proposed that these women saints starved themselves to death in the name of holiness (Bell, 1985). Only by fasting and self-punishment would these women be worthy of a relationship with God. As time went by the thinking of the religious authority changed as women came to be seen as immoral and deviant. Therefore, their religious fasting came to be interpreted as a form of madness and during the fifteenth and sixteenth centuries witch-hunts were undertaken.

Following the shift from a religious to a scientific or medical authority the meaning of witchcraft also changed. Witchcraft came to be understood as a consequence of women's hysteria, which signified a disordered mind. By 1874 Sir William Gull diagnosed women's food refusal as a nervous disease and ruled out any underlying organic cause. Anorexia became understood in medical literature as a problem of femininity and was seen as an extension of female irrationality. Thus, self-starvation was accepted as a psychological phenomenon that resulted from psychopathology. The category of anorexia nervosa was now constructed through psycho-medical discourse and constituted the very pathological behaviour it was seeking to explain.

This historical account of the changed meaning of anorexia illustrates how meaning is problematic because it depends on interpretation and cannot be fixed because it is constituted within language which is itself made up of a range of ways of thinking or discourses which may change over time. These discourses or meaning systems were conceptualised by Foucault (1980) to describe the way language constructs its objects. This occurs because as we acquire language we learn to give voice or meaning to our experience and to understand our experience according to particular ways of thinking or particular discourses. These ways of thinking constitute our consciousness and our sense of self, or in other words, our subjectivity.

In this way language does not just reflect what we think our reality to be, it also constructs our beliefs. Therefore language is the place where our sense of self, or subjectivity is constituted, and can therefore explain how our self-identity or subjectivity is socially produced from the range of cultural discourses

we encounter whilst growing up. This theory helps me to understand that my 'worthlessness' and subsequent self-starvation, described in my diary extract is not an expression of any innate self or something I was born with, as the DSM would have me believe, but rather how this worthless self-identity has been socially constructed. Because as social constructionists (Gergen & McNamee, 1992) inform us, our subjectivity or self-identity is mediated through culture. All knowledge including self-knowledge arises from social interchange and is mediated through language, which exists in specific discourses. This explains how my self-knowledge and my sense of worthlessness have arisen from my cultural background located in dominant 1950s discourses around gender, family life, religion, and education.

In previous research undertaken by Cooper, Todd & Wells (1995) other self-starvers' self-beliefs were also found to be negative and unconditional like mine. They included beliefs about being worthless, useless, inferior, a failure, abandoned and alone. The origin of these negative self-beliefs was investigated by asking the participants about their earliest recollection of having such thoughts. Most participants were able to identify specific origins for their negative self-beliefs. "These were usually unpleasant early experiences and included physical abuse, emotional abuse, neglect, and lack of attention or acceptance by others" (Cooper et al., 1995, p409). All these experiences were dependent on relationships, or social interchange, which the social constructionists tell us, is the site for developing a sense of identity or an inner voice. Therefore, since meaning is mediated through language in relationships, and bound up with knowledge, which is bound up with power, I believe that meaning, knowledge and power are inseparable in their constitutive aspects and in their ability to construct our identity.

To understand how this meaning, knowledge, power process interrelated to construct my sense of self which is my femininity, it is necessary to go back in time and attend to the discourses which have constituted femininity. Foucault (1980) has proposed that as a culture develops knowledge of what is legitimate, normalizing discourses are created and accorded truth status. Through power and knowledge these discourses become incorporated into human subjectivity and in this way we become normalised into femininity by cultural gender norms.

Bartky (1990) illustrated cultural construction drawing on Foucault's notion of the Panopticon. She reminds us we are born male or female but not masculine or feminine. To become feminine we have to learn society's gender norms, which become visible through our behaviours and physical appearance. The way these norms are played out is through disciplinary practices of the body, which socialise us into womanhood. And it is the same techniques of power that gave truth status to the anorexia diagnosis that have given truth status to society's feminine gender norms. It is through these gender norms that as women we unknowingly become subjected to and forge ourselves into 'docile bodies' using disciplinary practices. It is these practices which Bartky believes are a form of obedience to patriarchy because men are more often the instruments of the normalising gaze and women more often its subjects. And so we women become like the Panopticon inmate, objects of power and knowledge, and self-disciplined subjects constituted by procedures of surveillance and normalising judgements (Foucault, 1991).

In order to understand how and why I became so self-disciplined at adolescence before my anorexia diagnosis, consideration needs to be given to what adolescence means to girls in our society. Just as power techniques have produced dominant truths about femininity and anorexia, which are specific to women's lives and relationships, so have truths about adolescence been developed. This is evidenced in the traditional patriarchal developmental theories which view adolescence as a developmental stage of separation and individuation problematised as an inability to separate and to gain a sense of autonomy (Bruch, 1973).

Gilligan (1982) has argued that boys experience adolescence differently to girls. While boys' adolescence might be a time of separation and independence her research has shown adolescence for girls is a time of developmental crisis that is part of a cultural initiation into womanhood and is dependent on relationships. In their research on girls development (Brown & Gilligan, 1992) found that at adolescence girls showed increased self doubt about what they believed and were at risk of losing their inner voices. They have therefore proposed that at adolescence when girls begin to comprehend cultural values and expectations they begin to doubt the authority of their own experiences. As an effect, they become divided as to whether they should

follow their own inner beliefs or follow patriarchal cultural expectations, which demand independence and autonomy.

In this way society's cultural practices subject girls to fragmentation of their self and in their relationships within which feminine identity develops. This occurs because girls are more concerned with connectedness and relationships and fear being isolated from others. Brown & Gilligan's research findings identified three pathways through adolescence for girls. The first pathway was illustrated through a narrative of the girl who remains in touch with her own internal voice and expresses what she knows. An alternative pathway is the path taken by the girl who covers over her strong feelings and remains silent to protect her image and avoid hurting others. When a girl is unable to remain silent she is forced "into a 'psychological resistance', where she struggles to remain in touch with herself and her feelings" (p.185). And so the girl who self-starved disconnected from her childhood friends and aligned herself with standards of beauty and expected maturity norms. Out of relationship with others, the self-starver became more and more confused and out of touch with self, until she no longer knew what was happening in her abusive relationships or to herself. This girl had lost her ability to satisfy her needs while at the same time knowing practices of self-denial. From their research it has become clear that the desire of the self-starver is for relationship and it is only in relationship that there is a reliable chance for positive outcome (Bergin & Garfield, 1994).

The importance of relationships for me when a self-starver was highlighted by my diary where I talk about being very isolated and lonely and desperately wanting someone to talk with, who would be able to understand. Ironically my belief about my unworthiness would not allow me relationships. I pushed people away thinking I was unlikable and unworthy of friendship. In my case my cure was made possible by a relationship which did not see me as sick or worthless but rather regarded me as loveable and so I was able to begin to appreciate myself and feel worthwhile.

This need for relationship resonates with questions for me about how anorexia was able to strangle me at the time of adolescence. I understand, as Brown & Gilligan's research has shown that at adolescence girls become subjects subjected to cultural power relations that hold femininity in place. For me I became a subject of the gender norms I had been subjected to whilst

growing up. These were the typical character traits and behavioural dispositions of the truly feminine woman which cast women in the realms of the thin, attractive, nurturing, passive, gentle and warm subservient homemaker (Bartky, 1990). Combined with my family, educational and religious experiences that are also part of my cultural background and therefore involved in my identity, I developed my worthless identity. Then at adolescence when I so much needed to be in relationship to understand my experience, I rejected relationships believing myself unworthy and in so doing denied my need not just for relationships but also for food. Positioned as a needy (passive) woman in a discourse of the 'truly feminine woman' being diagnosed anorexic was all the proof I needed for my worthlessness.

My Study

Writing from the position of a woman who was once inscribed with the psychological discourse of anorexia nervosa I am concerned with power and the way it is inextricably bound up with meaning, language and knowledge. Today we have a multiplicity of often conflicting ways of understanding anorexia nervosa but it is still the mainstream medical diagnosis of anorexia which is given authority to prescribe how we should understand the experiences of girls and women who self-starve. Therefore, my concern with power relates to the power afforded to the medical profession to objectify the person who self-starves and classify her as psychologically disordered. In this way diagnostic classifications take attention away from the power of the gendered social relations in which the disorder of anorexia is constituted, regulated and maintained.

These power relations have been questioned by post-structuralist theories that challenge psychology's traditional scientific and objective study of the individual and focus instead on the relationship between human subjectivity, power, knowledge and discourses (Weedon, 1997). Therefore, as a challenge to the individualization of the women who self-starve I have taken as a focus for my research questions the often silenced voices of these women.

I take as my starting point the voices of the participants who will be asked to talk about their life experiences. These subjective experiences are all important because they represent subjugated knowledges that have been marginalised and disguised within mainstream theories of anorexia nervosa. By listening to the ways in which the participants make sense of their lives will be helpful in coming to an understanding of how power relations construct women's identity at a particular site.

Since voice depends on relationships because speaking relies on being heard and because self-identity takes place within relationships, I have used Brown & Gilligan's (1992) voice-centred relational method to listen to the participants' voices. As well as listening to their voices I will also be listening for others' voices which have been appropriated by the participants and which have constituted the participants' identity or subjectivity (Brown, 1998). Therefore I will be listening for the voices and attending to the various cultural discourses to which the participants have been subjected. These cultural discourses might have been appropriated and circulated through the voices of family, friends, education, religion, gender and the medical profession.

By listening to the voices of the participants I hope to come to a better understanding of the processes through which women and girls in our society today become inscribed with anorexia nervosa. In so doing we may be able to understand how the anorexic's suffering is not caused by some internal pathology as the DSM would have us believe but instead is constituted through a deep, internalized understanding of the various powerful cultural voices girls and young women encounter in today's society.

Chapter 2

METHODOLOGY

In my previous chapter I have shown how my diary writing voice came from discursive fields of the 1970s embedded in the culture of that time. Today my writing voice comes from the discursive fields of feminism, social constructionism and post-structuralism. And so my voice and the meaning I give to my experiences has changed because I now understand how meaning cannot be fixed for all time because it is open to reinterpretation (Weedon, 1997). In the '70s my life meant nothing but worthlessness to me generated from the way I storied my cultural background, reinforced by the dominant medical discourse of the day. Reinterpreting my life story and understanding how it enabled the shape of my life story, has meant I have a different story to live by – a story that makes my life worth living. This reconstructed story is achieved by coming to terms with the disciplinary and discursive practices of my culture.

This chapter introduces other women's stories of their lives and their experiences of anorexia nervosa. It also introduces the relational approach I have chosen to analyse these stories to come to an understanding of the meaning they have given to the events in their lives.

A narrative methodology is consistent with listening to women's stories because the focus of attention in narrative analysis is the stories told by individuals (Reissman, 1993). Polkinghorn (1988) equates 'story' to 'narrative' and explains how a story is composed of a series of actions or events that affect us. Narrative meaning focuses on the relationship between these actions or events. Analysing the contribution that these actions and events make to a

particular outcome and then organising these actions into an integrated plot creates meaning. A plot is the organising theme that identifies the importance of the events and actions of our lives. It enables a transformation of a list of discrete events and actions into a schematic whole by recognising their contribution to the development and outcome of the story. Without the plot each action and event would remain separate and its meaning limited to its space in time (Polkinghorn, 1988). Stories are able to connect events and in so doing give meaning to experience and it is this meaning which is identified in narrative research.

By taking a narrative approach I am assuming that narrative is a way of knowing, rather than a reflection or a mirror of a life. I know my '70s story was not just a reflection of my life because the events and actions that composed my story had real effects on my life. These real effects are evidenced in what I believed about myself and my self-starvation practices. I gave my meaning to my experiences through language, which is not a transparent medium for observing our world. Language actually constitutes and alters our very being. We are all born into a culture which is organised around language and as we acquire this language we learn to give meaning to our experience through discourses which Foucault (1980) has argued operate on us through power and knowledge which constitute our selves. Because we are often unaware of how we have absorbed or become inscribed by our cultures we subscribe to various discourses, or meaning systems, unknowingly. As Foucault (1980) argues these discourse then come to be seen as 'truth' about ourselves and who we believe ourselves to be. Such is the action of power through these discourses.

Anorexia as Experience

According to Brown (1998) very few women have spoken about their experiences of anorexia and often research has been confined to objective quantitative analysis. This traditional type of research is based on the idea of the known object (the people being studied), who is the object of inquiry, and a knowing subject (the researcher) who examines their subjective experiences and their social ramifications (Sauko, 2000). The person who self-starves

comes to be seen as anorexic with no other redeeming features - a passive object with disturbed cognitions such as a fat phobia and a distorted body image. Research that regards the person as the object of inquiry makes no attempt to understand the private subjective world of the person or to find the meaning of the self-starvation practices. This type of research limits the extent to which we can explore anorexia as a socially and discursively produced problem (Malson, 1998).

By regarding anorexia as a discursively produced problem dependent on discourses which according to Foucault (1980) are meaning systems bound up with power and knowledge, I have come to understand anorexia as constituted through meaning. I believe anorexia is a problem of meaning because I understand that my experience of anorexia depends on my interpretation. My interpretation, in turn, depends on the discourses that I have come to believe in. Previously I have equated 'meaning' with 'voice' in the sense that as we acquire language we give meaning or voice to our experiences. Because there is no truth in a fixed meaning Ribbens & Edwards (1998) also argue "that when we analyse interview transcripts we hear stories, accounts, or narratives spoken by a person in a voice/voices" (p136). Brown (1998) argues that a person's voice necessarily ventriloquates as it speaks through another voice or voices. This speaking through others is described as the appropriation of others voices that are able to change whole aspects of ones experience. Our own voice then, is a culmination of all the different voices that one hears in various relationships whilst growing up that constitutes the culture in which we live (Bakhtin, 1994). These are the very voices and relationships I propose to analyse in my research in search of meaning. Therefore, a voice-centred approach seemed most appropriate. So to analyse women's narratives of anorexia I have used Brown & Gilligan's (1992) Listening Guide which is a voice-centred relational method for doing psychological research.

This method assumes that narrative organises human experience and recognises that there are multiple layers of meaning in experiential narratives (Tolman & Brydon-Miller, 2001). Gilligan et al. (2002) have explained it is designed as a way of coming to know another person's inner world. It aims to uncover the range of different voices that compose the voice of any given person which is always embodied in culture, and in relationship with oneself.

Since 'voice' depends on relationship, because speaking relies on being heard this method is intended to offer "a pathway into relationship rather than a fixed framework for interpretation" (Brown & Gilligan, 1992, p.22). It is based on the social constructionist principles that the meaning we give to our experience occurs in relationship with others and, as such, our sense of self is inextricable from our relationships with others and with the cultures within which we live.

The Listening Guide has its origins in Gilligan's (1982) work on identity and moral development and was developed as a response to dissatisfaction with the coding systems being used to analyse qualitative data (Gilligan et al., 2002). These systems did not allow for multiple codings of the same text but rather placed codes into single static categories. In this way the complexity of relational meaning-making processes was simplified. At that time, many social scientists were becoming more interested in developing methods for studying and interpreting narratives as a way of understanding meaning processes. This interest in narratives was a part of a growing awareness that the emphasis on quantitative methods in psychology was limiting. Quantitative methodologies restricted our knowledge of experience to that which could be captured numerically. Many researchers worked to develop and define systematic methods for examining qualitative data in more complex ways.

According to Gilligan et al. (2002), the Listening Guide method has been used by many researchers who are interested in the importance of relationships and their subsequent affect on our behaviour. They have analysed a range of issues within psychology including girls' sexual desire (Tolman, 1994), adolescent girls' and boys' friendships (Way, 1998), girls' and women's experiences with anger (Brown, 1998; Jack, 1999), women's experiences of motherhood and postnatal depression (Mauthner, 2000), and heterosexual couples' attempts to share housework and childcare (Doucet, 1995)

These researchers have used Brown & Gilligan's (1992) voice-centred relational method which focuses on relationships and the relationship between the interviewee and the interviewer in search for meaning because it is only through the practice of relationship that meanings can emerge or become clear (Taylor et al., 1996). Who is listening, as well as who is speaking, is identified, because it is through the relationship that a narrative account is produced

interactivity. This depends not only on the questions of the interviewer and the experiences of the narrator, but also on the cultures of both which move them to speak and act in certain ways (Tolman & Brydon-Miller, 2001).

As well as being a relational method, it is also a feminist method concerned particularly with the reality of power relations (Taylor et al., 1996). Power relations that operate in the anorexia diagnosis position the medical profession as expert. They also constrain the woman who suffers from anorexia to a position as victim. Power which is embedded in the medical profession's knowledge about anorexia which has been given truth status through the knowledge and power of the medical discourse and because of this power women's knowledge about their own experience is excluded. What the diagnostic criteria tells us is not about the person diagnosed with anorexia but about the discourse that is being inscribed on the person (Saukko, 2003).

Being aware of the power relationship within the research relationship is also a common goal in feminist, voice-centred research. This method requires that I examine my own position and power with respect to the women I talk with. What is said, and not said, suggests the boundaries through which the speaker and the silenced are positioned. Using a semi-structured approach to the interviewing enables an understanding of anorexia from the women's perspective and enables the women to introduce important new knowledge that I had not anticipated.

Feminist Principles

Feminist research also advocates self-disclosure and Reinharz (1992) has suggested that disclosure can put women at ease and initiate dialogue so that both parties become co-researchers. As women co-researchers I want us to be collaborative with my telling of my story enabling them to trust me enough to share their experiences with me. Harding (1987) further supports this disclosure so that as well as being a researcher I appear also as a woman with feelings and emotions who has also suffered as they have. By respecting and encouraging each other's voice our collaborative relationship enables us the possibility to learn from each other. In this enabling I hope to be able to include

women's voices that have been excluded by the medical discourse that positions us as 'objects of inquiry'.

By recognising and disclosing my positions I can become aware of my own bias and remember that my interpretation cannot be objective, because the meaning of any story is created through the process of interaction between people and their interpretation. As Reissman (1993) argues this interpretation occurs during the whole research process. She identifies five stages of listening, telling, transcribing, analysing and reading. Each stage involves subjective interpretation on the part of the woman telling her story, myself as the listener and analyst, and also the reader. Although my goal is to retell the women's stories, my story about their stories is co-created through meanings that are not neutral and transparent but open to interpretation.

As well as self-disclosure, a feminist method also avoids decontextualising the interviewer and interviewee from their social and historical backgrounds. Decontextualising excludes women from their own experience as no account is taken of the way events and relationships shape our stories. Therefore feminist methods take cultures into account, including the dominant patriarchal culture. According to Peplau & Conrad (1989), contextualisation means the interviewer is aware there are many ways social forces shape human experiences. This assumes that an individual's words cannot be separated from the cultural context in which they are embedded. Based on this assumption during the interviews I was oriented toward understanding what cultural discourses are influencing the women's stories.

This method goes beyond an interpretation of voices or texts and creates relationships in which we as women are able to speak and listen to each other. It is through these relationships that language enables a connection. It brings the inner world of feelings and thoughts out into the open air of relationship where it can be heard by oneself and by others. Being embodied, language connects psyche and body, and because language is in culture, it also joins psyche and culture (Brown, 1998). Rather than focusing on objects to be studied, as traditional research does, a relationship is created through which we can voice our own thoughts and feelings and include women's voices in our search for meaning.

In the sections of the following chapter I will introduce the women who participated in this study by sharing their stories with me, the procedures through which these stories were constructed, and the analytic approach I have taken to reading the stories.

Chapter 3

METHOD

Participants

Three women agreed to participate in this study. At the time of the interviews the women's ages ranged between 35 to 42 years and had first been diagnosed with anorexia as teenagers or young adults. The women were recruited to participate through the technique of 'snowballing'. This technique involves using personal contacts to extend invitations to people who are known to me (the researcher) who have recovered from anorexia. The only criteria for an invitation was on the basis the person had been diagnosed as having suffered from anorexia and was recovered. The first person known to me to have recovered from anorexia was approached using a personal contact. Initially the woman agreed to participate but contacted me a week after the initial approach to say she did not feel well enough. She then gave me the names of three other women I could make contact with, in support of the study. Approaches were made and one of the women agreed to participate. She had recovered from anorexia but had circled through purging and bulimia as well. One woman did not meet the criteria as she had suffered from bulimia and not anorexia. The third woman lived in Christchurch, which I felt was too far away to ensure her safety while undertaking a series of interviews. I had great difficulty in finding two other women who fitted the criteria. It was while reading our local newspaper that I found my second participant. She described herself as having suffered from anorexia and depression and I scanned the local telephone directory to find her telephone number. She willingly accepted the

invitation to be a participant. Finding the third participant again took time and was located through a letter she had written to the editor of the newspaper. She had signed her letter with her name and suburb and I used the local telephone directory to find her telephone number. She had suffered from anorexia and now suffered from bulimia.

Procedure

Two women were interviewed three times and one woman was interviewed four times. Each interview ranged from 2 to 2 ½ hours. Two of the women were interviewed in their own homes and one woman was interviewed in my home. Prior to the first interview the women were given an information sheet (Appendix 1) and all participants signed the informed consent form (Appendix 2). This enabled the women to decide whether the audiotapes were to be destroyed or returned to them after the transcriptions were completed. The three participants chose to have their tapes destroyed which will happen at the completion of the project. During the interview process I was the only person with access to the tapes and they were stored in a secure location. The participants also chose their own pseudonyms to protect their identity when reporting my analysis. I also telephoned them to arrange the time and place for the first interview and engaged in some preliminary conversation to achieve rapport and answer any questions pertaining to the interviews. This process was approved by the Massey University Ethics Committee, Application 04/46.

The interviews were undertaken in the form of conversations about our life stories. These were semi-structured and I asked questions about the women's earliest memories, tracing through our childhoods and schooling and adolescence and the onset of anorexia and the effects of the diagnosis. I asked such questions to identify the cultural voices of the women's family, friends, education, religion, gender and the meanings that these voices held for these women. By identifying these cultural voices and storying these actions the women were able to give meaning to their lives.

As the interviewer I was also part of the conversation and shared my story where appropriate. I deemed this self-disclosure necessary to develop mutual empathy and a rapport so the women would feel more comfortable about sharing their own intensely personal stories with me. Once our child-hood through to present-day experiences had been storied questions were asked about how anorexia had affected the women's lives. This included its effects on family, peer relationships, social and working lives, with an emphasis on how it had affected their view of themselves. By asking such questions anorexia became objectified and no longer was the person the object of inquiry. The object anorexia became the subject of conversation.

Each interview was audiotaped and transcribed. The transcriptions included the contributions of both interviewer and interviewee. Pauses and 'umms' were included as well as other notations of meaning such as laughs. After each interview the transcript was posted to each participant for editing, comment and change before the next interview.

Responses to the interviews were very positive. Two of the three women have phoned since their last interview. An ongoing collaborative relationship with one woman has enabled us to continue to learn from each other. She has been encouraged and inspired to write more poetry about her experiences and continues to share her work with me.

The other woman who made contact used the following words to describe the effect of our conversations.

> *Thanks so much for the time you spent with me. I enjoyed it and you were an inspiration to me. Very few people are, but you certainly were.*

I could not help but be humbled by these words as I had learned so much from her. In sharing our stories we had both experienced catharsis in the sense that our stories had been transforming of our lives because each other's story had resonated with our own hopes and aspirations. That this research process enabled such transformation validates and affirms the aims of the project.

Analysis

Using Brown & Gilligan's (1992) Listener's Guide has provided me with a framework of analysis for listening to the various voices in women's relationships which social constructionist theory tells us are constitutive of the meaning of our self-identity. Post-structuralist theory assumes that this self-identity cannot be fixed because meanings are open to interpretation.

Once the interviews and transcriptions for each interview had been completed I undertook four readings of the interviews. These four readings were needed to identify the plot, the 'I' voice and the other voices (events and actions) which were integrated into the plot and constituted each woman's story.

I undertook the readings as follows:

First Reading

The first reading was comprised of two parts: listening for the plot and for the reader's response to the interview. First, I read through the text and listened for the plot so I could get a sense of the actions and events that were important to the development and outcome of the story. I had to ask myself which particular relationships were important to each woman. Repeated images and metaphors and dominant themes were noted as were contradictions and actions and events that were not expressed. As well the larger social context within which these stories were experienced was also identified, as was the social and cultural contexts within which the women and I came together (Gilligan et al., 2002).

This first reading also required a reflexive stance on my part. I needed to be very aware of how my own understanding affected what I heard. I knew that the way I heard these women would be influenced by my life story. Therefore, as the listener I tried to listen to the point of view of the woman talking. I needed to listen intensely to the unknown of myself and the woman without expecting to hear something determinate. I needed to listen for differences. This required my taking a reflexive stance in order to notice how I would create my own story from the woman's story. In this research model, self-awareness

and the ability to hear others from their own standpoints are interconnected (Gilligan et al., 2002). For this reason I needed to write out my own responses after this first reading so I could then consider how my thoughts and feelings affected my understanding and interpretation, and ultimately how I wrote about this woman.

Second Reading

In this reading I listened for the first person, 'I' voice. The purpose of this reading was firstly to enable me to listen to the woman's first-person voice and secondly to hear how she spoke about herself. During this reading an 'I' poem was constructed by underlining every first-person 'I' within the chosen passage along with the verb and any important accompanying words and maintaining the sequence in which these phrases occur in the text. Here I was trying to listen to what this woman knew about herself before I talked about her. It was meant to work as a way of my coming into relationship with her to prevent her objectification. Then I took out the underlined 'I' phrases, and placed each on a separate line, like lines in a poem. By placing the 'I' statements in sequence I could gain an impression of how this woman experienced herself in relation to the world in which she lived. It also portrayed a stream of consciousness carried by a first-person voice. "It brings one into relationship with the person partly by ensuring that the sound of the voice enters into our psyche and partly by discovering how she speaks of herself before we speak of her" (Brown & Gilligan, 1992, p.28). In this way I was able to connect with the way she interpreted her experiences. This affected me and I began to learn about the woman's world of self-starvation. This stage of the analysis represented an attempt to stay with the woman's multi-layered voices, views and perspectives rather than putting her words into my ways of understanding or into the categories of traditional anorexia literature (Gilligan et al., 2002).

These first two readings, identifying the plot and including the first person 'I', built up to the listening for the relationship between the various actions and events in the women's lives to identify their meaning from the woman's point of view.

Third Reading

In this reading I listened for relational voices and brought the analysis back into relationship with the research question and the relational voices that were constitutive of women's self-identity and self-starvation practices. This reading "offers a way of hearing and developing an understanding of several different layers of a person's expressed experience as it bears on the questions posed" (Gilligan et al., 2002, p.164). I read each woman's four transcripts through, listening for just one relational voice at a time. When one voice appeared I underlined it in the colour chosen to mark it. Then I read through each set of transcripts a separate time listening for each voice. These subsequent readings allowed for the possibility that one statement might contain multiple meanings or voices and therefore could be underlined multiple times. It also allowed me to begin to see and hear the relationship between the woman's first-person voice and the other voices. My listening for at least two voices took into account that the women could express their experiences in a multiplicity of voices or ways. It also allowed for the possibility that some of these voices could be in harmony with one another, in opposition to one another, or even contradictory (Gilligan et al., 2002). In this reading I listened for how the women spoke about their interpersonal relationships with their mothers, fathers, siblings, friends, religion and their self-starvation. I wanted to include the voices, which were responsible for the women's self-beliefs and ultimately their self-disciplinary behaviours.

Fourth Reading

In this reading I listened for voices that spoke to the women at the time of their adolescence. Brown's (1998) research has shown that at the developmental stage of adolescence girls are at risk of losing their voices. I wanted to find out what voices put girls at risk of being silenced.

Fifth Reading

In this reading I listened for the diagnosis and treatment voice. I wanted to find out if the women positioned themselves as 'docile bodies' or as 'rebellious bodies' able to resist the anorexia diagnosis.

Overall these five readings of the interview transcripts emphasised the multi-layered nature of the actions and events of the women's stories. By using this voice centred relational method through an empathic collaborative relationship I tried to understand how these stories were constituted through discourses embedded in our cultural relationships.

In the following chapter I present my analysis of the five readings of each woman's story.

Chapter 4

ANALYSIS

In this chapter I have used the Listening Guide and its suggested readings as a way into the complexity of our relational voices that speak to us of our identity (Gilligan, 1982). The Guide has enabled me to read the women's stories for the ways in which actions and events or relationships have given meaning to their lives.

In the first reading of the women's transcripts I identified the plot of each woman's story and I asked who? what? when? and where? questions about each woman's childhood. This opening into each woman's story related to the 'landscape of action' and I was able to identify the plot of each story. Bruner (1986) believes stories constitute people's lives and has described how people give meaning to relationships to constitute self-identity. He believes life stories unfold in a 'landscape of action' and a 'landscape of consciousness' which White (2004) has relabeled as a 'landscape of identity'. The 'landscape of action' involves organising sequences of events through time and is called the plot.

The second reading of the transcripts enabled me to identify how the women spoke about themselves and I constructed an 'I' story for each woman. This 'I' story became a story within a story because for the 'landscape of action' story to have meaning it needed to be developed into the 'landscape of identity'. This 'landscape of identity' was the space where the women plotted the meanings that related to their relationships in the 'landscape of action'. Reflecting on these two readings enabled me to understand the meaning the women had given to various relationships in their lives.

In the third reading I focussed on the social-constructionist notions of self being constituted by culture and our bodies being inscribed by cultural discourses embedded in relations of dominance and submission (Gergen & McNamee, 1992). This reading took the analysis to another level of meaning to discover the cultural voices speaking through the relationships which had unfolded through each woman's 'landscape of action' story.

The fourth reading enabled me to listen for the voices that spoke to the women at the time of adolescence. Brown & Gilligan's (1992) research has shown that at the developmental stage of adolescence girls are at risk of losing their voices. This reading focussed on the voices that put girls at risk of being silenced.

In the fifth and final reading I listened for the diagnosis voice and how the women had been treated following their diagnosis of anorexia. I listened for the effects of the power of medical discourse to position the women.

By utilising the five readings as described above I was able to read the women's transcripts to identify cultural voices or discourses embedded in the women's relationships that had been appropriated by the women to constitute their identity.

First Reading

The Plot

Reading for the plot I listened for the relationships and events that each woman plotted through time as being most significant in her life. In the following sections each woman's story of significant events in her childhood, adolescence, diagnosis and treatment is retold to identify landscapes of action.

Margaret spoke of a very unhappy childhood dominated by her mother and her religion.

> *I remember my mother complaining because I wasn't a very cuddly baby. And then 13 months after I was born she had my little brother and after he was born she didn't get sick and I always felt I was to blame and yeah basically she didn't understand me as a child um she always said my brother was more like her and he was more within the realms of shat she would call normality for a child and I*

was outside those expectations so um it was quite, yeah I had quite an unhappy childhood.

Religion was a big thing because my mother taught religious instruction. I actually was in a class once in the standards where some of my class mates had been in a class previously where my mother had taught the religious instruction and these kids would give me a hard time because Mum had given them a hard time during religious instruction classes. Mum didn't like me having heathen friends. She wasn't keen on me going to other kids' houses. Mum hated crucifixes. She actually gave me a smack once because somebody gave me a crucifix and I liked it and she caught me with it and I got a wack. She used to pick me up by the shoulders and she used to shake me a lot.

At home there was always this fear of displeasing the Lord and being forced to umm..... I sort of had a deviant streak, and I was always punished for it and then I sort of developed this body image thing. First of all I had two friends and they were both real beanpoles and um straight away I compared myself with them, fat. When I was about nine Mum caught me on my bed doing those bicycle in the air exercises and she asked me what I was doing that for and I told her my legs were getting too heavy and she was furious so I learned to shut up after that. I couldn't share intimate stuff with Mum because she used to react to everything.

By the time Margaret reached adolescence she had developed a 'fat fear' because she felt different and decided to leave school.

I didn't really look normal at 15. I was quite frightened of puberty and I managed to stop myself going through that puppy fat thing. I managed to stave off periods until I was 17. I had what they call these days fear of obesity which was restricting my food intake and making me exercise a lot. I didn't do very well academically. I didn't see the relevance of school anyway. So I got myself a job so I didn't quite actually finish the fourth form. I worked for five years right up till I went overseas. When I first went over there I had this romantic notion I might meet a nice Israeli but the more obsessed I got with food and dieting and that, nothing else really mattered.

For Eliza it was her relationship with her father and his actions that dominated her life story.

My family situation was difficult in the fact that my parents used to fight all the time. It was kind of like a war zone in a way and part of my role in the family was as the peacemaker. I was Daddy's girl umm but he would do things like have huge fights with my mother and then say 'I'm leaving now', and I'd say, 'please daddy don't go' and he'd say umm, 'I'll only stay if you want me to stay'. He was also a very

inappropriate umm and I think a lot of his emotional needs were met through me, emotional and physical. We moved when I was 7 and that was kind of when the abuse kind of started as well and I'd done academically very well and then we moved the abuse started and I became unable to do anything really. And also my father is fat obsessive. He used to say to my mother, 'you're fat', and my mum is a tiny woman. So I got the message that fat women were bad and I wanted to be you know thinking about my role with my father I wanted to be liked by him so I decided to join the family. I went on my first diet when I was about 10 and because my family was always dieting.

By the time Eliza reached adolescence she wanted to die. She also left school because she could not cope.

I was about 13 and the abuse stopped. I used to get up and wish I was dead. I had a sense of not belonging. I started to be really restrictive when I was 16. I was trying to find purpose and meaning. I became very devious and I just fought and fought with my family because they were concerned with my weight. They just nagged me to eat so I would and then just be sick. I had to leave school towards the end of the year because I couldn't cope. I got a part time job and went to university but in the second year I just couldn't cope. I became bulimic. I felt worthless when anorexic but if you can lose some weight then that means you can do something and you are worth something. With bulimia I didn't have that at all, my life was so chaotic. I left university and got hopeless jobs and then went flatting and I became quite isolative. I thought I can't cope with being with people, if they knew what I was really like, they wouldn't like me. I was always thinking about being dead.

Charlee also spoke about a dominating father whose standards she could never meet.

I had a good upbringing but my Dad was very strict, a very dominating man. My Mum was as long as I can remember always on a diet and Dad would always make comments about it. I never actually felt that I could meet a standard. Mum kept a lot of things from Dad. The problem with that though was when Dad would find something out it would be me who was accused of being a liar. One day at school there was a boy behind me kicking my chair and I turned round and asked him to stop while the teacher was reading a story and she strapped me. But I didn't tell my parents because I thought it was my fault. You see there were a lot of instances like that where I'd get into a fight with somebody at school and they'd really hurt me or something and I wouldn't go and say anything about it.

I was really into gymnastics and I remember always being very self-conscious about wearing a leotard because I was chubby and my brother was very skinny. I always felt envious of him because he was like really sporty and Mum and Dad were interested in his sports and gymnastics wasn't a big thing.

By the time Charlee reached adolescence she felt really bad about herself and started to fail at school.

I thought I was fat. Dad would make remarks and my brother of course he used to call me a fat whore. And my cousins were really skinny and all the boy friends I had were all really skinny so I just felt really bad. I wanted to be a boy. I didn't want to be a woman. I was terrified, absolutely terrified. About 13/14 I got a period and I cried and cried and cried. I properly didn't get periods until I was about 15 and they were horrific and that's when I started really dieting. I remember starting to not do well at school because I was messing about with the wrong people.

From this first plot reading I identified the 'landscape of action' of each woman. This included the significant actions and events, which the women plotted through their childhoods and their adolescence. Margaret identified her relationship with her mother and her religion and her fear of obesity and in the end wanting to die as being the most significant events in her childhood. For Eliza and Charlee it was their relationship with their fathers that dominated their stories. Eliza remembers vividly her dieting family, which she joined to please her father. When she could not manage things any more she also saw dying as a way of ending her misery. Charlee also remembers being criticised for her weight and never being able to measure up and always feeling bad about herself.

This first reading also required a reflexive stance because as a woman in the powerful position of interpreting the life events of these three women I needed to consider the implications of this process. I could very easily overwrite the women's stories with my story if I concentrated on similarities and ignored the differences in our stories. I needed to be very aware of how my childhood experiences would affect what I heard. By documenting my own responses I became aware of differences as well as similarities in our stories. My responses enabled me to consider how my thoughts and feelings could affect my understanding and interpretation and subsequently the way I wrote about each woman.

Taking this reflexive position I found myself being moved in different ways as I listened to each story. Initially I was very emotionally moved. I cried over each story because I could empathize so easily with each woman's hopelessness and despair. But I was also moved beyond this initial empathic emotion to a much deeper level of emotion. This deeper level of emotion is what White (2004) describes as catharsis. A cathartic experience transforms understanding on account of having listened to another's experience. This occurred for me because each woman's story touched on the history of my own experiences and triggered resonances for me. On account of what I had heard my experience of anorexia was validated and affirmed. As these stories resonated within me I had this powerful sense of knowing that our experiences of anorexia spoke of our thin stories. Each of our stories was thin because they each spoke of dominating relationships in our lives. These stories made me very aware of the importance of relationships in our lives and made me wonder what different stories we would be telling if only there had been some more powerful relationships to counteract the dominating relationships. Such relationships would have enabled us to thicken our thin stories and give a different meaning to our lives.

I noticed as I evidenced this repeated image of one particular relationship dominating each woman's childhood that it was not always the mother/daughter relationship that dominated. This finding contradicts Hilda Bruch's (1973) work on eating disorders. She argued that it is the mother/daughter relationship which is both the site of instruction and a model for future relating and that the cause of anorexia was the girl's lack of a sense of autonomy due to an oppressive family environment and in particular an overpowering mother. This first reading of these stories did not speak of overpowering mothers but rather overpowering fathers and a mother overpowered by religion. Instead of being positioned as overpowering the mothers in these stories were positioned as subservient and obedient to the overpowering fathers.

As well as validating my experiences of anorexia my reflexive responses to the stories also highlighted that the context of the events and actions in our lives had been very different. I had grown up the second to oldest of five children in a 1950s Catholic family. Margaret had grown up the older of two children during the 1960s in a very religious family. Charlee and Eliza were

younger women having grown up in late 1960s and '70s families, with each woman being the older of two children. This made me wonder about the difference in our experiences of anorexia. All three women talked about their 'fat fear' and dieting and regarded it as a major event in their lives. I could only find a couple of references in my diary to weight and 'fat fear'. As I reflected on this difference in our diagnostic symptoms of anorexia I saw a connection between the different childhood eras we grew up in. My childhood occurred during the 1950s and Margaret's during the 60s, which was earlier than the other two women. DSM IV tells us that anorexia has only become increasingly prevalent since the 1960s which is attributed to the cultural norms regarding desirable body shape and weight (APA, 1994). This connection caused me to go back and reread each woman's plot story. Margaret talked about developing a complex that she was fat. Eliza spoke about her family always being on a diet and her fat obsessive father. Charlee also experienced fat obsessions in her family with her mother on a continual diet. Both Eliza and Charlee experienced dieting as the norm in their families whereas Margaret and I had not experienced this cultural obsession with dieting. It became obvious that Charlee and Eliza had experienced more cultural voices warning them of the evils of fat than Margaret and I had because they had grown up during the time when this cultural voice was more prevalent.

Continuing with my self-reflexive response to our stories and also being aware of the many family differences in our stories I found myself identifying most easily with Margaret's story. After our interviews were completed Margaret shared the following verse with me which describes her response to her religious education.

At Church they taught me 'self-denial'
It was preached 'Go sell all you have and give the money to the poor'
Then the idea came to me
'But you can give everything to the Op. Shop'
The impulses were so strong,
It must be from God and I did it.
Next it was 'You have to stop eating meat or else everything with sugar in it'
To be on the safe side I think I did both.

Margaret's self-denial practices resonated with my encounter with religion whilst growing up. Religion was not a means of manipulation in our home as it was in Margaret's, but it was in the Catholic girls' school I went to through the

1950s and 60s. I remember feeling guilt ridden because the Catholic religion seemed to me to focus on people as sinners and their unworthiness. Confession and the dark confessional box with the priest behind the sliding screen to whom we had to confess all our sins was a dominant feature of my school life. My religious experience was one of guilt and repentance and still never worthy enough and so we had to fast at Lent. Denying oneself food would help to make oneself worthy of God. My self-starvation practices speak to me so vividly of ascetic values and I can identify with the Italian saints who starved to be worthy. Listening to Margaret's religion story I noticed how well we learned those early lessons of self-denial and the effect those religious discourses of the 50s and 60s had on our lives.

This similarity of experience was not reflected in the other women's stories. Religion had not been a dominant feature of their lives. Rather for Eliza:

> *God was like an energy force. I talked to God a lot. I used to make pacts with God. I trusted God would look after me.*

Eliza's God was a caring one. For Charlee religion did not feature at all except for going to catechism classes and to church for a while:

...but that sort of stopped because Dad didn't go.

This self-reflexive response to the women's stories increased my awareness of the diversity of our childhood relationships and experiences and yet we had all had experiences of anorexia. Being aware of these differences highlighted and confirmed Malson's (1998) findings that anorexia is constitutive of a multiplicity of cultural experiences and not just one cultural experience such as the cultural norm prevalent during the 1960s relating to desirable body weight and shape.

Despite our very diverse childhood experiences the significant similarity that I did notice was that we each spoke about one particularly powerful relationship, which dominated all of our other relationships. This powerful relationship constituted our 'landscape of action' stories as being very thin because healthy 'landscape of action' stories should be thick with a variety of empowering relationships from which we could plot our identity.

To understand how the women plotted meaning and identity from these 'landscape of action' stories I needed to listen to the women's voices from their

own standpoints. The following second reading enabled me to come to an understanding of the meaning each woman gave to her 'landscape of action' story.

Second Reading
The 'I' Voice

In this second reading I tried to listen to each woman's voice and discover how she spoke of herself before I spoke of her. I listened intensely to each woman's voice by identifying her 'I' voice. When I read an 'I' statement in each woman's story I rewrote it in the form of verse and in this way I constructed an 'I' poem for each woman. When I had written out all her 'I' statements and read through them again the repetitive 'I' was not simply a transcript of her story but her actual 'I' voice separated out to impact upon me. Her 'I' voice displayed in this stanza form was a very powerful way of my coming to know what this woman knew about herself. These repetitions of the 'I' powerfully reinforced each woman's identity as separate from each other and mine.

Margaret said:

I grew up believing I was evil.
I knew I was an unliked child.
I developed a great fear of my mother, tremendous fear of my mother.
I know I didn't have as many friends as my brother.
I sort of had a deviant streak.
I was always punished for it.
I developed a complex that I was fat.
I took religion seriously.
I think about killing myself.
I couldn't cope with conflict.
I left home.
I was very withdrawn.

Margaret believed she was deviant, evil, unliked and fat

Charlee said:

I remember always being very self-conscious.
I was chubby and my brother was very skinny.
I was always quite aggressive and assertive.
I never actually felt I could meet a standard.
I always thought I was fat.

I wanted to be a boy.
I didn't want to be a woman.
I started really dieting.
I remember starting to not do well at school.
I was messing about with the wrong people.

Charlee always felt fat and she didn't want to be a woman.

Eliza said:

I was a really social child.
I was a good girl.
I did things to please and keep the peace.
I was daddy's girl when I was little.
I'd have to go and talk to him and make him happy and that was my job.
I always felt fat.
I got the message fat women were bad.
I became incredibly withdrawn.
I became really unlikable.
I was 13 and I used to get up and wish I was dead.
I don't belong.
I started to be really restrictive when I was 16.
I felt there was something wrong with me and I needed to fix it.
I was trying to find purpose and meaning.

Eliza also always felt fat and believed fat women were bad. She tried to give meaning and purpose to her life by restricting her food intake.

These 'I' stories constituted the women's 'landscape of identity' stories and enabled me to hear what the women believed about themselves. Having these identity stories before me I was able to connect them to the women's 'landscape of action' stories. I could now understand the relationship between actions and events in the women's lives and the meaning they gave to their identities.

Margaret's 'landscape of action' spoke about a very unhappy childhood dominated by her powerful religious mother. From this landscape Margaret plotted her identity and came to believe she was evil, deviant, unliked and fat. Charlee's action landscape spoke of a childhood dominated by an overpowering strict father whose standards she could never meet. From this landscape she plotted her identity and came to believe she was fat and could never measure up to being a woman. Eliza's action landscape spoke of a childhood dominated by her emotionally needy father. Plotting her identity Eliza came to believe she was the peacemaker in her family and needed to please everyone. Believing

she was fat she came to see herself as bad. Each woman had interpreted the dominant relationship in her life to give meaning to her identity.

As well as being a relational method the Guide is also a feminist method because in the third reading it required me to become a resisting listener. As a resisting listener I needed to give voice to a different reality and bring a different subjectivity to our gendered cultural system. Therefore, in the third reading I listened for the gendered subject positions constituted through dominant discourses. I listened for the ways the women spoke about appropriate feminine behaviour and whether they accommodated or resisted these subject positions. More specifically I identified the ventriloquized voices or cultural voices of feminine subject positions. This ventriloquation refers to the process whereby one voice speaks through another voice (Bakhtin, 1994). Firstly, I listened for these cultural voices speaking through the 'I' voice and then I tried to identify where, and from whom these voices had been appropriated.

Third Reading
Cultural Voices

During this reading I identified four different cultural voices which were constitutive of the women's identities. These voices emerged as the women spoke of how they understood themselves as women. I identified these voices as the 'subservient woman voice', the 'fat voice' the 'boys better than girls voice' and the 'education voice'.

The 'Subservient Woman' Voice

This voice spoke of patriarchal domination. In Margaret's family this patriarchal power manifested itself through God to whom Margaret and her mother were both answerable.

> *God spoke directly to her (mother). She believed God spoke directly to her and you know she was sort of because I was young, I think she tried to become a sort of a go between, between me and God and you have got to do this because the Lord has told me.*

In Charlee's family, her father dominated Charlee and her mother.

My father was a very dominating strict man. I was often quite frightened. I'd get a good thrashing too. He dominated Mum who was very subservient.

In Eliza's family, her father also dominated.

I was the good compliant girl. I did things to please. I was scared of how dad was.

This voice reminded me of Foucault's Panopticon guard who treated the Panopticon inmates as objects under constant surveillance. Being objectified the inmates evaluated themselves and constituted themselves according to the guard's specifications. The subservient woman's voice was acting as a guard to protect patriarchal power and keep women subservient and under control.

The 'Fat' Voice

This voice spoke through each woman's 'I' voice telling her she was fat and not good.

I always felt fat. My father was fat obsessive. I got the message fat women were bad. (Eliza)
My father and brother used to call me fat. I wanted to be like my skinny brother. (Charlee)
I developed a complex that I was fat. I think I used my friends as a yardstick and I saw skinny as more desirable. (Margaret)

This voice also acted as a guard and enabled the women to start dieting and to undertake disciplinary practices on their bodies as they became socialised into womanhood. Through processes of objectification they became the subjects of their own subjection without even knowing it. They became like the Panopticon inmate, objects of power and knowledge and self-disciplined subjects in an attempt to constitute themselves as acceptable women under the patriarchal gaze.

The 'Boys better than Girls' Voice

This voice highlighted women's social position in society and was evidenced in the families where there were boys. In these families the boys were more favoured.

> *Mum said my brother was more like her and he was more within the realms of what she would call normality for a child and I was outside those expectations. She said if she had to have a couple of daughters or a couple of sons she said umm sons. ...she latched onto my younger brother who umm she related to and that's where she got the idea I think that sons were better. (Margaret)*

Whilst growing up Charlee also believed boys were better because:

> *I was really into gymnastics. And my parents were really into my brother's sports which were like soccer and cricket and we would drive around the country to go to his cricket and soccer and gymnastics wasn't a big thing. I started playing cricket and soccer as well because my brother was sporty and my parents went with him so I thought I had to play too.*

Again this voice is acting as a guard to protect patriarchal power which enabled Margaret and Charlee not to value themselves as women.

The 'Education' Voice

This voice also spoke of women's social position and in particular the judgement prevalent during the 1950s and '60s that education and having a career was not important for women. This knowledge was evidenced in Margaret's words.

> *We went to Australia for three weeks when I was in the 3rd form. I couldn't afford to miss three weeks of school. The reason we went that year was because they didn't want to interrupt Andrew's education.*

It was obvious Margaret's education was less important than her younger brother's. Margaret said:

> *My mother didn't go to secondary school because she wanted to make sure her mother could afford to send her younger brother to secondary school. So she gave up education so her younger brother could have one.*

And here we hear Margaret's mother giving the same meaning to this subject position for her daughter.

Charlee also spoke of how education and a career were not seen as being of importance for girls:

> *And then I got a letter from the school saying I should go to university. And of course that wasn't an option. 'Why would a girl go to university' my parents would say. 'Get a job'. One of the things that has always pissed me off was my uncles, who were in the money markets, got my cousins and my brother jobs in the school holidays. Because they were boys and I was a girl, so I worked at the supermarket. And they have all gone on to have excellent careers. And it's sort of like I didn't have that opportunity. They went and worked in the school holidays and I was down at the supermarket packing groceries because that's what girls do.*

This 'Education' Voice was not evidenced in Eliza's story because she was the older of two girls with no brothers.

These cultural voices identified above illustrate Foucault's (1980) argument that as a culture develops knowledge of what is right, normalizing discourses are created and legitimated. Through power and knowledge these discourses or cultural voices become appropriated by the 'I' of our identity landscape and we become normalised into womanhood by these feminine subject positions.

In each of our stories these cultural voices had the power to make us not like ourselves and not value ourselves as women. As well this power had a silencing effect. Eliza spoke of this silencing effect in her relationship with her mother.

> *When I was younger I experienced her as being emotionally distant and kind of very shut down. I think living with my father is the reason why.*

Eliza's words tell of the effects of her father's power over his family. Eliza's mother had been silenced, shut down by her father and unable to respond to her daughter's needs. Not only had family relationships been narrowed but also Eliza's relationships with boys. Eliza had become fearful of males because her father did not approve of her mixing with boys.

> *My father really frightened me about boys. He'd say 'you know boys only want one thing from you and they'll hurt you', and I became very paranoid. He just instilled this fear.*

While I was listening for these cultural voices in the women's childhood stories I heard how they responded as young girls to these subject positions. Eliza responded by becoming a 'docile body' and joined her dieting family to please her father who made her believe fat women were bad women. Margaret also tried to comply with these subject positions. She became a 'docile body' taking her religion very seriously and practising the self-denial her religion had taught her. Charlee's response was different in that she resisted these subject positions by not wanting to be a woman. She said:

I wanted to be a boy. I didn't want to be a woman.

While listening for these cultural voices and our responses I also heard a voice of not-speaking which occurred for each woman around the time of adolescence. Discerning this voice took me into my fourth reading where I had planned to listen for the voices that spoke to us at this developmental time of adolescence.

Fourth Reading
Adolescent Voices

Silenced Voices

Brown's (1998) research found that young girls' ability to express themselves seemed to narrow as they became increasingly pressured at adolescence to fall in line with feminine cultural expectations. Their subordination enabled them to find approval and acceptance and avoid conflict and anger. The girls showed increased self-doubt about what they believed and how they valued themselves. At adolescence when they began to comprehend cultural expectations they began to doubt the authority of their own experiences and so they became divided as to whether they should follow their own inner beliefs or follow society's expectations. Whilst listening to the women's stories I also heard this adolescent silence. Eliza said:

I was really chatty in the 3rd, 4th, and 5th forms but I became incredibly withdrawn and isolated in the 6th and 7th forms.

Charlee remembers always being:

> *...quite aggressive and assertive*

but when she was about 15 she said:

> *I was messing about with the wrong people. I suppose I started experimenting sexually because it was like acceptance. You think you are worthless and you can't accept yourself and you think nobody is going to accept you. I had relationships with guys and they were always disasters. I would choose somebody who was abusive. I need to self-destruct. That's all I deserve.*

Charlee got in with the wrong crowd to find acceptance. She was subordinated in her relationships. Her earlier assertive childhood voice, which I interpret as demonstrating how she had once valued herself, had been silenced.

Margaret remembers being quite outspoken as a child but later:

> *I just got really, really lonely. I had no one to talk to. I couldn't cope with conflict. I couldn't cope with displeasing them.*

At adolescence Margaret could no longer cope with conflict or displeasing her parents, as she had been able to in former years. She left school and lost touch with her friends and became more withdrawn. As Margaret withdrew she became more silent and increasingly lonely.

As I listened to the women I heard how outspoken and social they had been as children. This enabled me to question the legitimated truths of Bruch's (1973) findings which give descriptions of the anorexic as having been obedient, conscientious, lonely, shy and unable to get angry as a child. Through the power of discourse these descriptions have been legitimated and constitutive of the anorexic. I was hearing very different truths as the women's stories contradicted these legitimated truths about the anorexic. Their stories did not speak of obedient, timid, shy and lonely children. Rather Charlee said she was an assertive and aggressive child always getting into fights. Margaret spoke about getting angry as a child and Eliza said she had been a really social child. Then I heard the women speaking about how this outspokenness became silenced at adolescence. Eliza became withdrawn and isolated. Margaret became really lonely and Charlee got in with the wrong crowd and her earlier assertive voice was silenced. For each of the women I identified that their outspoken and social voice had become silenced at adolescence. I began

to question what was behind this silencing. Then in conjunction with this silence I discerned the voices of anorexia.

Anorexia Voices

Eliza said:

> *I started to be really restrictive when I was 16 and in the 7th form. I felt there was something wrong with me and I needed to fix it. I chose food because I think it was the only thing I could choose.*

Eliza was able to talk very specifically and clearly about her anorexia voice. When she was in hospital and being encouraged to eat, her anorexia voice would come through:

> *'You can't eat, you can't eat, you're fat, you're revolting'.*

She added:

> *The voice I heard was sometimes very loving and very tender and very caring when I was doing what it wanted me to do, and then at other times it went, if I was trying to eat, 'what are you doing? This is not what you are supposed to be doing' like, kind of like an angry protector. 'Don't do this, you can't do this'.*

Eliza then explained how after she had got over the anorexia and had become depressed and bulimic she wrote in her journal:

> *I look for my anorexia and I call for her but she doesn't answer. Where is she? Why has she forsaken me?*

Charlee described her voice of anorexia as:

> *...all the negative thoughts and all that negativity which tells you, you've eaten that, it's terrible, you can't justify that, it's like you haven't exercised enough or you are going to get fat and no one is going to like you.*

Margaret talked about her anorexia voice being a very critical voice relating it to the critical parent voice. Talking about the idea of voices with Margaret she explained how in her religion they were taught that if you pray God will probably want to say something back to you:

> *I used to hear a lot of other stuff you know, like if I was in a Christian worship meeting, I used to hear a lot of other things as well, which at the time I thought were God. For example, I thought that God told me to give up eating sugar once, so you can never be quite sure.*

But if it happens, if you are in worship service, or if saying your prayers, you assume it's God. It sounded quite an authoritative kind of voice.

Before listening to these stories I believed the anorexia voice would always be a negative voice. But I was now hearing it described in other ways. I heard how Eliza's anorexia voice made her feel masterful and gave her a sense of achievement:

You can lose some weight...that means you can do something and you are worth something.

Charlee said:

I can control my weight, fantastic. I never have to be fat again, because I will always have that and what an achievement.

Margaret also talked about a false sense of everything being all right because when she didn't eat she also felt good.

Comparing my anorexia voice I found myself identifying with Margaret because I also felt a sense of things being better when I didn't eat because I didn't feel guilty. Eating caused me to feel guilty because I wasn't worthy of food so I avoided food to avoid the guilt.

Reflecting on these voices of anorexia and thinking about their storied connections to childhood reminded me of the women's dominant relational voices, which had been appropriated by cultural voices. Then at adolescence a loss of voice or a silencing of voice was replaced with the anorexia voice. It would appear that the anorexia voice now had all the power to influence us. It had appropriated the power of former voices and it was at the time of adolescence when girls are at risk of losing their voices that anorexia's power manifested itself.

This developmental stage of girls' adolescence has been highlighted by Brown & Gilligan's (1992) research. They found that girls' adolescence is the time when girls' relationships are affected by society's gender norms that constitute society's expectations for women. Outspokenness and assertiveness therefore becomes silenced as girls move into womanhood. Girls experience a conflict between becoming independent and autonomous at adolescence and still feeling a need for connectedness and relationships. They are often fearful

of being isolated from others. Brown & Gilligan's (1992) research identified three ways the girls negotiated this adolescent conflict. One girl remained in touch with her own voice and continued to express what she knew. Another girl remained silent to protect her image and avoid hurting others. The third girl self-starved in an effort to remain in touch with herself and her feelings. She disconnected from her friends and aligned herself with beauty standards and expected maturity norms. Out of relationship with others she became more and more confused and out of touch with herself until she no longer knew what was happening in her abusive relationships or to herself. These three pathways through adolescence explained the way three girls negotiated adolescence and highlighted the importance of holding onto their former experiences and relationships as a way of grounding themselves and finding their identity. These findings helped me to understand how the girls' 'landscape of identity' as women was dependent on how they connected with their 'landscape of action'. This 'holding onto experiences' and former relational voices was what I identified as happening to us when I listened to the women's adolescent stories.

Charlee often talked about never being able to measure up and Margaret suffered from the critical parent voice echoing in her head. Eliza grew up believing fat women were bad women and I grew up believing I was never quite worthy enough. Just because we separated physically from our parents at adolescence did not mean we necessarily separated from their voices or the cultural voices, which we had appropriated. I remember one psychiatrist telling me my problem was all about not being able to leave home and separate from my mother but she didn't explain to me the difference between physical separation and internal separation. I managed the physical separation but I could not separate from the relational voices of my childhood. This came through in the other stories as well. Charlee, Margaret and Eliza all separated willingly from home but we were not easily able to separate from the relational voices of former years.

Because our identity is connected to our relationships Josselson (1989) has argued that adolescence is a time for a revisioning of relationships rather than abolishing them or maintaining their status quo. In light of this Gilligan (1982) believes self-starvation practices signify a relational crisis. She argues the relational crisis for girls at adolescence is marked by a struggle to stay in

relationship rather than abolish relationships. She argues girls feel pressured by our cultural gender norms to take themselves out of relationship with themselves and with women as they reach adolescence. For girls at adolescence to say what they are feeling and thinking often means losing their relationships and finding themselves powerless and all alone. So they disavow themselves and deny self. Margaret illustrates this scenario so well. At adolescence she tells us:

> *I couldn't share intimate stuff with Mum. I left school...I just got really, really lonely...I think about killing myself. I went to church twice on Sunday with Mum and Dad but that didn't help. I couldn't cope with displeasing them. I always seemed to have issues with mum even though I was trying to be good. I had no one to talk to.*

We hear Margaret no longer getting angry and being in conflict as she did when younger:

> *I got angry and I wiped my hands all over her. I was the one who did the provoking sort of stuff.*

Margaret came to see herself as being evil having been punished for being outspoken and in adolescence we find her using more covert ways of responding to hurt feelings or disagreements within her relationships. According to Gilligan's (1982) interpretation Margaret is succumbing to what she has grown to believe about herself. Her healthy relational strengths of earlier years were lost to her. Instead of being able to revision earlier relationships she can see only separation as the answer and so is keen to get away from home. However, she is unable to separate herself from the power of former relational voices. So in adolescence we find Margaret trying to please and disavowing what she feels. She loses touch with herself and the relational voice gets louder and louder.

Listening to Charlee we track how she had always been quite aggressive and assertive and open and often called a *...smart ass...* always able to beat up on her older brother. When going through adolescence she got in with the wrong crowd and started smoking and using marijuana and drinking and experimenting sexually because *...it was like acceptance*. Her relational voices told her she could never measure up and would never be good enough. Instead of revisioning these voices Charlee accepted them. No longer do we

see the healthy resilience of outspokenness about what she feels. Thus for Charlee the open conflict of her earlier years gave way to acceptance and she came to ignore or not know the signs of emotional or physical abuse and her relationships suffered. This was all she was worthy of. She so much wanted to be accepted:

> *...you think you are worthless, and you can't accept yourself, and you think nobody is going to accept you, so you are desperate for relationships. I had relationships with guys and they were always disasters.*

Eliza said:

> *I was a really social child. I got on really well with lots of kids. But when the abuse started I became unable to do anything really. I would just disassociate.*

And it was at the time of adolescence that Eliza really started to restrict her food. She became incredibly withdrawn and isolated. She lost her relational skills. She separated from herself, family and friends, but she could not separate from those relational voices of former years. It appears that we had been assertive and outspoken as children but at adolescence we lost this relational ability. Those relational voices of earlier days had taught us the lessons of self-hate and denial too well and so we tried desperately to change ourselves.

In the fifth and final reading I listened for the voice of the medical profession and the effects of its power when we were diagnosed. I heard this voice when we shared our diagnosis and treatment stories.

Fifth Reading
The Diagnosis Voice

Reading for the plot in our diagnosis and treatment stories I listened for the relationships and events that each woman plotted as being most significant when she was diagnosed and treated for anorexia.

Margaret talked about the time when she was overseas and she had joined a Christian group and her diagnosis was like a spiritual revelation whilst

talking to God. This voice told her she had anorexia and she had to start eating three meals a day. This was back in 1982/83 and Margaret thought anorexia was a disease where they tube fed you in hospital and you threw up a lot. For Margaret it was sort of like a relief:

> *...but it was also a total shock because it differed from what I thought it was.*

Margaret then struggled to make herself eat because *...fasting for the Lord* was a major event in the community where she was living, and so she battled with her religious voice over whether she should fast or not. She remembers breaking the fast:

> *...but felt terrible about what I'd done and so then I got this idea that I would have to somehow make it up to God so I'd have what I'd call meeting days and fasting days.*

When she returned to New Zealand she went flatting and managed but would not take medication because she was scared it would make her fat. In the end she succumbed and took anti-depressants to alleviate her anxiety. She married and after a time the fat fear started to resurface. Her food restriction started and she felt good for being in control again. She abandoned the anti-depressants. This continued for a few years until she was referred to a psychiatrist and she saw a senior social worker every week. She was put back on medication and Margaret felt angry and humiliated. In the end she went to a private therapist but things didn't really get any better and after a year she was sent to another psychiatrist who prescribed fluoxetine hydrochloride (Prozac).

> *I think what it did for me was it gave me more power over what I thought. It was all the negative thoughts and also from the religion. I felt hell to have these thoughts I didn't want. I think that Prozac was the beginning of anorexia losing a bit of its hold.*

When I asked Charlee about her first diagnosis with anorexia she said:

> *I knew it myself. I knew exactly what I was doing. Exactly that is what I had when I was 15/16.*

She knew herself because it was very well known and everyone knew anorexia. It was so often in the media in the 80s and 90s. When I asked her how she felt she said:

> *I can control my weight, fantastic. I never have to be fat again. Because I will always have that and what an achievement you know.*

When she was 15 she would restrict her food and then be able to just snap out of it when she got too weak. One of the workers at her treatment centre said to Charlee one day:

> *'Charlee you are the type of person that one day, you're just going to go (click fingers) and you'll be out of it'.* Charlee said:
> *...yeah, that's what's been happening to me for 20 years.*

And so Charlee circled in and out of anorexia for years and covered it up with bulimia because she was terrified of her parent's reaction. Charlee believes her anorexia was all about control:

> *You know when I feel out of control I can control my weight. I can feel really good about myself because I have achieved something at the end of the day.*

She believes for her it is a slow suicide so you eventually just fade away into the background:

> *...because yes, you do think you are worthless and you can't accept yourself and you think nobody else is going to accept you so it is a slow suicide. It's nice and tidy. I wanted to be insignificant. I wanted to be small because then I wouldn't get hurt. Because I had been hurt and abused and if you're small you're not going to get beaten up or whatever you know.*

Charlee managed and got married and looked after her husband:

> *...having somebody that was very needy actually helped me. Because then I can concentrate on that person. I can organize everything and I can control everything.*

Charlee got to a point where she couldn't cope and was also prescribed Prozac. This did not work for her and after a year of side effects and suicidal thoughts she demanded an alternative. Charlee also went to a treatment centre which she found very supportive but:

> *...it was more about force feeding people and it's a very competitive environment.*

Charlee said that when she was forced to eat she just lied:

> *...and constant, constant, thoughts of food, calories, constantly looking in the mirror.*

Losing weight was Charlee's only measure of success or failure. She found it stupid when she was in treatment and:

...when they say you're fine now, you've reached 50 kilos, you can leave the clinic. You can be sure those people are going to come back and they're going to be even less when they come back.

Charlee believes her treatment forced her into bulimia. She says:

...when I'd eat something and the guilt, you can't justify that, you haven't exercised so you develop bulimia which releases it. You've got to get it out and you'll feel better.

Eliza reiterated Charlie's' story to an extent where she tells us how she started to be really restrictive with her food intake and she became very devious but her bubble burst while on camp and she taught herself to throw up. So Eliza got into the purging because her family was continually nagging her to eat and she started to feel really negative about herself because she was being forced to eat. She talks about going for six years with bulimia and feeling worse with bulimia than with anorexia. Anorexia gave her some purpose, whereas bulimia meant that she always felt like a failure. She also married and her bingeing and purging reduced to once a day. She worked long hours and started compulsively eating. She became bigger and hated how she looked. Then she started restricting her food and feeling better. Again her fasting got out of control and she was referred to specialists and diagnosed with anorexia. This made her feel really angry and Eliza resisted this diagnosis. Her condition worsened and she was admitted to hospital.

By the time I got help this voice had been in my life a long, long time. I've had this since I was about 13.

She was put on a nasal gastric tube and medicated. She spent three months in hospital. As Eliza said:

...they thought they were challenging the eating disorder voice but they weren't. It was becoming stronger and ingrained. I had this person in my head and that's all I needed. We were a team.

Weighing 43 kilos Eliza left treatment vowing that she wasn't coming back. She went out into the community and her weight fell to 35 kilos. She was readmitted to hospital. She was very resistant to her diagnosis and experienced panic attacks and disassociative symptoms. It was during this admission that she accepted she had anorexia. A younger patient said to her:

'I think what it is, is you're having a battle with your anorexia and you've eaten something and it's really attacking you'.

And Eliza remembers it was like a revelation to her as she could finally acknowledge her anorexia. When I asked Eliza why she could accept the diagnosis from another patient and not the therapists she said:

> *...it was someone who had the experience who has accepted her diagnosis and was on the road to recovery. And she was the one who helped me see.*

Eliza talked about how therapy to change thoughts and eating behaviours enabled her to gain weight. She believes what was really helpful was the catch up time she had each shift with the nurses. It was the relationships that really helped. They were very kind and very caring and very firm. This first admission lasted for about 5/6 months.

> *The crap voices were there but I was always able to say 'this is what I am here for'. What happened in that first admission was acceptance, but there was like, we didn't kind of get to any underlying issues.*

Eliza was released and went home but started to experience panic attacks and got into the exercising and losing weight again. Three months later she had her second admission after losing 8 kilos. During this admission they did a lot of therapy on stress and panic management as well as food, food exposure and body image. They also taught Eliza about Post Traumatic Stress Disorder. She was discharged at 45 kilos and started working again but the restricting cycle and exercising started again and panic and PTSD symptoms returned. Eliza was once again referred and went back into anorexia denial. She was admitted to hospital a third time and during this admission she heard herself being referred to as a 'chronic incurable'. Eliza believed this was a turning point for her as it made her very angry and so she gorged. She became very ill but after three months she weighed 40 kilos and was discharged. Eliza kept herself out of hospital and is managing well with ongoing support. These days Eliza says the voices are still there but much easier to discount. Now she can hear all the good messages, which can no longer be blocked by the other voices.

Listening to Eliza's treatment story reminded me of my own treatment and I couldn't help but remember my times in hospital and being told I would be allowed out when I weighed 8 ½ stone. In hospital on bed rest and not going anywhere, I just ate and ate. I achieved the goal weight, was discharged and

lost weight again. For me this type of treatment was ineffective because the continual surveillance over food only enabled me to be more surveillant and more self-disciplined once I was out of hospital. This behavioural modification treatment illustrates the power of the surveillance concept and the production of 'docile bodies' as described by Foucault's Panopticon model.

Being diagnosed with anorexia was different for each of us. Having been diagnosed in the late 1960s when there were no other available meanings for anorexia apart from the diagnosis, I was relieved to be labelled. I had never heard of anorexia and I do not remember resisting treatment. Because of the diagnosis I became a 'docile body'. I do not believe the various treatments I underwent helped very much at all. Finally, when I could no longer cope with living I was admitted for intensive treatment. My diary tells me that this place of treatment was like a haven, no more medication, no more anxiety, no more fear of what others would think. No one knew me so I did not need to be ashamed of myself. And with the help of therapy that no longer focussed on weight issues but rather emphasised writing my life story and coming to terms with my experiences, I was able to recognise the voices that had come to represent my identity.

Sharing our diagnosis and treatment stories has confirmed my belief that the anorexic label led us to understand and interpret our self-starvation practices in terms of the language of the diagnosis. Through the techniques of power and knowledge the anorexia diagnosis has been legitimated and afforded 'truth' status. Being diagnosed we became objectified and constituted as anorexic. Being treated as objects we came to see ourselves as problem objects. From this 'landscape of action' we connected with our 'landscape of identity' and saw ourselves as anorexic. Not only was the diagnosis able to make us believe we were the problem and responsible for the anorexia but the medical profession and family and friends also viewed us as the problem and so we became the focus for treatment. We were all subjected to the same type of mainstream modification treatment. We became as 'docile bodies' treated for our 'fat fear' so as to be transformed and improved. Such was the insidious effectiveness of this power as it incited us to co-operate in our own subjugation. Our only understanding of the origins of our self-disciplinary practices was to believe that we were sick and in need of psychological services.

Despite the ineffectiveness of the behavioural interventions the women were subjected to I also identified various recovery turning points. These turning points were always associated with supportive relationships. Eliza believed it was the relationships she had with the nurses that were really helpful. Charlee talked about managing best when she was looking after her husband and in control because for her anorexia was all about control. Margaret also talked about her marriage and highlighted the importance of this relationship in her recovery from anorexia.

These five readings have opened up our diverse stories and have revealed the layers of voices in our lives from which we have plotted our identities. Very different relationships have been uncovered but the common theme running through our stories is that these relationships caused us to dislike ourselves as women. So when we reached adolescence, which for girls is a time of reconnection with self, others and the world (Gilligan, 1982), we connected with a worthless self, a self we hated because of the cultural voices we had appropriated whilst growing up. We wanted to change ourselves and believing that there was no other way we starved ourselves. Finally we could achieve something and we did change our external appearance. But this was not the answer because no matter how thin and how changed we became we failed to change those relational voices we had absorbed from our earlier years. Instead of revisiting and re-authoring the relational voices they became more entrenched. Then being diagnosed and treated as anorexics, we all in the end became 'docile bodies' and underwent the prescribed mainstream treatment which only served to make us even more weight conscious. It was only when we came to an understanding of the meaning behind our self-starvation practices that we were able to make a choice about changing our behaviour. It would seem forcing us to change our behaviour without understanding how our self-disciplinary practices were a product of our socialisation into femininity only led us into further self-loathing. We needed so much to be able to re-author those voices of former years and thicken our thin stories with new voices that could value us and help us to value ourselves as women. I witnessed this re-authoring when we spoke about the supportive relationships we experienced during the recovery process.

Chapter 5

DISCUSSION

The intention of my thesis was to listen to women who had been diagnosed with anorexia nervosa to understand how these women story their lives. This intention was informed by my understanding that we live our lives and identify ourselves by our stories. Stories tell of the events and actions in our lives that speak to us of our identity. White (2004) using the work of Bruner (1986) has described how our identity and these events are mutually constituted because our stories are composed of a landscape of action and a landscape of identity. The landscape of action includes events that are linked according to a plot while the landscape of identity includes categories of identity. These categories of identity are framed by our dominant cultural knowledges. For women in our society these cultural knowledges specify a highly individual and gender specific way of being in the world.

Listening to our stories it became clear that the conclusions we came to about our worthless identities were arrived at through reflection on the events of our lives that were mapped into landscapes of action. These events involved the relationships and voices that we absorbed and made our own and which continued to speak to us of our identity. Not one of us was easily able to ignore these voices. We became ensnared in a single identity. This identity spoke us through a sense of worthlessness, emptiness, shame and despair. We linked events and relationships in our lives in a sequence that unfolded through time according to worthless themes. We felt trapped whilst growing up by those voices which spoke to us as worthless. We were not able to access other voices that could speak to us of a different way of being.

While engaging with my analysis I traveled to a narrative therapy workshop in Adelaide. This workshop enabled me to understand how people experiencing anorexia nervosa may be living by very thin stories. I was so transformed and affirmed by my experience of the workshop that at its conclusion I wrote:

Emaciated, thin bodies are testimony to thin stories.
Gaunt, hollow cheeks epitomise hollow stories.
Sunken sad eyes speak of sad stories.
Frail, fleshless bones creak of fleshless stories.

As I reflected on our experiences of anorexia I could not but think how we needed to be enabled to thicken our sad, hollow, thin stories. It is through the work of Michael White and David Epston, cofounders of narrative therapy that I have come to understand how anorexia depicts this notion of thin identities and thin stories. We have sculptured ourselves into such thin bodies because we have such thinly drawn identities.

In therapeutic re-authoring conversations Michael White (1993) has described how thin stories can become thick stories. To thicken our stories, White (1993) has proposed deconstructing our thin stories by objectifying the problems for which persons seek therapy. This objectification engages persons in externalising conversations which encourages persons to identify the stories and cultural knowledges that they live by and that speak to them of their identity. These externalizing conversations help persons to understand how their identity has been constituted across time through their relationships. White (1993) illustrated this process when he reviewed with Amy the effects that anorexia was having on her life and how it required here to be very self-disciplined and engage in operations on her body so as to become acceptable. He also reviewed how she had been recruited into these practices and Amy was able to identify a history of this recruitment through familial, cultural and social discourses. Through narrative therapy anorexia was objectified and Amy became separated from it and more able to challenge its claims to her life through re-membering conversations and outsider witness conversations. As Amy separated from her dominant story that was constitutive of her life it became possible for her to hear other voices and in this way her story moved from being a thin story to a thick story.

The stories of anorexia I listened to also told of very thin conclusions about our lives and identities. Not one of us was fortunate enough to have experienced narrative therapy in the early stages of our treatment. Instead through the techniques of power and the practice of diagnosis and objectivisation we unreflexively became the subjects of our own subjection. Our initial treatment enabled us to become even more self-surveillant with little opportunity to become aware of the power of the discourses that were constitutive of our identities. Rather than objectifying the person as mainstream treatment does, narrative therapy objectifies the problem. No longer is the person the problem but the problem is the problem and so we have a chance of separating from anorexia and coming to an awareness of the relational processes of constructing anorexia.

By taking a narrative approach to understanding anorexia nervosa I have not attempted to discover certainties or 'truths' about this disorder. Rather the narrative approach has led me to various understandings or perspectives on anorexia. These understandings do no just include those of the medical profession (including psychology) but also those of the sufferers. The theories that frame these understandings suggest that anorexia nervosa has been constructed by cultural discourses to make the experiences of anorexia nervosa comprehensible. I have tried therefore to avoid the tendency to diagnose these women as being under the influence of certain discourses or in denial of the true meaning behind their self-starvation practices as this would only work to discredit views that contradict my own. What I have come to understand is that we were all riddled with self-hate and this self-hate manifest itself in our self-starvation practices. There was no one single cause for our self-hate. Rather, it was a product of our cultures and the powerful discourses we were exposed to during our childhoods. And then at the developmental stage of adolescence we were unable to separate from those earlier discourses that had become powerful voices telling us of our identities.

What is the value of this research within psychology?

In a field dominated by objectivist assumptions I wonder what I can hope to achieve in retelling our stories of anorexia. At the very least I hope our stories will develop an awareness of how meaning has been given to our lives. These meanings have been constructed through discourse and have the power to speak to us of our self-identities. "In fact, power produces; it produces reality, it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him (sic) belong to this production" (Foucault, 1991, p.205).

At the outset I spoke the meaning we give to anorexia as constitutive of the problem. Understanding the construction of meaning and the role that power and language play in the construction of anorexia is important for the field of psychology. This involves being aware of the meaning we give to anorexia and being aware of how the questions we ask construct our understandings and position those we are talking to or trying to help. We can understand the effects our conversations have on how people understand themselves and how they give meaning to their lives by being aware of our own assumptions and the meaning we give to anorexia nervosa. This awareness of the importance of meaning and how it is constructed through power and knowledge is very relevant for psychology because awareness makes available the possibility for change.

Listening to the women's accounts of their experiences of anorexia has made me very aware of the effects of multiple relationships in our lives. The relationships that enabled healing from the effects of anorexia were those that were able to create openings for other ways of storying our lives through a process of speaking the silences. The importance of speaking the silences in relationship was powerfully reinforced for me by one of the research participants when she said she could now understand how she interpreted events and actions in her life to give meaning to her experience of anorexia.

I began my preface of this thesis with some diary lines describing the strength of my tormentor whilst I was caught within its stranglehold. I will finish my thesis with my diary conclusion, which is in stark contrast to the time when anorexia was in control of my life. These lines describe how I felt when I no

longer identified with anorexia - my tormentor had been overthrown and its voice silenced by a very different relational voice. This voice broke through the silencing voice and enabled a space for healing from the effects of anorexia. It was able to make me aware of how worthwhile I was, and therefore worthy of food.

Gone are the dirges of days, come are turning days
thinking's idealizing
I know where I'm going
I am me, identified
Life is for living, for people
For the great, the poor or otherwise
If we believe
God'll care
I believe
My belief o'rides the disbelief
Today closes, the night opens
To envelop me with restful sleep
Tomorrow, untold beauty of the dawning day.

References

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd Ed.). Washington DC.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th Ed.). Washington DC.

Bakhtin, M.M. (1994). *The Bakhtin Reader: Selected writings of Bakhtin, Medvedev and Voloshinov.* (Pam Morris Ed.). London: E. Arnold

Bartky, S. (1990). *Femininity and Domination. Studies in the Phenomenology of Oppression.* New York: Routledge.

Bell, R.M. (1985). *Holy Anorexia.* Chicago: The University of Chicago Press.

Bergin, A.E., & Garfield, S.L. (1994). *Handbook of Psychotherapy and Behavior Change.* (4th Ed.). New York: John Wiley & Sons Ltd.

Bordo, S. (1993). *Unbearable Weight. Feminism, Western Culture and the Body.* London: University of California Press.

Brown, L.M. (1998). *Raising Their Voices. The Politics of Girls' Anger.* London: Harvard University Press.

Brown, L.M., & Gilligan, C. (1992). *Meeting at the Crossroads. Women's Psychology and Girls' Development.* USA: Harvard University Press.

Bruch, H. (1973). *Eating Disorders: obesity, anorexia nervosa and the person within.* London: Routledge & Kegan Paul.

Bruner, J. (1986). *Possible Minds, Possible Worlds.* Cambridge: Harvard University Press.

Cooper, J., Todd, G., & Wells, A. (1995). Content, Origins, and Consequences of Dysfunctional Beliefs in Anorexia Nervosa and Bulimia Nervosa. In R.L. Leahy & E.T. Dowd (Eds.). *Clinical Advances in Cognitive Psychotherapy.* (pp.399-417). New York: Springer Publishing Company.

Foucault, M. (1980). *Power/Knowledge: Selected Interviews and other writings. 1972-1977.* (C. Gordon, Ed. and Trans.). New York: Pantheon Books.

Foucault, M. (1991). *The Foucault Reader. An Introduction to Foucault's Thought.* (Paul Rabinow, Ed.). London: Penguin Books.

Gergen, K., & McNamee, S. (1992). *Therapy as Social Construction.* London: Sage Publications.

Gilligan, C. (1982). *In a different voice: psychological theory and women's development.* Cambridge: Harvard University Press.

Gilligan, L., Spencer, R., Weinberg, M., & Bertsch, T. (2002). On the Listening Guide. A Voice-Centred Relational Method. In Paul M. Camic, Jean E. Rhodes & Lucy Yardley (Eds.). *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design.* (pp157-169). Washington, DC: American Psychological Association.

Gremillion, H. (2003). *Feeding Anorexia. Gender and Power at a Treatment Centre.* London: Duke University Press.

Harding, S. (1987). Introduction. Is there a feminist method? In Sandra Harding (Ed.). *Feminism and methodology: Social science issues.* (pp.1-14). Bloomington: Indiana University Press.

Hepworth, J. (1999). *The Social Construction of Anorexia Nervosa.* London: Sage Publications.

Josselson, R. (1989). *Finding Herself, Pathways to Identity Development in Women.* California: Jossey-Bass Limited.

Malson, Helen (1998). *The Thin Woman. Feminism, post-structuralism and the social psychology of anorexia nervosa.* London: Routledge.

Peplau, L.A., & Conrad, E. (1989). Beyond nonsexist research. The perils of feminist methods in psychology. *Psychology of Women Quarterly.* Vol. 13. p.384.

Polkinghorne, D.E. (1988). *Narrative Knowing and the Human Sciences.* New York: State University of New York Press.

Reinharz. A. (1992). Feminist interview research. In *Feminist methods in social research.* New York: Oxford University Press.

Reissman, C.K. (1993). *Qualitative Research Methods.* USA: Sage Publications Inc.

Ribbens, J., & Edwards, R. (Eds.). (1998). *Feminist Dilemmas in qualitative Research. Public Knowledge and Private Lives.* London: Sage Publications Ltd.

Robertson, M. (1992). *Starving in the Silences. An exploration of Anorexia Nervosa.* Australia: Allen & Unwin Pty. Ltd.

Saukko, P. (2000). Between Voice and Discourse: Quilting Interviews on Anorexia. *Qualitative Inquiry.* Vol. 6(3). pp299-317.

Saukko, P. (2003). *Doing Research in Cultural Studies. An Introduction to Classical and New Methodical Approaches.* London: Sage Publications Ltd.

Taylor, J., Gilligan, C., & Sullivan, A.M. (1996). Missing voices, changing meanings: Developing a voice centred, relational method and creating an interpretive community. In Sue Wilkinson (Ed.). *Feminist Social Psychologies. International perspective's.* (pp.233-257). Buckingham: Open University Press.

Tolman, D.L., & Brydon-Miller, M. (Eds.). (2001). *From Subjects to Subjectivities. A Handbook of Interpretative and Participatory Methods.* New York: New York University Press.

Weedon, C. (1997). *Feminist Practice and Poststructuralist Theory.* Oxford: Blackwell Publishers Inc.

White, M. (1993). Deconstruction and Therapy. In Stephen Gilligan & Reese Price (Eds.). *In Therapeutic Conversations.* New York: W.W. Norton & Co. Inc.

White, M. (2004). Working with people who are suffering the consequences of multiple trauma: A narrative perspective. *The International Journal of Narrative Therapy and Community Work.* Vol.1. p.47.

Appendix 1

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Anorexia Nervosa Stories

Information Sheet

Researcher:
This research is being conducted by me, Marion Gibson, as partial fulfillment of the requirements for a Masters Degree in Psychology. With a history of anorexia and through my experience as a teacher, I hope to offer an understanding of anorexia from the point of view of those who are affected by it. It will be supervised by Dr Leigh Coombes. Our contact details are below:

Marion Gibson **(04) 562 6069**
gibsonarchitects@clear.net.nz

Leigh Coombes **School of Psychology**
Massey University
(06) 350 5799 ext 2058
l.coombes@massey.ac.nz

If you have any questions, please don't hesitate to ask. I can answer any further questions you might have at the interview, should you decide to participate.

What is this study about?
The aim of this study is to explore life stories told by women affected by Anorexia Nervosa. The intention is to gain an understanding of the development of anorexia nervosa from the anorexic's perspective. Attention will be paid to the anorexic's voice, which has often been missing in theories of anorexia nervosa, to identify what anorexia means to the anorexic.

What would I have to do?
If you agree to participate you would need to be available for four interviews with the researcher to share your life story and your understanding of anorexia nervosa. The interview will be audio taped and transcribed by the researcher. No identifying information will appear on the transcript as pseudonyms will be used. Audio tapes will be erased or returned to you after transcription as you so desire.

How much time will be involved
Each interview will take approximately one hour. Interviews will take place at a location and time that is convenient for you as participant.

Appendix 1

What can I expect?
If you choose to take part in the research, you have the right to:

- refuse to answer any questions
- turn off the audio tape at any time during the interview
- withdraw from the study at any time
- ask any further questions about the study that occur to you during your participation
- provide information on the understanding that it is completely confidential to the researcher. All records will be identifiable only by pseudonym, and will be seen only by the researcher and her supervisor. Though excerpts from your transcript may be included in the thesis it will not be possible to identify you in any reports that ensue from this study.
- have access to your transcripts and be able to comment on or make changes to them.
- be given a summary of the findings from the final report.

Yes, I would like Marion Gibson to contact me regarding my participation in her research or to answer some questions regarding her research. I can be contacted in the following way:

Telephone: ..... or

Email: ..... or

By post: .....

.....

Name: .....

Please note: supplying the researcher with the above details does not in any way oblige you to participate in this research.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Application 04/46. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email humanethicspn@massey.ac.nz.

Appendix 2

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Anorexia Nervosa Stories

PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me.

My questions about the research have been answered to my satisfaction and I understand that I may ask further questions at any time.

I also understand that I am free to withdraw from the study at any time and to refuse to answer any particular questions.

I agree to provide information to the researcher on the understanding that it is completely confidential and will not be used for any purpose other than this research.

I agree to the researcher audio taping the interview and I know that I have the right to ask for the tape to be turned off at any time during the interview.

I wish the audio tape to be destroyed/returned to me after the transcription is complete.

I understand that my responses will be analysed during the study. To illustrate research findings, excerpts of some of my responses may be included in the study as direct quotations. I wish the following pseudonym to be used when reporting my responses_____.

I wish to participate in this study under the conditions set out on the information sheet.

Signed: .....

Name: .....

Date: .....

Researcher: .....

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