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Being and Becoming

A Narrative Inquiry into Teenage Girls'
Online Discussion of Eating Disorders

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ABSTRACT

This study takes a social constructionist approach, using narrative inquiry methods to analyse posts made by teenager girls on an online eating disorder forum. The study draws upon the sociology of childhood, which argues that children should be recognised as social actors, and as both ‘beings’ in the present, as well as future ‘becomings’. The study also draws upon the sociology of diagnosis, which recognizes the contested nature of diagnoses and medical authority in contemporary society. As lay people have increasing access to information, they have more power to challenge the ways in which their bodily experiences are constructed, as well as their potential medicalisation and demedicalisation.

The study makes use of data from a website called *TeenHelp*, focusing specifically on the ‘eating disorders’ forum. Posts were selected from those made by girls aged 13 to 19 over the two years prior to the study (i.e. 1 April 2014 – 1 April 2016). Posts from 12 girls were analysed using narrative inquiry methods.

The study identified the following six narratives: 1) identity narratives; 2) health narratives; 3) diagnostic narratives; 4) lay and expert narratives; 5) demedicalisation narratives and 6) recovery narratives. Importantly, these narratives do not exist in isolation from one another, but interact resulting in the ‘co-construction’ of eating disorders. These narratives are also not static, but are contested – constantly being challenged and negotiated on the forum.

Overall, the posts analysed in this study showed that these teenage girls are always walking a fine line between being and becoming. They occupy a liminal space between being ‘thin’ and ‘fat’; between being ‘sick’ and ‘healthy’; between being ‘lay patients’ and ‘expert advisers’; between ‘treatment’ and ‘recovery’. The narratives analysed here show how these young women are wrestling with the complex notion of eating disorders as a potential source of identity, a medical diagnosis and condition which they may or may not ever fully recover from.

Keywords: *teenage; girls; eating disorders; online forum; narrative inquiry*

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ACRONYMS AND ABBREVIATIONS

AN: Anorexia Nervosa

BED: Binge Eating Disorder

BN: Bulimia Nervosa

BMI: Body Mass Index

BPD: Borderline Personality Disorders

DMS: Diagnostic and Statistical Manual

ED: Eating Disorder

EDNOS: Eating Disorder Not Otherwise Specified

Pro-Ana: Pro-Anorexia

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INTRODUCTION

Research problem

Eating disorders are an important cause of physical and psychosocial problems in young women (Fairburn & Harrison, 2003, p. 407). Whilst there is much clinical research on the topic, there is a lack of research on how young people view and experience eating disorders. As young people are growing up and developing their sense of identity, they have to navigate through a maze of different discourses which seek to prescribe how their bodies should look and how these bodies should be achieved and maintained. At the same time, they seek to construct their own identities and narratives which frame their lives and experiences in particular ways. In this study I will take a social constructionist approach to analysing the narratives which I identify on an online forum where teenage girls discuss their experiences of their eating disorders.

Research aim and questions

This research aims to provide an understanding of the narratives of teenage girls with eating disorders on an online discussion forum. The focus is upon the ways in which these narratives serve to ‘construct’ what an eating disorder is, as well as the ways in which narratives are ‘co-constructed’, reinforced, challenged and negotiated by various actors on (and beyond) the online forum. Whilst much literature focuses strongly upon biomedical perspectives of eating disorders, the current study seeks to make a contribution by focusing on the narrated experiences of young women with eating disorders. As Jutel et al. (2009) note, medical narratives come from an institutional position and rarely recognize the lived, embodied illness experience of the patient (ibid, pp. 287-288). There is thus an important need to focus on ‘patients’ stories and how they narrate and make sense of their potential illnesses and diagnoses. It is also important to recognise the value of young people’s current experiences as ‘beings’, rather than only thinking of them as future or ‘becoming’ adults (James and James, 2012, p. 59).

In particular, the study seeks to answer the following research questions:

1. What narratives are present on the online forum?
2. How do different narratives compete and influence each other?
3. What are the implications of these narratives for understanding eating disorders?

Situating the Study

This research draws strongly upon the sociology of childhood. Childhood studies refers to the “interdisciplinary study of the early period of the human life-course that is legally recognised and socially [...] defined as childhood, as distinct from adulthood” (James & James, 2012, p.18). This study focuses specifically on girls between the ages of 13 and 19¹ (i.e. teenagers) who can be seen as being in between childhood and adulthood. The sociology of childhood recognizes the importance of viewing children and young people as social actors with agency rather than as passive objects of adult socialisation (James & Prout, 1997, p. 4). One of the central debates in childhood studies is the dichotomy between children as ‘becomings’ and children as ‘beings’ (Prout, 2005, p. 66). Lee (2001) has argued for the importance of recognizing that both children and adults are mutually-dependent beings who are in a constant process of change and ‘becoming’ (cited in Prout, 2005, p. 66). The current study views teenage girls as both ‘beings’ and ‘becomings’ as they navigate and narrate their eating disorder experiences online.

This study is based on the ‘child’s perspective’ as opposed to the ‘perspective of the child’. Whilst the latter examines what is said *about* children, the former focuses upon what children *themselves* say and how they make sense of their experiences (Sparman & Lindgren, 2010, p. 260). Following from this, the current study focuses on the ‘voices’ of young people. However, the notion of ‘voice’ can also be problematic. For example, one could question what really constitutes an ‘authentic’ child’s voice, how such a ‘voice’ could be accessed and how such few voices could be considered to speak for the diverse range of experiences that children and young people in different contexts may have (Spyrou, 2011, p. 152). There are also the politics of representation, which relate to the ability of an adult researcher to ‘represent’ a child or young person’s voice (James, 2007 cited in Spyrou, 2011, p. 152). In spite of these limitations, it is still worthwhile to try to access young people’s voices and to give them representation within research – whilst always remaining cognisant of these challenges and seeking to overcome them.

The study also draws upon the sociology of diagnosis, which recognizes the contested nature of diagnosis and medical authority in contemporary society (Jutel, 2009). According to Blaxter

¹ I recognise that biological age is also a social construct in the sense that maturity and development do not progress in a uniform manner in all children across time and space. However, this age group has been selected to assist with the sampling procedure in this study.

(1978), a diagnosis includes the categories that medical professionals use to designate a specific condition, as well as the process by which such a label is applied. Diagnosis is central to the way in which medicine creates social order and exerts its role in society (Jutel, 2009, p. 278). It organises illness by providing an ‘explanatory framework’ for disease and by identifying treatment options (ibid, p. 278). However, as lay people have increasing access to information, they have more power to challenge their doctor’s opinions (Lupton, 1997 cited in Jutel, 2009, p. 284). According to Frank (1995), telling stories about illness allows us to “give voice to the body” (Frank, 1995, p. 2). The current study attempts to ‘give voice’ to the bodies and experiences of teenage girls with eating disorders by analysing their conversations in an online forum.

The Value of ‘Small Stories’

This study focuses upon teenage girls’ stories, using narrative inquiry as an analytic tool. For the purposes of this study, I draw upon Georgakopoulou’s (2006, p. 122) notion of ‘small stories’. Georgakopoulou highlights the contested nature of what constitutes a story in the first place, but also what constitutes “a story worthy of analysis” (ibid). She defines ‘small stories’ as “snippets of talk” (p. 123) which do not fit within the typical narrative canon. The narrative canon has often been biased towards stories with a clear plot line, temporal progression and with a beginning, a middle and an end (ibid, p. 124). In contrast to this, Georgakopoulou (2006) draws attention to the value of ‘small stories’ which she defines as an umbrella-term that includes under-represented narrative activities. These activities include “tellings of ongoing events, future or hypothetical events, shared (known) events, but also allusions to tellings, deferrals of tellings, and refusals to tell” (ibid, p. 123). These stories are generally physically ‘small’ when compared to the long transcripts of interview narratives. However, they are also metaphorically ‘small’ when compared to ‘big stories’ and ‘grand narratives’ which focus on ‘fully-fledged’ stories (ibid). However, as Georgakopoulou (2006) puts it, “small stories research can offer a way out of celebratory, idealizing and essentializing accounts of self” (p. 129) – and this is precisely what I aim to do in the current study.

According to Cain et al. (2013), social science researchers have taken a ‘narrative turn’ in understanding experience since the late 1980s/early 1990s (Pinnegar & Dayness, 2007 cited in Cain et al., 2013, p. 574). Cain et al. (2013) speak of a “narrative way of thinking about phenomena” (p. 575). Indeed, such ways of thinking are fundamental to the current study. By this I mean taking a view of ‘small stories’ as being significant in our understanding of

ourselves and others. As Andrews (2007) puts it, stories are “one of the primary means through which we constitute our very selves [...] we become who are we through telling stories” (pp. 77-78). In this way, stories are understood as playing an important role in the construction of people’s identities.

Stories are also profoundly social, as they are always told *to* someone or with some potential reader or audience in mind (Frank, 1995, p. 3). As Cain et al. (2013) notes, stories “offer us insights into experiences and resonate in ways that help us to learn and form connections with others” (p. 583). Recognizing the importance of stories in general, and ‘small stories’ in particular, the current study focuses upon the narratives of teenage girls regarding their experiences and potential diagnoses of eating disorders. Their narratives are not treated as ‘objective truths’, but rather are seen in the context of a reality that is constituted by many different voices in different contexts. I shall now go on to highlight the relevant literature, as well as outlining the conceptual and theoretical framework which the study draws upon.

LITERATURE REVIEW

Introduction

In this literature review, I will highlight some of the key concepts and studies relevant to the topic of eating disorders in young people. I will begin by outlining two key models in approaching health and illness. I will then discuss the notions of ‘medicalisation’ and ‘demedicalisation’ in relation to the changing nature of the ‘doctor-patient relationship’ in contemporary society. I will also consider the medicalisation (and potential demedicalisation) of eating disorders such as anorexia nervosa. I will then discuss the notion of ‘narrative’ in relation to the lay illness experience as well as medical narratives related to the diagnosis of disease. Finally, I will explore the notion of ‘futuraity’ in relation to young people’s health.

Approaches to Health and Illness

The biomedical model has dominated Western medicine since the end of the eighteenth century (Nettleton, 2008, p. 2). This model views the health of an individual as being purely biologically determined, without taking social or environmental factors into consideration. It assumes that the body and mind of an individual can be treated separately. It treats a ‘sick body’ like a malfunctioning machine that can be repaired by medical professionals. The model takes

a reductionist approach by focusing on the biological causes of disease, while overlooking social and psychological factors. As Walker et al. (2004, p. 91) note, “Scientific or modern medicine offers rational, measurable and directly observable explanations for disease”. However, this model has been criticised because it does not locate the body within its social and environmental context (Nettleton, 2008, p. S5).

In contrast to the biomedical model is the social-environmental model. As Nettleton (2008) argues, patterns of morbidity and mortality vary according to various social and environmental factors including race, class, gender, age and socio-economic status (p. 5). The fact that such patterns exist shows that health and illness are not determined solely by individual biology. Rather, health is influenced by many factors that are internal and external to the individual. The current study recognises both the ‘biomedical’ and the ‘social-environmental’ models of health as having the power to influence how individuals construct and make sense of their experiences of having an eating disorder.

Medical Authority

Historically, the main role of the physician was to treat disease and to restore the health of their patients (Dubos, 1984, p.7). As Jutel (2009) notes, “Medicine has an officially approved monopoly over the right to define health and to treat illness, which results in high public esteem” (p. 284). Doctors have the authority to make a medical diagnosis based on their observations (Freidson, 1972, p. 261). It is the doctor’s supposedly superior knowledge and status, as well as medicine’s authority, which sets the doctor apart from the lay person and other professionals (ibid). Indeed, medicine’s authority at an institutional level translates into authority at the individual level – as manifested in the power of the doctor to make diagnoses (Freidson, 1972, p. 244).

The increasing scope of medical authority has been understood through the notion of ‘medicalisation’. According to Conrad (1992), medicalization is “a process by which non-medical problems become defined and treated as medical problems, usually in terms of illness or disorders” (as cited in Abraham, 2010, p. 604). Anorexia is another condition which has come to be understood medically since the 19th century. Prior to that, it had been understood through the medieval notion of female fasting as a manifestation of religious devotion (Brumberg, 2000 cited in Fox et al., 2015, p. 944). In this way, eating disorders such as anorexia

have come under the ‘medical gaze’, thus falling within the ambit of medical authority.

Diagnoses are a key element of medical authority, and are often framed within the powerful language of science, rationality and objectivity. A diagnosis is supposedly a neutral, objective, expert opinion based on observations. However, in reality, as the sociology of diagnosis clearly highlights, a diagnosis is a social construct which can change greatly over time (Jutel, 2009). As Jutel (2009) notes, “medicine is temporally situated, and makes its diagnoses on the basis of the technology and values available at a specific point in time” (p. 281). A classic example of this is the removal of homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (DSM) due to the protests of gay activists (Kirk and Kutchins, 2008, pp. 81-90). If diagnosis were indeed a neutral observation of natural fact, then such a change in diagnosis would be impossible. In reality, far from being neutral and objective, a diagnosis often provides a cultural expression of social norms (Jutel, 2009, p. 279).

Once a patient has been given a diagnosis, they are expected to comply with it and to adhere to their doctor’s advice (Jutel, 2009, p. 293). However, today’s patients are increasingly able to resist and to challenge medical authority (Lupton, 1997, p. 373). This is evidenced by the increasing willingness of patients to criticise their doctor and to seek advice outside of the doctor-patient relationship (ibid, pp. 376-377). As Jutel (2009) notes, patients living in an information-rich, contemporary world sometimes circumvent the doctor altogether. For example, “They calculate their BMI², take depression self-tests, or use medical terminology to describe their idiosyncrasies and those of their friends” (ibid, pp. 293-294). Patients are also able to challenge doctors’ diagnoses, with diagnosis becoming “an important site of contest and compromise, because it is a relational process with different parties confronting illness with different explanations, understandings, values and beliefs” (ibid, p. 279). The current study explores the ways in which teenage girls confront the notion or diagnosis of ‘eating disorders’ in relation to these varying explanations, understandings, values and beliefs.

Eating Disorders

From a biomedical perspective, eating disorders are classified into three categories: anorexia nervosa, bulimia nervosa and atypical eating disorders, but patients frequently move between these three disorders (Fairburn & Harrison, 2003, p. 407). From a clinical perspective, anorexia

² BMI: Body Mass Index

nervosa and bulimia nervosa are both related to patients over-evaluating their shape and weight (*ibid*, p. 410). According to Fairburn & Harrison (2003), "...patients with anorexia nervosa or bulimia nervosa judge their self-worth largely, or even exclusively, in terms of their shape and weight and their ability to control them" (p. 407). In the case of anorexia nervosa, weight loss is achieved through selective restriction of food intake and 'over-exercising'. In the case of bulimia nervosa, patients alternate between periods of binge-eating and self-induced vomiting or excessive use of laxatives and diuretics (*ibid*). The current study focuses on 'eating disorders' more broadly as a category including people who may have anorexia, bulimia or some combination of the two.

Another 'eating disorder' which has recently been recognised in the Diagnostic and Statistical Manual (DSM V) is called 'orthorexia'. According to Musolino et al. (2015), orthorexia is "a new food regime with an explicit mantra for 'healthy', 'pure' and 'natural' eating" (p. 19). It is characterised as "extreme care for and selection of what is considered to be pure, healthy food" (Bartrina, 2007, p. 313 cited in Musolino et al., 2015, p. 22). Orthorexia is often connected to a binary distinction between 'good' and 'bad' food. As Lupton (1996) puts it, 'Good' food is often described as nourishing and 'good for you', but is also indicative of self-control and concern for one's health, while 'bad' food is bad for one's health and on a deeper level of meaning is a sign of moral weakness" (Lupton, 1996, p. 27).

Orthorexia is closely linked to the notion of 'healthism'. Crawford coined the term 'healthism' to refer to a particular way of viewing health that is associated with new health consciousness and health movements (1980, p. 365). However, the world has changed since Crawford's initial conceptualisation, as we now have an increasing appetite for health consumerism (Musolino et al., 2015, p. 18). Recent socio-political changes "have extended and cemented the idea that one should take responsibility for one's health and place the pursuit of a healthy lifestyle at the centre of moral virtue, personhood and citizenship" (Musolino et al., 2015, p. 18). Musolino et al. (2015) connect healthism to Foucault's (1991) concepts of 'biopower' and 'governmentality' in relation to health activities and public health programmes (p. 18). Indeed, healthism is a "dominant ideology of wellness" which emphasizes healthy living and exercise based on 'rationality' and 'logic' through a continuous process of "self-examination, self-care and self-improvement" (*ibid*, p. 19). In line with this, Musolino et al. (2015) found that their participants in a study of anorexia, actively sought out information regarding health, nutrition and exercise in order to self-regulate and monitor their diet and weight (pp. 18-19).

In line with this view of ‘healthy anorexia’, we have seen some contentious calls for the demedicalisation of eating disorders such as anorexia nervosa. As Brown and Zavestoski (2004) argue, the misfit between patient and medical explanatory models may generate the politicisation of illness, with social movements advocating for either the ‘medicalisation’ or ‘demedicalisation’ of their condition. In the case of anorexia, there has been an ‘underground’ social movement which has advocated for the demedicalisation of the ‘disease’, precisely because of this misfit. Fox et al. (2005a) collected ethnographic and interview data from participants in a ‘pro-anorexia’ online forum. The pro-anorexia movement encourages the use of weight-loss pharmaceuticals to maintain low body weight, while simultaneously encouraging a ‘healthy’ diet to sustain an anorexic way of life (p. 944). Fox et al. (2005a) argue that the ‘pro-ana’ movement has a fundamentally different underlying ‘explanatory model’ of the disease compared to medical, psychosocial, sociocultural and feminist models that encourage a ‘normalisation’ of body weight and shape. Fox et al. (2005a) suggest that for participants in pro-ana, anorexia represents stability and control, rather than a disease to be overcome (p. 944).

Although eating disorders are the focus of this study, I am not interested in the biomedical ‘diagnoses’ which would apply to the girls on the forum. Rather, I am interested in the ways in which the girls navigate and construct their experiences of eating disorders in relation to the notion of diagnosis. I shall now discuss the literature on different types of ‘narratives’ in terms of how illness is represented.

Representations of Illness

The first type of representation of interest is the ‘illness narrative’. An illness narrative arises when someone feels unwell and they describe and contextualise their complaint (Jutel, 2009, p. 287). As Jutel (2009) notes, “there is more than one narrative: both the patient’s and the doctor’s stories juxtapose and merge for a diagnosis to materialise” (p. 287). A diagnosis is thus co-constructed as the doctor and patient narratives are brought into dialogue with each other. The patient’s stories come from their own experience and culture, but those stories can be also transformed into medical accounts (ibid, p. 287). Indeed, the doctor retells the story in order to shape it into a diagnosis (Hunter, 1991). Illness is the story of how the individual sees things, while diagnosis is “the story of medicine, told in the language of disease” (Jutel, 2009, p. 287). Frank (1995) speaks of ‘narrative surrender’ – where being ill involves the social

expectation that the patient will firstly, seek care and secondly, relinquish their story to the doctor's story, allowing it to be told through diagnosis (pp. 5-6).

The second type of representation of interest is the 'expert narrative'. Foucault (1984/1988) discusses how modern institutions (e.g. hospitals) produce expert discourses of knowledge. However, the information age has also given rise to the 'expert patient' as lay people increasingly have access to detailed medical information online. Expert patients are "those who can manage their own illnesses and conditions by developing knowledge relevant to maintaining health and countering illness" (Shaw and Baker, 2004 cited in Fox et al., 2005b, p. 1299). However, as Fox et al. (2005a) argue, the concept of the 'expert patient' is "medico-centric and retains a subordinate role for lay definitions of health and illness" (pp. 945-946). The current study examines the ways in which lay and expert narratives interact and are appropriated by different actors at different times within the online forum, resulting in different ways of constructing and conceptualising eating disorders.

The third type of representation of interest is the 'diagnostic narrative'. The 'illness narrative' and the 'medical narrative' interact to produce a 'diagnostic narrative'. The 'illness narrative' comes from the patient's perspective and includes the practical management of symptoms etc. (Jutel et al., 2009, p. 287). The 'medical narrative', on the other hand, comes from the institutional position and rarely recognizes the lived, embodied illness experience of the patient (ibid, pp. 287-288). It is important to note that 'patient narratives' and 'medical narratives' do not exist in isolation from each other, but often influence each other (Klawiter, 2004 cited in Jutel, 2009, p. 288) resulting in a diagnosis which is 'co-construction'.

Although a medical diagnosis makes an illness 'legitimate', the diagnosis does not necessarily align with the patient's narrative. As Jutel (2009) notes, this is because these stories are being told from different positions (p. 287). Hunter (1991) encapsulates the disconnection between the languages of disease and illness when she writes that the "transformed and medicalized narratives may be alien to the patient: strange, depersonalized, un-lived and unlivable. Returned to the patient in this alien form the medical narrative is all but unrecognizable as a version of the patient's story – an all but useless as an explanation of the patient's experience" (Hunter, 1991, p. 13). This occurs when the medical narrative does not take adequate account of the lived, illness experience of the patient. This results in the patient being unable to incorporate

the medical narrative into their personal narrative through the diagnostic label (Jutel, 2009, p. 288). On the other hand, medical narratives can also be adopted and included in personal narratives.

There are thus three main types of representations of interest in the current study. These include illness/patient narratives, medical/expert narratives and diagnostic narratives. I shall now discuss the notion of young people's health in relation to views of 'the future'.

Youth People's Health and 'the Future'

Having discussed the notions of 'medicalisation' and 'demedicalisation' in relation to eating disorders, as well as the importance of 'narratives' in diagnosis, I shall now go on to consider 'eating disorders' in relation to young people's health and the future. 'Child health' is a term used to refer to "the health status of children as individuals, and also to the institutional arrangements and provision of health services for children" (James & James, 2012, p. 66). A young person is one who is too old to be regarded socially as just a child, but who is not yet legally an adult (ibid, p. 140). In the case of the current study, the focus is upon young people's health – in particular, the mental and physical health of teenage girls. According to Rose and Abi-Rached (2013), we are no longer living in the age of "risk management" but have now moved into "a general regime of futurity" (p. 14). As they put it, "The future now presents us neither with ignorance nor with fate, but with probabilities, possibilities, a spectrum of uncertainties, and the potential for the unseen and the unexpected and the untoward" (ibid, p. 14). Thus, there is a focus on early detection and even preventative intervention (ibid, p. 15) - particularly when it comes to the health of children and young people.

The notion of 'futurity' is of great importance in the field of Child Studies. James and James (2012) define futurity as "The recognition, in the present, of the child's potential for being different in the future and the predication of present actions on the basis of this recognition" (p. 57). As James and James (2012) note, the investments that all societies make to ensure the health and well-being of their children in the present is also an investment in their future (pp. 58-59). From the perspective of childhood studies, the significance of this is that it serves to "detract from the recognition of the importance of children's experiences of the present and the significance of these experiences in shaping the adults they will become" (ibid, p. 59). As Lee (2001) argues, if we only focus on children as 'becomings', this will blind us to their agency

as social actors in their own right. The current study recognizes teenage girls as *both* ‘beings’ and ‘becomings’. Although the focus is upon the girls’ experiences of eating disorders as affecting their current state of being, I also recognize the girls’ awareness of both the past and the future, in relation to their thoughts about who they may *become* in the future. This temporal dimension is of fundamental importance.

Having highlighted the conceptual framework of the study, as well as the relevant literature, I shall now go on to discuss the methods of the study as well as addressing the methodological and ethical considerations.

METHODS AND METHODOLOGY

Epistemology and Ontology

A fundamental question for social researchers is “whether the things we perceive are simply given and correctly perceived by our senses (empiricism), or whether the things we perceive are rather the product of our conceptualizations (constructivism)” (Kratowil, 2008, p. 81). The current study takes a social constructionist, rather than an empiricist approach. Conrad and Barker (2010, p. S67) define social constructionism as “a conceptual framework that emphasizes the cultural and historical aspects of phenomena widely believed to be exclusively natural”. Social constructionism is sometimes mistakenly taken to mean that the physical world is the product of the imagination of the social scientist (Della Porta & Keating, 2008, p. 24). Rather, social constructionists contend that classifications are based on convenient ways of representing the world, as opposed to being ‘true’ in the empirical sense of the word (Hacking, 1999, p. 33). In other words, “The world is not just there to be discovered by empirical research; rather, knowledge is filtered through the theory the researcher adopts” (Della Porta & Keating, 2008, p. 24). This is indeed the case in the current study.

Some critics of social constructionism have argued that “if all knowledge and social identities are taken to be contingent, then it follows that everything is in flux and there are no constraints and regularities in social life” (Jørgensen & Phillips, 2002, p. 6). Although social constructionists acknowledge a certain degree of ‘relativism’, they do not throw themselves into the “abyss of arbitrariness” (Kratowil, 2008, p. 82). As Kratchowil (2008) puts it, “Far from justifying the inference that ‘anything goes’, we simply have to be careful in specifying

the frames within which we argue and make truth claims” (p. 82). Indeed, most social constructionists view the social world as relatively rule-bound. As Jørgensen and Phillips (2002) note, “Even though knowledge and identities are contingent *in principle*, they are always relatively inflexible in specific situations” (p. 6). Thus, while recognizing identities as being socially contingent, I also recognize some degree of stability and continuity which provides a legitimate (although, always contested) basis for analysis. In the current study, the classifications of ‘eating disorders’ are not taken as objective, empirical truths. Rather, they are viewed as social constructs which arise through being co-constructed by different actors in different contexts. I also treat notions of ‘health’ and ‘illness’ as being socially constructed (James & Hockey, 2007, p. 3). Indeed, the same is true of ‘diagnoses’, as discussed below.

As discussed in the literature review, a diagnosis is often presented as a neutral, objective and natural. However, as Hacking (2001) notes, “the idea of nature has served as a way to disguise ideology, to appear to be perfectly natural” (cited in Jutel, 2009, p. 281). On the one hand, diagnosis is fundamentally connected to notions of ‘truth’ and ‘legitimacy’ – and in this way, is connected to epistemological and ontological questions. As Dummit (2006) highlights, there is an “intense interplay between diagnosis and legitimacy: without a diagnosis and other forms of acceptance into the medical system, sufferers are at risk of being denied recognition of their very suffering and accused of simply faking it” (cited in Jutel, 2009, p. 290). Once a diagnosis is made, the condition (and the suffering) are considered as legitimate, and in this sense ‘true’. However, this ‘truth’ is far from absolute. As Jutel (2009) puts it, “Diagnoses do not exist ontologically” (p. 294). Similarly, for the purposes of this study, diagnoses are not treated as being ‘true’ or ‘false’, but as being socially constructed. It is these constructions which are of interest.

Data

In this study, I have made use of ‘existing’ data. According to Robinson (2001), “Existing means collected (i.e., on the shelf) prior to the research for a purpose other than the proposed research” (p. 709). My data consists of “unsolicited first-person narratives” (Robinson, 2001, p. 708). As Robinson (2001, p. 709) highlights, the relative anonymity of the Internet seems to allow people to speak openly about personal experiences. In her research, Robinson (2001) found that many of the accounts were “written very informally, with numerous spelling and grammatical errors, but with a depth of feeling that is usually not present in more formal

communication” (p. 709). Similarly, this was the case with the data in the current study.

The data I have used comes from a website called *TeenHelp*. I came across this website while I was searching for online forums for young people. *TeenHelp* is a non-profit organisation run by volunteers³. These volunteers are people of all ages from across the world, and they provide free support and advice to people who use the website. They report to the Project Co-ordinators of the website, who are also volunteers. The website acts as an anonymous forum for online communities of teenagers and young people. Users who want to start threads or reply to existing threads need to register on the website. When they do so, they create a profile which is linked to their chosen alias. They are able to choose how much information they share about themselves, e.g. their country, age, sex, gender etc. Whenever a user starts a thread or posts a reply, it is connected to their alias name and *TeenHelp* profile. Users can access the various forums to discuss topics of interest to them and receive advice and support from peers and adult moderators. One of the support forums on the website is entitled “Eating Disorders” – and this is the forum I have focused on.

In terms of potentially harmful behaviours (such as self-harming and eating disorders) *TeenHelp* is also explicitly ‘pro-recovery’. This is in contrast to some websites (such as ‘pro-ana’ websites) which position themselves as being ‘anti-recovery’ (Fox et al., 2005, p. 945). The terms of conduct state that “*TeenHelp* encourages positive, safe, recovery-focused choices and will not tolerate advice that encourages harmful behaviour”⁴. *TeenHelpers* often share videos and information on the eating disorder forum in order to ‘assist’ people with their recovery.

The website also discourages ‘inappropriate behaviours’. The *TeenHelp* terms of conduct specify what is considered as “inappropriate content”. Such content includes “‘Food diaries’, or any indication of body weight (including actual weights, BMIs, clothing sizes or ‘tickers’ that measure weight loss)”⁵. So it is not uncommon to see “edited” written in many of the posts made in the ED forum where people have posted such information. The *TeenHelpers* are responsible for “editing” such content, as it is considered to be potentially “triggering” to other users. For example, seeing that someone else only weighs a certain amount or only consumes

³ I refer to these volunteers as ‘TeenHelpers’ in the analysis section.

⁴ <http://www.teenhelp.org/terms/conduct/> accessed 06/05/2016

⁵ <http://www.teenhelp.org/terms/conduct/> accessed 06/05/2016

a certain number of calories per day, may motivate another user to follow their example.

The eating disorder forum is a form of Computer-Mediated Communication (CMC). CMC is an interdisciplinary field which focuses on language and language use in computer networked environments (Herring, 2004, p. 1). CMC focuses on the communication produced when people interact with each other by sending messages through networked computers (*ibid*). Most CMC is text-based as messages are typed on computers and read as text on computer screens (or other devices such as smart phones or tablets). The linguistic properties of the messaging system depend upon the social and cultural context in which the communication is embedded (*ibid*). Computer mediated exchanges are generally faster than other forms of written exchanges (such as letters or emails), and yet they are significantly slower than spoken exchanges because typing is slower than speaking (*ibid*). CMC also allows messages to be shared with an unseen (and often unknown) audience, while at the same time creating a feeling of personal and even ‘private’ exchanges (King, 1996). Text-based CMC is also a good way of studying social interactions because it allows users the time to choose their words with greater care than spontaneous speech would allow (Sproull & Kiesler, 1991). CMC takes a variety of forms, such as email; discussion groups, real-time chat and role-play games. The focus of the current study is upon an online forum discussion of eating disorders, where the CMC is treated as ‘data’.

Data Analysis

As of 24 February 2016, the eating disorders forum contained 2307 threads and 12 536 posts. Naturally, I had to be selective in choosing which posts to focus on. I limited my focus to posts made over a two-year period, i.e. 1 April 2014 -1 April 2016. I decided to focus exclusively on posts made by teenage girls, as eating disorders are generally far more common among women than men (Fairburn & Harrison, 2003, p. 407). I also eliminated any posts where the poster was over the age of 19 (or where the age was not specified). This provided me with a sample of 30 girls between the ages of 13 and 19. I drew up a table listing the poster’s username, age, location and writing a short summary of each post they made in the relevant time period. I read through these posts carefully and started to identify preliminary themes and patterns which appeared to be emerging.

From there, I turned to the literature in order to see if there were any additional themes I may

not have thought to look for. It was this point that I realized the relevance of the literature on the sociology of diagnosis and decided to use this as the framework for the study. I then returned to the posts I had gathered and selected posts which had relevance to the theme of diagnosis. This reduced my sample size to 12 posters. I read through these posts several times in order to identify key narratives and grouped the posts according to these narratives. I continued to work iteratively between the data and the literature, continually revising and refining the themes and narratives that I had identified until I felt that my analysis provided a meaningful representation of the data.

I considered various potential methods of data analysis for this study. Originally, I had planned to use discourse analysis. However, I came to realise that narrative inquiry was a more suitable means of capturing the ‘personal’ elements of people’s stories before connecting them to the broader social context. There were two main reasons why I chose narrative inquiry as my method of analysis. The first reason was because it corresponds with my view of the relationship between narrative, experience and identity – that ‘who we are’ is fundamentally narrative in nature (Clandinin & Connelly, 2000 cited in Cain et al, 583). The second reason was because I view a diagnosis as a kind of ‘story’ or narrative for making sense of an illness experience. Thus, narrative inquiry seemed to be the method that was best suited to use in analysing the data in this study.

It is important to acknowledge that ‘narrative’ is an elusive and contested term which means different things in different contexts (Georgakopoulou, 2006, p. 122). A narrative can be understood as a way of making sense of the world and of one’s experience. It can be understood as a type of discourse with “conventionalised textual features” (ibid). It can also be understood as an epistemology, a methodological perspective, a means of communication, a type of text or even “an antidote to positivist research” (ibid). In the current study, I use the term ‘narrative’ to refer to the ‘small stories’ (Georgakopoulou, 2006, p. 122) that are told by young women on an online eating disorder forum. Their narratives constitute the data for the study, but also have important epistemological implications – as discussed earlier.

Georgakopoulou (2006) clarifies the distinction between ‘narrative inquiry’ and ‘narrative analysis’. Narrative inquiry scholars use narratives as a method, with a focus on what stories

tell us about the teller's self through studying *what* is said and by *whom* (ibid, p. 125). In contrast to this, narrative analysts prioritise *how* stories are told, where the study of narrative constitutes an end in itself rather than a means to an end (ibid). However, Freeman (2003, p. 338) warns that the distinction between these two (i.e. narrative inquiry and narrative analysis) should not be seen as a dichotomy. Similarly, Georgakopoulou (2006, p. 125) is in favour of finding the synergies between these two approaches. Her work shows that through analysing the 'who', 'what' and 'how' of narratives, researchers can gain a better understanding of how identities are invoked, inflected and reworked through the telling of stories.

Whilst recognising the synergies between 'narrative inquiry' and 'narrative analysis', I have drawn most strongly upon Cain et al.'s (2013) understanding of narrative inquiry. Cain et al. (2013) emphasize the importance of temporality, location and sociality in narrative inquiry (p. 577). In my study, some of the participants give their physical location, but the real 'location' of interest is the virtual location that is the *TeenHelp* website in general and the eating disorder forum in particular. The element of 'sociality' is studied through the interactions between the various posters as well as with the '*TeenHelpers*'. The element of 'temporality' is often reflected in the narrative itself, and is of particular interest in the current study.

The method I have used in analysing my data is in line with many of Cain et al.'s (2013) requirements for 'narrative inquiry'. In particular, I have taken a narrative approach to 'experience', with a focus on temporality, location and sociality (ibid, p. 577). Given the centrality of notions of 'being' and 'becoming' in childhood studies, I have focused particularly on the notion of 'temporality' in the girls' narratives. I have also attempted to connect individual narratives with broader institutional narratives (ibid, p. 577) – in particular the institution of medicine. However, according to Cain et al. (2013), a key aspect of narrative inquiry is that it is 'relational' with a focus on the relationship between the researcher and the research participants (p. 577).

In the case of the current study, the data was 'naturally occurring' (Silverman, 2011, p. 201) and did not involve any direct interaction between myself and the participants. However, I would argue that the data still involves a high degree of interaction between the participants; and between participants and '*TeenHelpers*' – something which is a key element of the analysis. Thus, I use the term 'narrative inquiry', recognizing that I am using it in a slightly different context from the way that Cain et al. (2013) use it – although with due regard for the

importance of taking a ‘narrative approach to experience’.

Reflections on Research Design

One advantage of this study is that the data are easily accessible without me needing to create a profile or to login to view the forum. This is important, as many websites only allow limited access to ‘guests’. The website also allowed me to use the data for research purposes without requiring me to contact posters individually to obtain consent (discussed further below under “Ethical Considerations”). The *TeenHelp* website also has a forum which is specifically dedicated to “Eating Disorders” – thus providing a rich source of data to use in attempting to answer the research questions of this study. Another advantage is that the data are ‘naturally occurring’. Silverman (2011) distinguishes between naturally occurring data and researcher-provoked data, with the former being “derived from situations which exist independently of the researcher’s intervention” (p. 201). This allowed me to get a greater sense of accessing young people’s voices. Naturally occurring data also has the advantage of producing ‘automatic transcripts’ since the participants ‘type’ their narratives directly on the forum. This avoids the need for transcription, as is the case with verbal interviews.

Although attempting to access children’s voices was discussed under ‘advantages’ above, this notion also has its limitations. For example, James (2007) warns that there is a tendency of childhood research to portray itself as representing ‘authentic’ voices of children which risks simplifying and reducing the complexity of children as social actors. There is thus a need for reflexive research which “accepts the messiness, ambiguity, polyvocality, non-factuality and multi-layered nature of meaning in ‘stories’” (Spyrou, 2011, p. 162). Bearing this in mind, I have attempted to draw on a standpoint theory of childhood research, which acknowledges the different positions from which children speak rather than seeking to represent a single, ‘authentic’ voice of children (Elden, 2013, p. 67).

Another important limitation of the study relates to “the veracity of the materials” (Robinson, 2001, p. 712). I cannot be sure of the ‘truth’ of the identity of the posters or the ‘truth’ about what they post. Even if someone claims to be a female adolescent with an eating disorder, there is no way for me to verify this information. However, following the example of Osvaldsson (2011), the unit of analysis for this study is the posted texts (or “postings”) as opposed to the

individuals who posted them. This reduces the significance of the ‘true’ identities of the people who post on the forum. There is also the question of the ‘truth’ of what people post on the forum. However, since the study takes a social constructivist approach, the ‘truth’ is not as important as what is *presented* as being ‘true’ (Robinson, 2001, p. 712). Furthermore, the focus on the value of experience is fundamental to the study. As Iversen (2014) notes, “Referring to one’s experience can be valid evidence because it is first-hand knowledge...” (p. 369). My epistemological approach in this study recognizes that constructions always have an object side and a subject side (Iversen, 2014, p. 369). I do not claim to have access to ‘truth’ in any absolute sense – only to the representations of individual, subjective experiences of ‘reality’. However, I have also aimed to be as explicit as possible when making the “normative choices regarding whose perspective to consider and how to interpret it” (Sköld, 2016, p. 17) in order to increase the transparency of the study.

One of the limitations of qualitative research is that the findings often have limited generalizability. This may indeed be the case with the current study. It is particularly important to recognize that there are many stories, and that I do not seek to establish a single narrative to represent the many, diverse experiences that teenage girls may have with the diagnosis of eating disorders. As Richardson (1997) notes, a

story of a life is less than the actual life, because the story told is selective, partial, contextually constructed and because the life is not yet over. But the story of a life is also more than the life, the contours and meanings allegorically extending others, others seeing themselves, knowing themselves through another’s life story, re-visioning their own, arriving where they started and knowing ‘the place for the first time’ (p.6).

In my analysis, I have attempted to ‘tap into’ elements of individual narratives which may potentially resonate with other people’s stories, looking for patterns in order to shed some light on the ways in which teenage girls more generally may navigate the diagnosis of an eating disorder. This gives the findings of the study some meaning *beyond* the individual narratives which I draw upon.

Ethical Considerations

According to Cain et al. (2013) "...narrative inquirers hold responsibilities and obligations for, and towards, the people whose stories are lived and told" (p. 576). They continue to note that "...narrative inquiry is first and foremost a relational research methodology, and, while it is research, it is also a transaction between people, which makes ethical issues and concerns about living well with others central to the inquiry (Clandinin & Connelly, 2000)" (p. 578). Although, as I have noted, I did not have any direct interactions with the participants, I still had access to their very intimate and personal stories. I considered it a great challenge and responsibility to be able to represent their narratives and experiences in a fair and balanced manner.

Ethical considerations are also of great importance when making use of unsolicited first-person narratives from the Internet (Robinson, 2001, p. 709). In this study, I used data from an online forum for teenagers. While online communities may be a useful source of data, they also raise important ethical concerns (Eysenbach & Till, 2001, p. 1103). One concern is that internet communities' members do not expect to be research subjects (*ibid*). Finding out that a support forum is being used for research purposes can undermine participants' sense of safety and security in accessing such sites (*ibid*, p. 1104). A second consideration is what constitutes a 'public space' versus a 'private space'. According to the "Ethical Guidelines for Research Online" (Bruckman, 2002), a researcher may freely quote and analyse online information without consent if:

1. It is officially, publicly archived
2. No password is required for archival access
3. No site policy prohibits it
4. The topic is not highly sensitive

In the case of *TeenHelp*, I am able to access the "Eating Disorders Forum" without needing to register, subscribe or login. This creates the sense that the forum is a public rather than a private space. In their "Terms of Conduct", the website explicitly states the following with regard to "Research and data collection":

Users should not use *TeenHelp* to conduct research intended for any form of publication whatsoever without explicit approval of a Project Coordinator. Users wishing to conduct

research will be expected to explain their consideration of the following before approval to conduct research will be granted⁶.

Since the data is being used for a thesis rather than for a publication, I was not required to obtain permission from the Project Coordinator. Since the information regarding research is explicitly published in the *TeenHelp* terms of conduct, people using the forum are implicitly accepting those terms of conduct when using the website. The fact that I do not need to contact individual posters directly also has the ethical advantage of not disrupting their online interactions or their use of the website. Although the topic of eating disorders could indeed be considered as sensitive, I tried at all times to protect the identities of the posters and to treat their narratives with respect.

One possible alternative (or compliment) to using this existing data was to conduct interviews with teenage girls with EDs. However, I decided against this for various reasons. One factor related to ethical considerations, with the possibility of teenage girls with eating disorders being a potentially vulnerable and over-researched group. Other factors related to practical considerations, such as time constraints and the potential difficulties associated with finding participants. Given these factors, I decided that it would be best to use the existing narratives as the basis for the study.

According to the principles of beneficence and non-maleficence, researchers should aim to maximize possible benefits and to minimize possible harm to participants (Farrell, 2005, p. 4). A long-term benefit to the posters could come if the research is able to shed greater light onto the issues relating to eating disorders as understood from a sociological and child studies perspective. In terms of potential harm to participants, it is possible that participants could recognize themselves in the report if they were to gain access to it. In order to protect their identities, I have anonymized the data. Although participants already make use of pseudonyms on the website, I have made use of alternative pseudonyms to provide an extra layer of protection. In addition to this, I have aimed to write with care and sensitivity, avoiding including any potentially identifying information in the report.

⁶ <http://www.TeenHelp.org/terms/conduct/> accessed 22 February 2016

ANALYSIS

Introduction

From the data I collected on the Eating Disorders forum, I was able to identify six predominant narratives:

- 1) Identity narratives
- 2) Health narratives
- 3) Diagnostic narratives
- 4) Lay and expert narratives
- 5) Demedicalisation narratives
- 6) Recovery/recovering narratives

Diagnosis plays a key role in all of these narratives, and is the ‘red thread’ running through the analysis. For each narrative identified, several quotes are included to illustrate the various dimensions of the narrative. Below is a list of the participants’ pseudonyms, ages and locations as well as an analysis of the distribution of the participants’ ages.

No.	Username	Age	Location
1	LILLYLO	19	USA
2	Neo	18	Netherlands
3	Bazinga	17	Not indicated
4	DogLover	18	Not indicated
5	Its.Just.Cait	14	Not indicated
6	BornBad	18	Netherlands
7	MG	18	USA
8	CuriousMiss	15	USA
9	RainbowRider	15	Not indicated
10	Nvivo91	15	Not indicated
11	Pattycakes	19	Not indicated
12	Badger360	17	Ireland

The mean age of participants was 16.9 years, while the median age was 17.5 years. Although these average ages are relatively high (i.e. towards the end of adolescence), these participants were chosen because of the relevance of their narratives to the topic being researched, i.e. eating disorders in general and questions of diagnosis and (de)medicalisation in particular.

Identity Narratives

The *TeenHelp* website provides a virtual platform where young people (predominantly teenagers) can meet and discuss issues of interest to them. In the case of eating disorders, the forum appears to perform the function of conferring “collective identity on patients, removing them from the isolation of their suffering and providing them with new potential networks of support” (Jutel, 2009, p. 288 with reference to Chong, 2001). The forum has a strong emphasis on support, as illustrated by the description of the forum: “If you or someone close to you is struggling with an eating disorder, reach out here to ask questions or to receive support for recovery”. As Jutel (2009) notes, the collective identity may be a virtual one, where a growing number of internet communities are diagnosis-focused (p. 289). Internet communities can provide an alternative support structure. These communities “create their own separate and distinct medical culture, a culture that gives primary importance to the role of the subjective experience” (Goldstein 2004: 127). The eating disorder forum thus allowed participants to access and construct a collective ‘illness identity’.

Some of the posters seemed to identify strongly with their ‘ED identity’. For example, LILLYLO (aged 19) begins her post by describing how she used to suffer from an eating disorder but that is now in recovery. She goes on to say:

I just... Miss who I was with my eating disorder. I feel so lost. I don't like who I am now. I have no focus. My grades are slipping. All I care about is my weight. All I can think about is how thin I used to be. And I look at these pictures of me and think about how beautiful I was and I just feel like crying because I gave it all away (25/03/2015).

In LILLYLO's post, the ‘temporal’ dimension of the narrative is key. LILLYLO is contrasting the person she was ‘before’ (i.e. when she had an eating disorder) and the person she is now (i.e. a person in recovery from an eating disorder). The photographs she has of her ‘past self’ come to symbolize that identity, which she now idealizes. Whilst her ‘past self’ was thin, beautiful, focused and successful; her current self feels lost and out of control. In response to her post, *BornBad*⁷ (aged 18) reminds LILLYLO to “remember how much you hurt back then” (25/03/2015) – i.e. when she had an eating disorder. In this way, *BornBad* is acting as a *TeenHelper* and promoting the ‘pro-recovery’ stance of the website.

⁷ *BornBad* is also a poster on the forum, but here adopts the position of ‘helper’ rather than the one being ‘helped’. See ‘Diagnostic Narratives’ for an analysis of a post in which *BornBad* is the one asking for help.

From LILLYLO's narrative, it is clear that an ED can offer a potentially attractive identity, symbolizing attractiveness and self-control. As Lupton (1996) notes, "A slender/attractive body is interpreted as a healthy, normal body, tangible evidence of rigid self-discipline. By contrast, an obese/ugly body is understood as unhealthy and deviant, out of control, a moral failure" (p. 137). Lupton (1996) continues that exercising control over one's diet can provide a sense of having power over one's body (p. 142).

Following on from the potential appeal of an 'ED identity', *Neo* (aged 18) posts that she wishes that she had an eating disorder. This is what she posted under the title "I'm a monster" (29/03/16):

I kinda want to have anorexia. And I feel really disgusting about it. I just want to feel proud and strong and be thin and all those people trying to help you and the attention you'll get. But it just makes me feel pathetic. Especially since I know having a ED really isn't fun.

Having an ED is an appealing identity to *Neo* for several reasons. She associates having anorexia in particular with feeling proud and strong and thin and getting attention from people who want to help. However, she describes herself as a "monster" and feels disgusted that she wishes she had anorexia. This ambivalence indicates that whilst the image associated with the disorder is attractive, she recognizes that the disorder itself is "really isn't fun".

Health Narratives

In contemporary society, "... health has become a 'self-project' (Pond et al., 2010, p. 736), and for women in particular, 'taking care of oneself' through careful attention to appearance and weight is elevated to a moral status of virtue (Fullagar, 2002)" (Musolino et al, 2015, p. 18). Health narratives are often aligned with the notion of 'healthism' whereby individuals are encouraged to take responsibility for their own health by exercising and eating 'healthily' (ibid, p. 19). This notion of 'health' as an ideal was common in the narratives on the eating disorders forum. For example, *Bazinga* (aged 17) posts under the title "Could I have an eating disorder?" (31/12/2015):

So I'm 5'2" maybe 3" and I'm a 'healthy weight', I have BPD⁸ and am not yet in DBT⁹. I've become obsessed with counting calories and restricting to under [edited], I also work out everyday to burn most or all of what I eat off. I've thought about purging, and make sure to stop eating at 7 and not to eat until 7am. I don't want to be a healthy weight though, I want to be underweight and my sister is tiny and every time I see her I want to be skinny like her. (She's older than I am). I have no idea how to deal with this nore [sic] do I know if I want to. When I went to hospital all they just told me was to eat and take care of myself... I'm a healthy weight so I don't think I can have an ED but does this matter? (31/12/2015).

Bazinga describes herself as being a "healthy weight". She does not say on what basis she makes this judgement, but it is possible that her weight is considered 'healthy' in terms of her BMI (since she mentions her height). It is interesting to note that she describes her weight as being healthy rather than describing herself as being healthy or saying that she eats healthily. This may be because she knows that the behaviours she goes on to describe are generally not considered as 'healthy', e.g. restricting, purging and 'over' exercising. She also notes that she does not want to be a "healthy weight", but rather wants to be "skinny" like her older sister. She also notes that she has been to hospital (implicitly in connection with issues related to eating). Again, she emphasizes that she is a "healthy weight", so it seems likely that this is what she was told at the hospital. From this, she concludes that she does not think she could have an eating disorder. However, she also asks "but does this matter" – possibly questioning whether it may indeed be possible to be a "healthy weight" and to still have an eating disorder. The advice she was given at the hospital is also noteworthy, simply to eat and take care of herself. This advice is in line with the ethic of 'self-care', as discussed earlier (Musolino et al, 2015). The advice to "eat" seems to point to the biomedical emphasis on being a 'healthy weight' without taking into consideration full the psychological (and physical) implications of an eating disorder. In the second line of *Bazinga's* post, you will notice the word [edited]. This is an example of the kind of content that *TeenHelp* considers as 'inappropriate' in terms of their 'pro-recovery' stance. Thus, a *TeenHelper* has 'edited' this information, ostensibly for the good of the other users of the forum.

In a similar vein, *DogLover* (aged 18) posts: "I'm a vegan, I eat healthy. I have an eating disorder, I binge and purge or outright starve myself, and have done so for years, but when I

⁸ BPD: Borderline Personality Disorder

⁹ DBT: Dialectical Behavior Therapy is a cognitive behavioral treatment that was originally developed to treat chronically suicidal individuals diagnosed with borderline personality disorder (BPD)

binge it's a cup of rice" (20/10/2014). She begins by connecting being vegan with being healthy as these two statements are part of the same sentence. Her next sentence is a statement that she has an eating disorder. These two sentences are not connected by any conjunctions, so it is not clear how they are related to each other (e.g. if they are seen to be contradictory or compatible ideas). However, several studies have connected eating disorders with the restrictive eating styles of vegans and vegetarians (Vitousek and Watson, 1998; Gilbody et al., 1998; Sullivan and Damani, 2000; Bas et al., 2005 cited in Musolino et al., 2015, p. 21). Being vegan or vegetarian is often associated with being 'healthy' while having an eating disorder is often associated with being 'unhealthy'. However, in *DogLover's* narrative, these two ideas are brought together, with her eating disorder being presented as a (possibly extreme) form of a healthy lifestyle. As Musolino et al. (2015) note, "significant socio-political changes (such as the rise of neoliberalism and increasing appetite for health consumerism) have extended and cemented the idea that one should take responsibility for one's health and place the pursuit of a healthy lifestyle at the centre of moral virtue, personhood and citizenship" (p. 18).

In *DogLover's* narrative, the 'enemy' is presented as being things such as sugar, carbohydrates (rice and potatoes) as well as processed foods. She positions herself as "healthy" because she does not consume these "unhealthy things". When she does "binge" (i.e. eat foods which she considers to be unhealthy), she "purges" to rid her body of these undesirable types of food. This narrative is closely connected to the binary notion of 'good' and 'bad' food. As Lupton (1996) puts it, good food is associated with being nutritious and healthy as well as with self-control and discipline (p. 154). Bad food, on the other hand, is associated with hedonism and is seen to be polluting and fattening (ibid).

DogLover's post can be connected to what Musolino and colleagues (2015) have dubbed "Healthy Anorexia" (also known as 'orthorexia'). "Healthy anorexia refers to the idea that someone can still be healthy, while maintaining their disordered eating" (Musolino et al., 2015, p. 21). This is also connected to the 'pro-Ana' movement which encourages the use of weight-loss pharmaceuticals to maintain low body weight, while simultaneously encouraging a 'healthy' diet to sustain an anorexic way of life (Fox et al., 2005, p. 944). *DogLover* sees herself as healthy because she engages in what she sees as a 'healthy' lifestyle. Whether *DogLover* would be considered 'healthy' from a biomedical or psychological perspective is not what's important here. What is important is that she *views herself* as eating healthily and that this is the way in which she presents herself (and constructs her eating disorder) through her online

post.

Diagnostic Narratives

Another type of narrative that emerged on the forum was the ‘diagnostic narratives’. Here I have analysed posts which include the possibility of someone being ‘pre eating disorder’, as well as posts which question whether it is possible to have an eating disorder if one is not medically considered as ‘underweight’. I shall begin with an analysis of the post dealing with the possibility of being ‘at risk’ of developing an eating disorder. *BornBad* is an eighteen-year-old female from the Netherlands. Here is her post entitled “Starting ED?”

“For about a month now I noticed light ED-voice thoughts. However I don’t really restrict just sometimes a little and then I have days I don’t care because I love food too much. I have purged a few times but don’t do it that regularly or often. Some days I count calories and some days I can not do that. It’s just constantly changing and nothing is really a big problem. I do one behaviour a little bit for a few days or even a few hours and then another. Binging/ counting calories/ exercising / purging / restricting. In one of your videos you said you can’t have an ED voice without an ED and in another you said you can’t switch your ED on and off. And if I try I still can stop behaviours. Could this be the beginning of an ED. Or am I just exaggerating. Could someone tell [sic] me how you can notice and [sic] ED in it’s [sic] early stages when it couldn’t even really be diagnosed as an ED yet?” (25/03/2015).

Here, *BornBad* describes engaging in some ‘ED behaviours’ such as “Binging/ counting calories/ exercising / purging / restricting”. However, she emphasizes that she loves food, and that she “can not” engage in these behaviours. This unusual grammatical construction emphasizes her sense that *she* is in control, i.e. she is able to choose whether or not to engage in these behaviours. She does not consider herself to have an eating disorder (yet) because these behaviours come and go and because of her feeling of being able to control them. She wants to know if she might be in the “early stages” of an eating disorder, although it might not yet be developed enough to be “diagnosed”. She also makes reference to “one of your videos”. Here she is referring to videos shared by *TeenHelpers* to provide information regarding eating disorders.

The notion of being ‘pre-eating disorder’ is also connected to what Rose and Abi-Rached (2013) refer to as a “general regime of futurity” (p. 14) – as discussed in the literature review

(p. 10). This involves making early interventions into children's lives in order to prevent them from developing mental illnesses in the future. In this case, it is *BornBad* who is imagining her own future and seeking advice on how best to avoid an unwanted future of developing an eating disorder. Again we see the importance of temporality. The narrative is being told in the 'present' with reflections on the past and out of concern for the future. As Cain et al. (2013) put it, "...our stories over time and places and relationships, focus on memory and on the present moment of our experience, on being, as well as our future" (p. 581). This also connects to the notions of 'being and becoming' which are so important in Child Studies. This post highlights that *BornBad* is aware of herself as both a present 'being' and a future 'becoming'.

A similar response was posted to *Neo* when she posted that she didn't have an eating disorder but she wished she did so that she could be thin and get attention (see p. 23). This is what *nygirl123* (01/04/2016) posted in response:

From personal experience I can 100% promise you that you DO NOT want an ed. You miss out on so much good food, you lose a lot of friends, you no longer have personal likes and dislikes, you never do anything social, and you never really achieve your "ideal body". It's not a way to live and exercising and eating well will give you a WAY better body i promise. The recovery isn't fun either. Nothing about it is fun so please get help before it even begins.

This emphasis on getting help "before it even begins" also points to a potential 'risk' of developing an eating disorder. As Jutel and Nettleton (2011) put it, "Diagnosis categories are less bounded, with the dualism of disease and non-disease collapsing in the face of new categories of potential disease and risk factors" (p. 793). Salter et al. (2011) discuss clinical risk assessments in the case of osteoporosis screening in older women:

"Citing the work of Novas and Rose (2000), Salter et al highlight how this pre-disease identification gives rise to a new category of patient whose 'at risk' status comprises a novel source of social identity. The well person is diagnosed as the person 'at risk of illness', not only through the behavioural or social characteristics but increasingly through the identification of biological markers. This highlights the blurry frontier between risk factors for a disease and the disease itself [...] Diagnostic labels now go beyond the disease itself to include risk factors for disease [...] At the same time this gives rise to a new source of the social identity, namely a pre-disease (risk of disease) status" (Jutel & Nettleton, 2011, p. 795).

This can be linked to what Armstrong (1995) calls ‘surveillance medicine’ which is “a perception of human existence which sees everyone as normal, but no-one as truly healthy” (cited in Jutel, 2009, p. 291). This is also related to the notion of ‘healthism’, where individuals are increasingly encouraged to take responsibility for the monitoring and maintenance of their own health.

Several posters also seemed to suspect that they may have an eating disorder but were not sure because they did not conform to the stereotypical “anorexic body”. For example, *Bazinga* notes that she is a “healthy” weight and wonders if she could still have an eating disorder since she engages in restricting and purging (31/12/2015). Several posters also questioned whether they could have an ED if they were overweight. For example, *MG* (aged 18) made a post entitled “Eating disorder and overweight??” (08/11/2015). She notes, “I binge and purge basically everyday [sic] and some of the times more than that”, adding “...but I am LEGITLY overweight!” Here she is raising the question of legitimacy, as strongly emphasized by her use of all-caps and exclamation marks. She is stating that she is legitimately overweight (although she does not say how she came to this conclusion) but questions whether her eating disorder can be considered legitimate if she *is* overweight. The implication here is that anyone who has a legitimate eating disorder would not be ‘overweight’.

Lay and Expert Narratives

Hunter (1991) discusses the notion of “narrative ownership”, noting that there is often competition between the patient and the doctor with one version of the story being prioritised over the other (cited in Jutel, 2009, p. 289). In terms of the narratives which are presented in the eating disorders forum, the focus is predominantly on the lay ‘illness experience’. The usual medical expert (i.e. the doctor) is not directly part of the conversation. However, that does not mean that there are no ‘experts’ present, nor does it mean that medical narratives are entirely absent. With regard to the former, it is the *TeenHelpers* who often perform the role of a substitute/ lay ‘experts’ in the absence of actual medical professionals. In the website’s terms of conduct, the following is included under “General Posting Guidelines”: “*TeenHelp* should not be used as a substitute for seeking medical advices in emergency situations. Users may ask for ideas of what conditions they could face, but it is not possible for us to diagnose medical, mental or veterinary disorders¹⁰”. Here we see a clear deference to medical authority. Doctors

¹⁰ <http://www.teenhelp.org/terms/conduct/> accessed 06/05/2016

have a high position in the hierarchy of expertise and this allows them to exercise authority over other health professionals and over lay people (Freidson, 1972, p. 261). Although the *TeenHelpers* are only officially there to provide support, they often speak with a voice of authority which draws upon medical narratives and vocabulary in order to establish its legitimacy. They often appear to be well-versed in the medical literature and terminology and often function as ‘lay experts’, as the examples below will show.

A good example of where *TeenHelpers* function as ‘lay experts’ and mimic an authoritative, medical voice is in cases where people post questions regarding ‘healthy’ dieting. For example, *Neo* asks the question, “When [does] healthy dieting become a [sic] ed or a problem? And how do you recognise this in yourself and others? What does healthy weightloss [sic] dieting look like?” (28/01/2016). In response to this question, she receives this answer from a *TeenHelper*:

Healthy dieting is when you aren’t doing any harm to your body. You are conscious of what you eat, and let it progress naturally. No purging, no bingeing (calorie/portion control), no restricting. Eat three meals a day, proper portions, let it process and break down naturally. Don’t interfere with it (29/01/2016).

The *TeenHelper* highlights the notion of “harm” and implicitly presents healthy eating as being harmless, while eating disorders cause harm to the body. There is also an emphasis on letting food be digested “naturally” and without interference. Bingeing, purging and restricting are all highlighted as problematic. The voice of the *TeenHelper* is confident and unequivocal. It is possible that the *TeenHelper* may have received similar advice from a doctor herself, or have read the information online. Although *TeenHelpers* often preface their comments with statements such as “Well I’m not a doctor, but...”, this was not the case here. This is likely because the advice did not involve any kind of diagnosis but relatively general information that many people would likely agree with.

Another example is in the response to *CuriousMiss* question: “Can overweight people have eating disorders?” (17/11/2015). Here is the response she received from a *TeenHelper*:

Short answer to your main question? Yes, absolutely. Eating disorders do not in any way discriminate by weight, no more than they discriminate by hair colour or name.
Long answer: Although you may see weight being included in the diagnostic criteria for specific

eating disorders, only one eating disorder I know of actually even includes weight at all. And there are so many subtypes and so many different behaviours that are classified as disordered eating that I would honestly advise you to not even try and diagnose yourself- instead, from what you've described, I'd recommend you seek help for your problems surrounding eating. You describe some pretty unhealthy and dangerous behaviours there, and regardless of frequency the fact you're even thinking of acting in this way, never mind carrying it out, indicates some kind of problem. Making yourself sick, or purging, as it's referred to medically, is not something people with normal eating habits do; nor is fasting or excessive exercising. It doesn't matter to what extent you're doing these things, it's important you seek help for them (17/11/2015).

Here, the *TeenHelper* gives a clear, unequivocal answer to *CuriousMiss*'s question and tells her that she absolutely can have an eating disorder even if she is overweight. The *TeenHelper* draws strongly on a medical vocabulary in her narrative, making reference to “diagnostic criteria”, “subtypes” of eating disorders, and refers to some of the poster's behaviours as “unhealthy and dangerous”. She also advises her against diagnosing herself, and advises her to seek professional help for her problems surrounding eating. When speaking of self-induced vomiting, she first uses the ‘lay’ terminology, i.e. “making yourself sick”, and then adds “or purging, as it's referred to medically” (adding the ‘expert terminology’). She notes that this behaviour is “not something people with normal eating habits do”. Here she is positioning *CuriousMiss* (and other who engage in purging) as being ‘abnormal’ in relation to people with supposedly normal eating habits.

Other responses from *TeenHelpers* provide equally valuable insights. *Its.Just.Cait* (aged 14) asks whether she would be classified as having an eating disorder and describes her feeling of confusion. In response, a *TeenHelp* counsellor (*Jessie*, 22/03/2016) noted that she is not able to provide a diagnosis but describes that she herself had been diagnosed with EDNOS¹¹ and bulimia. By disclosing that she herself had been diagnosed with EDNOS and bulimia, *Jessie* could be seen to be positioning herself as a ‘lay’ patient. However, she could also be positioning herself as an ‘expert’ patient – i.e. someone who has knowledge based on their personal experience of a medical condition and interaction with medical practitioners and information. *Jessie* goes on to say, “Eating disorders are hard to get through like any other illness”. Here she is reinforcing the framing of eating disorders as a medical condition “like any other illness”.

¹¹ EDNOS: Eating Disorder Not Otherwise Specified

This implies that it can be medically treated and potentially even ‘cured’. I will return to the notion of recovery later in the analysis.

Demedicalisation Narratives

Another type of narrative which I identified in the eating disorders forum were ‘demedicalisation narratives’. Here I have included narratives which question the value of being diagnosed with an eating disorder, as well as the questioning of whether ‘eating disorders’ should really be viewed as medical conditions at all. For example, *Its.Just.Cait* questions the notion of diagnosis in relation to eating disorders. She notes that her mom “struggles with one” (i.e. an eating disorder) but is not sure if her mom was diagnosed by a doctor. She wonders “why people even have to be diagnosed” and asks, “Isn’t it just a way someone is around food?” Here she is downplaying the seriousness that is usually associated with the diagnosis of an eating disorder and dismissing it as being just the way someone is around food. Indeed, the questioning of the medicalisation of a condition is not unusual. For example, many patients and advocacy groups have challenged the medicalisation of obesity (Gard and Wright 2005, Campos et al. 2006 cited Jutel, 2009, p. 291). Similarly, the ‘pro-ana’ movement has sought to redefine anorexia outside of medical discourses (Fox et al., 2005, p. 945). *Its.Just.Cait*’s narrative can thus be connected with broader ‘demedicalisation’ narratives which seek to reconstruct the way a particular experience or behaviour is positioned.

I noticed similar attempts to downplay the strength of the biomedical narrative in a post by *RainbowRider* (aged 15). She describes a situation that is troubling her – she is meant to be going to eat in a restaurant with her class and she is trying to get out of it. She says, “I hate eating in front of people because I don’t eat most of my food on my plate and everyone will think that I’m weird if I don’t eat it” (15/10/2015). She also says, “I don’t want people worrying because there isn’t anything wrong I just hate eating. It just makes me feel guilty” (15/10/2015). When she says there isn’t anything wrong, she is attempting to downplaying the situation. This highlights the tension between how she perceives her behaviour (i.e. as having nothing wrong with it) and how others might perceive it (i.e. as “weird”). She also says that she just hates eating. Her use of the word “just” implies that this is not something serious or problematic – although she is clearly aware that it may be perceived as such by others. She goes on to explain why she hates eating – because it makes her feel guilty. Here she is trapped between her desire to seem normal to others (i.e. not to seem “weird” by not eating in a social situation) and her

desire to avoid the guilty feelings she associates with eating.

Recovery Narratives

The final type of narrative which I identified on the forum are the ‘recovery narratives’. From a medical perspective, it is well documented that eating disorders are difficult to treat, with many people being either reluctant to seek treatment or denying that they have a problem in the first place (Vitousek and Watson, 1998 cited in Musolino et al., 2015, p. 19). As Musolino et al. (2015, p. 19) highlight, there may be a difference between how people with eating disorders see themselves (i.e. as not ill) compared to how a clinician would view their ‘disordered’ eating and the subsequent need for treatment. Indeed, the notion of ‘demedicalisation’ of eating disorders has important implications for treatment and recovery. If eating disorders are not recognized as a disease, condition or illness in the first place, then there is no need for treatment or recovery. For example, Fox et al. (2005) have described the ‘pro-ana’ movement as having an “anti-recovery stance” because it does not view anorexia as a disease (p. 945).

The first ‘recovery narrative’ comes from *Nvivo91* (aged 15), who writes a post entitled “After Anorexia?”. She notes that it has been almost a year since she has stopped seeing her doctor for anorexia and her weight “has been recovered” (07/04/2016). She asks: “Will I ever get over anorexia? Or is it gonna be in my head everyday, haunting me?” (07/04/2016). She notes: “even though I am ‘recovered’, it doesn’t feel like it when the same thoughts run through my head 24/7” (07/04/2016). Here she is highlighting the disconnect between being medically considered as “recovered” and her experience of still being “haunted”. Just as it may cause conflict when an individual does not see themselves as ill but a doctor does, so too can it be problematic when a doctor sees an individual as recovered when the patient’s experience does not reflect this. I will reflect on the implications of this in the concluding discussion.

These sentiments are closely echoed by *Pattycakes* (aged 19). She posts: “I’ve recovered from ED long time ago. A professional helped me, but this time I feel my ED is coming back [...] What should I do? It’s making me scared?” (03/06/2015). The notion of an ED being a frightening or haunting presence that comes and goes unpredictably appears to be a source of great distress to these young women. Although *Pattycakes* had “professional” help, this did not seem to have been enough to keep her ED from “coming back”.

The final ‘recovery narrative’ helps to explain why people with eating disorders might be so reluctant to seek treatment in the first place. *Badger360* (aged 17) made a post entitled “Help” (19/04/2015). She describes how she recently started “excessive dieting” whereby she restricted her daily caloric intake. She notes that she makes herself sick (i.e. vomits) when she has gone over her daily limit. She also self-harms, usually cutting herself on her thighs, but cutting herself on her stomach “to punish [herself] for overeating” (19/04/2015). She also says,

“I’m pretty sure I know why I’m doing this. My whole life is a mess. I don’t really have anything. I don’t have parents that are together or a big house and lots of money. My dad’s mentally ill and abusive and hates me. I’m not pretty or smart or talented or popular... The only thing that I can be in control of is how skinny I am, at the moment it’s the only thing that I have. I have told people about everything, the self harming, my dad, etc. But nobody knows about the eating thing. It really sucks, but if I tell people they’ll try and take my only sense of control away from me... I really don’t know what to do” (19/04/2015).

In this post, *Badger360* makes an explicit link between her life being “a mess” and her having an eating disorder. This is not so much an attempt to blame her eating disorder on her circumstances, but rather to explain why she fears telling people about her eating disorder. *Badger360* feels dissatisfied with herself and her life for various reasons (which she describes). She notes that the only thing she really feels she can control is her weight (implying that she feels out of control in other areas of her life). Her eating disorder is not her only problem – she is also being abused by her father and engages in self-harming. Whilst she has told people about the abuse and self-harming, she is reluctant to tell people about “the eating thing”. Her reason is that if she tells them, they will try and take away her only sense of control. This finding is in line with Fox et al. (2005a) who found that for participants in ‘pro-ana’, anorexia represents stability and control (p. 944). This finding also has important implications which shall be discussed in the next chapter, i.e. the concluding discussion of this study.

CONCLUDING DISCUSSION

Introduction

In this final chapter, I return to the original research questions as presented in the introductory chapter. I will attempt to answer these questions based on the analysis presented in the preceding chapter. The research questions were as follows:

1. What narratives are present on the online forum?
2. How do different narratives compete and influence each other?
3. What are the implications of these narratives for understanding eating disorders?

Narratives identified

Using ‘narrative inquiry’, I was able to identify six key narratives. The first narrative was the ‘identity narrative’ which revealed how having an eating disorder could be a potentially appealing identity for teenage girls wishing to appear attractive and in control. The second was the ‘health narrative’, where the possibility of having a ‘healthy’ eating disorder was discussed in relation to the biomedical model of health. The third was the ‘diagnostic narratives’, which explored the possibility of being ‘pre eating disorder’. These narratives also questioned what qualifies as a legitimate ED diagnosis, and if one could have an eating disorder without being medically ‘underweight’. Fourth were the ‘lay and expert narratives’. On the website, *TeenHelpers* and other lay posters often presented an ‘expert narrative’ in responding to posts and answering each other’s questions on the discussion forum. It was interesting to note that it was possible for posters to ‘switch roles’, at times being the person *asking* the questions, and at others, being the person *answering* the questions. Fifth were the ‘demedicalisation narratives’. Here, posters questioned the necessity of having an eating disorder diagnosed, as well as questioning the medicalisation of their eating disorders. The final type of narrative related to recovery and were grouped as ‘recovery/ recovering narratives’. Some posters described themselves as medically ‘recovered’, and yet they still felt ‘haunted’ by their ED. One poster presented ‘recovery’ as something that threatened to take away her only sense of control in life – a finding which has important implications for the treatment of EDs.

Relationship between narratives

It is important to note that the ‘narratives’ listed above have been separated conceptually, but in practice, they do not exist in isolation from one another. Rather, they compete and interact, resulting in the ‘co-construction’ of eating disorders. These narratives are also not static, but are contested – constantly being challenged and negotiated on the forum. Two types of narratives which appeared to compete with and influence each other were the ‘medicalisation’ and ‘demedicalisation’ narratives, with the former advocating for seeing certain behaviours as an eating disorder, while the latter opposed this medicalised view. The tension between these

two types of narrative was predominantly because of their different explanatory models for understanding eating disorders (Fox, 2005a). Other potentially ‘competing’ narratives were the ‘lay’ and ‘expert’ narratives. As Fox et al. (2005b) argue in their study of an internet forum for obese and overweight people, an ‘expert patient’ narrative may be desirable but it may also be constraining. They found that “exchanges between the users in the forum perpetuate a biomedical model of overweight as a condition to be overcome” (ibid, p. 1299). Likewise, it could be argued that the use of ‘medical narratives’ on the online forum serves to reinforce the power of the biomedical view of eating disorders. This, in turn, risks downplaying the emotional and psychological dimensions of the condition. It also weakens the power of ‘demedicalisation’ narratives which question whether eating ‘disorders’ should really be considered as pathological in the first place.

Implications

The most powerful implications of the findings of this study are related to the notions of diagnosis, treatment and recovery. With regard to diagnosis, it may be important to recognise that it is possible for someone to have an eating disorder, even if they may be considered as medically ‘overweight’ or even have a weight that is considered as medically ‘healthy’. It may be important for clinicians to be aware that even if a person is not ‘underweight’, they may still seek treatment for an eating disorder.

In terms of ‘treatment’, an exclusive focus on the ‘biomedical’ dimensions of eating disorders could also have seriously negative implications. For example, if someone with an eating disorder has been in ‘recovery’ and achieves a ‘healthy’ weight, they may be considered as ‘cured’ from a biomedical perspective (since being under or over-weight was the medical problem identified). However, such an approach would fail to take account of the social, emotional and psychological dimensions of eating disorders, which may still be present even once a ‘healthy’ weight has been achieved. Since ‘recovering’ from the emotional side of an eating disorder is likely a long-term process, it may even be worthwhile to see people with eating disorders as ‘recovering’ rather than ‘recovered’ or ‘cured’. As in the case of ‘recovering’ alcoholics, such an approach would acknowledge that the condition is often chronic and although it may be managed, rarely disappears entirely.

The final recovery narrative (by *Badger360*) also highlighted the importance of ‘control’ in understanding eating disorders. This finding has important implications for the treatment of eating disorder, as any treatment that involves removing the ‘patient’s’ sense of control over their bodies (through practices such as forced ‘re-feeding’ etc.) risks removing their only sense of control in an otherwise potentially chaotic and stressful life. One possibility would be to provide emotional support to make the person feel more in control of their lives before (or at least while) attempting to change their eating habits. This is not a new finding, as Lawrence (1979) highlighted the problem of doctor’s therapeutic goals focusing on weight gain without focusing on the issues which caused the weight loss in the first place. As Lawrence (1979) notes, “They see anorexics as young women who are exercising too much self-control. They simply don’t take account of the intense feelings of being out of control which accompany this” (p. 100). Some of the narratives analysed here drew strongly on a biomedical understanding of eating disorders, while others overtly challenged such a model and questioned the medicalisation of eating disorders. The danger with focusing too strongly on medical narratives is that it risks underplaying the emotional and psychological dimensions of eating disorders – which have important implications for treatment and ‘recovery’.

Overall Conclusion

The posts analysed in this study showed that these teenage girls are always walking a fine line between ‘being’ and ‘becoming’. Like all teenagers, they lie between the worlds of childhood and adulthood. But as people living with eating disorders, they also occupy a liminal space between being ‘thin’ and ‘fat’; between being ‘sick’ and ‘healthy’; between being ‘lay patients’ and ‘expert advisers’; between ‘treatment’ and ‘recovery’. Whilst ‘being’ in the present moment, their narratives traverse temporal boundaries in order to remember past ‘bodies’ and to imagine their potential future ‘becomings’. Overall, the study of this online forum allowed me to identify various important narratives which shed insight into the ways in which young women experience, navigate and make sense of eating disorders. These narratives provide a powerful new perspective on eating disorders – one which draws upon the multiple voices of young women. These young women are wrestling with the complex notion of eating disorders as a potential source of identity, a medical diagnosis and condition which they may or may not ever fully recover from.

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