Narrating Anorexia: "Full" and "Struggling" Genres of Recovery

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Abstract Exploring narrative processes through which women treated for anorexia reframe their illness and recovery experiences, I identify features of two distinct genres, "full recovery" (FR) and "struggling to recover" (SR) that differently shape, while also being shaped by, women's lived senses of self. Analysis suggests that full recovery may entail a temporal disjuncture between past and present selves, and the construction of a coherent empowerment narrative with clear beginnings, turning points, and felicitous, institutionally condoned endings. Alternatively, the habitual telling of equivocal struggling to recover narratives, in which protagonists question received wisdom, ponder past and hypothetical life paths, and envision self-starvation as both good and bad, may perpetuate a cyclical life course in which anorexia recurs and permanent recovery eludes narrators. Illuminating why complete recovery may remain ephemeral and, perhaps, not desirable, for some women, this article contributes to scholarship on the possible role (and limits) of narrative as a therapeutic medium and resource for confronting illness. [storytelling genres; illness, recovery, and self; empowerment narratives; anorexia nervosa; healing dramas]

In this article, I analyze two genres of self-starving women's narrative practices to discern how some of those diagnosed with anorexia nervosa conceptualize and enact processes of recovery. Foregrounding the voices and perspectives of anorexics to operationalize what may constitute recovery from the disorder,[1] I use narrative analysis to illuminate how recovery is not only achieved but also how it is lived and represented. In this respect, the analysis contributes to

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research on the role of narrative as a therapeutic medium and resource for humans to confront illness (Capps and Ochs 1995; Frank 1995; Kleinman 1988; Mattingly 1998; Mattingly and Garro 2000). As noted by Elinor Ochs and Lisa Capps in a review of the literature,

> Narrative is an essential resource in the struggle to bring experience to conscious awareness. . . . [Situating] narrators, protagonists, and listeners/readers at the nexus of morally organized, past, present, and possible experiences . . . narratives have the potential to generate a multiplicity of partial selves . . . and may illuminate life as we know it by raising challenging questions and exploring them from multiple angles. [1996:21–23]

In identifying two narrative practices that recovered and recovering anorexics employ in recounting their experiences, specifically, the "full recovery" (FR) and "struggling to recover" (SR) genres, this article distills some of the struggles these women face in relinquishing their symptoms and authoring plots of personal growth and recovery.

To date, most scholarship on recovery from anorexia has focused on outcome measures, defining recovery in terms of the cessation of symptoms (Beresin et al. 1989; Jarman and Walsh 1999).[2] A number of studies have reported the percentage of anorexics who die, relapse, or regain their menses and weight and resume normal eating habits and thought patterns about body shape and size at various time intervals post treatment (Fichter et al. 2006; Steinhausen 2002). In these studies, the rate of recidivism among Euro-American anorexics remains high, and studies show that the prevalence of anorexia has also grown in all corners of the world (Anderson-Fye and Becker 2003).

While clinicians often characterize anorexics and their illness trajectory as "mysterious," "enigmatic," "unpredictable," and "intriguing" (Bruch 1978; Lee 1995; Pike 1998), feminist and transcultural theorists consider anorexia as a predictable symptom of anxieties and fantasies fostered by contemporary social views of the body in relation to gender and power relations both in the West and in societies undergoing modernization and westernization (Bordo 1993; Katzman and Lee 1997; MacSween 1993; Orbach 1986). This discrepancy may reflect clinicians' frustrations with treating individual sufferers, and social theorists' frustrations with what they perceive as oppressive and injurious facets of society itself. As an attempt to bridge the two perspectives through the medium of narrative, this article enriches recent anthropological analyses of

eating disorders (Banks 1996; Garrett 1998; Gremillion 2003; Lester 1995, 1997) in suggesting that recovery is both an individual and a social process, neither fully determined by and situated in the personal psychology of any particular sufferer nor transcendent of that sufferer and her particular conceptions and relations.

As such, recovery may be understood as a psychological and interactionally discursive reframing of past, present, and imagined future selves,[3] collaboratively authored by the self-starver and her clinicians and/or other relational partners. More specifically, I identify two genres of illness–recovery narratives: in the case of the FR genre, the reframing is complete, depicting a break from a former relatively incapacitated self and a transformation to a self more capable of handling life's contingencies. Alternatively, in the case of the SR genre, past, present, and imagined future selves are narrated as continuous and conflicted versions of an ambivalent person who is sometimes cast as an agent of her life, while other times remaining an experiencing patient.

Analysis of these variable narrative realizations of recovery leads me to suggest that FR and SR stories represent two genres that differ from the restitution, chaos, and quest narratives depicted by Arthur Frank's (1995) model in that they do not necessarily map onto or follow the linear temporal trajectory implied in his typology of illness narratives. Rather than an individual achievement, recovery is here conceived as in part dependent on the coconstruction and appropriation of "healing dramas" as described by Cheryl Mattingly, in which through interactions with caregivers and others, "*an* experience" emerges, calling into being new visions of possible selves deemed worth striving for (1998:81–84).[4] Yet, rejecting the a priori assumption that illness necessarily presents an unwelcome interruption to one's life and using the notion of "narrative pulls" delineated in Ochs and Capps (2001) and Ochs (2004), I show that for those diagnosed with anorexia, narrative dramas may hold a paradoxical twist when sufferers find that reexperiencing these dramas is sometimes more compelling than the permanence of "full recovery."

Corpus

The corpus for this article consists of narrative data drawn from nine hours of audio-recorded semistructured, open-ended interview–conversations conducted with three women (age range 19–29) who participated in a larger

snowball-sample study in which I explored the role the label "anorexia" played in slim women's lives.[5] The three participants, whom I call "Emma," "Carolyn," and "Tessa" are highly educated, middle-class Euro-American women who had been treated for anorexia at least once at progressive eating disorders programs on the East Coast.[6] At the time of the research, Emma, who had been hospitalized only once for a four-month period and then continued outpatient therapy three years prior, considered herself "fully recovered," while Carolyn and Tessa, who had been hospitalized multiple times and continued outpatient therapy, considered themselves as not permanently and completely recovered but "struggling to recover."[7] The two genres of recovery narratives examined in this article, FR and SR, are based on categories that arise from the women's own self-attributions in relation to their illness and recovery processes.

Emma, who at the time of the research worked as a professional for an organization committed to preventing eating disorders, represents an extreme end on a continuum of recovery used by clinicians, while Carolyn and Tessa belong to the often-neglected middle on this continuum.[8] Their stories share features with those narrated by other participants in the study and depicted in novels and memoirs of eating disorders patients (see Grant 1995; Hornbacher 1998; MacLeod 1981; Place 1989; Shute 1992). Taking narration as a primordial form of social action (Bruner 1990), I suggest then that anorexia's transitoriness or chronicity in some women is related not simply to personality or social factors, but to the type of narrative a person coconstructs with and tells to others as well as herself, the narrative potentially contributing to an experience of recovery as an ongoing, not necessarily linear, process rather than quest.

Narrative Pulls: FR and SR Genre Features

Ochs and Capps suggest that humans use narrative in association with two potentially conflicting desires: "the desire for a stable reconstruction of our remembered past and the desire for an authentic reconstruction of the past," so that "narrators are pulled in the direction of formulating a tightly organized storyline with a beginning and an end, or in the direction of what transpired" (2001:17). These desires yield two distinct genres of narrative: "coherent" and "authentic." "Coherent" narratives tend to be presented as an orderly, linear temporal and causal progression of events involving a beginning, middle, and end and a certain and constant moral stance, leading to a clear resolution of the

problematic or unexpected event being recounted. By contrast, narratives that prioritize "authentic" experience often involve musing, inquiry, contradiction, dispute, and revision and present experience as an "enigmatic life episode" (Ochs 2004:269). This second genre tends to involve a fluid and shifting moral stance and an indeterminate plot line that may not be linearly structured. Unlike the first narrative practice, which strives for causal and temporal coherence, this narrative practice tolerates ambiguity and doubt and may afford heightened self-awareness at the expense of one's sense of self-continuity.

Having charted participants' illness and recovery narratives along the dimensions outlined above, I suggest that FR stories resemble narratives that favor "coherence" while SR stories resemble narratives that favor "authenticity." In particular, these stories differ in the relative linearity of plot structure and in consistency of their moral stance. These differences may speak to the narrators' differing goals and ideologies. Emma's FR narrative, for example, strives for teleological unity and aligns with feminist–psychoanalytic explanations and the preferred treatment modes and recovery outcomes for anorexia. In transforming a restitution narrative (in which clinicians provide a cure) into a "healing drama" (Mattingly 1998), Emma comes to delineate a successful quest narrative, in which she becomes the "true teller" of her tale (Frank 1995:115). By contrast, Tessa and Carolyn's SR stories convey a search for authenticity of self and experience, articulating the women's ambivalences about their conditions and relations to their clinicians and presenting a conflicted alternation among multiple, possible versions of life experience. Here, clinical drama does not result in complete recovery or an empowerment story but sustains an equivocal conflicted self cum protagonist.

As summarized in Table 1 and demonstrated below, the women's narratives are differentiated along a set of four dimensions, including degrees of: (1) Epistemic Certainty, (2) Affiliation with Clinical Typifications and Master Narratives of the Disorder, (3) Continuity between Past and Present Selves, and (4) Linearity of Temporal and Causal Progression of Events.

The FR genre (Emma's full recovery story) is cast in terms of "empowerment," characterized by high degrees of epistemic certainty, causal and temporal linearity, and affiliation with a clinical master narrative of the disorder, as well as by a relatively sharp break between past and present selves. By contrast, the SR genre (Carolyn and Tessa's struggling to recover stories) is characterized by a

TABLE 1: FR vs. SR Genre Features

Dimensions	FR Narratives	SR Narratives
Certainty	High	Varied
Affiliation with Institutional Narratives	High	Rife with ambivalence
Past and Present Selves	Sharp break	Porous boundaries
Linearity	Step-like progression, foreshadowing and backshadowing	Cyclical and step-like progressions, sideshadowing and hypotheticals

lack of consistent epistemic certainty and ambivalent, shifting stances toward clinical typifications and master narratives of the disorder. Rather than portraying a unitary self progressing linearly through time, Carolyn and Tessa narrate porous boundaries between past and present selves, and their stories are rife with ambivalence about the prospects and possibilities of full recovery. A sample of quantitative measures of discursive features distinguishing the two genres during the first two hours of interviews with each woman is presented in Table 2 below.[9]

TABLE 2: Discursive Features Distinguishing the Genres

Dimension	Discursive Feature	Emma	Carolyn	Tessa
Certainty	Strong cognitive verbs (*realize*, *know*)	25	18	16
Ambivalence/ Disaffiliation	Weak cognitive verbs (*guess*, *think*-conjugations)	38	164	132
	Hedges & mitigations (*but*, *almost*, *just*, *sort of*)	125	415	273
Past-Present	Continuity adverbs (*always*, *still*, *whenever*)	21	93	91
Linearity/ Experientiality	Progressive tense verbs	101	329	512
	Experiential nouns and verbs (*feel*-conjugations)	28	89	111
	Direct reported speech and thoughts	32	150	154
	Subjunctive constructions (*maybe*, *if*)	28	85	65

Before illustrating specific discursive and structural characteristics of the narratives told by Emma, Carolyn, and Tessa, I first briefly introduce these women and the two types of stories they tell. I suggest that the moral and epistemic stances they take vis-à-vis their illnesses are both reflective and *constitutive* of the type of recovery processes they have undergone. The rest of the article will then be devoted to a closer examination of the relation between recovery process and the kind of narrative genre to which the women's discourses give rise.

Emma's Story of Empowerment and Full Recovery

I met Emma for the first time in June 1997 for a two-hour open-ended interview at her office in a Boston-area eating disorders counseling center. She was lean but not bony, casually yet elegantly dressed, well made-up, and exuded an air of confidence and professionalism. We sat across from each other at Emma's desk, and she filled out a preliminary questionnaire, her confidence and ease emanating as she wrote her answers quickly in large, capital-block letters, noting with an exclamation mark that she considered herself "FULLY RECOVERED!" from "ANOREXIA AND COMPULSIVE EXERCISE." As the interview unfolded, she conveyed that she had an explicit agenda of what she wanted to tell me. Her story was logical and clear, almost formulaic. She was not at all hesitant but, rather, seemed practiced in the art of telling her tale. Her story about illness and recovery, I found out later in the interview, is one that she often tells as part of her job, in which she coordinates outpatient group programs for eating disorders and "do[es] educational prevention." Across the interview, narrative episodes highlight her exemplary, successful recovery, and as will be discussed in more detail shortly, Emma's discourse is imbued with unmitigated markers of certainty and a sense of completion, leaving little place for doubt as to the function and reasons behind her descent to illness and ascent to full recovery.[10]

Carolyn and Tessa's Stories of Struggle and Equivocal Recovery

I originally met Carolyn and Tessa at a progressive Boston-area treatment facility for eating disorders in 1996, and then in summer 1997, at least ten months after their last hospitalizations for anorexia, I met them again individually to conduct interview–conversations.[11] In these sessions, Carolyn and Tessa

claimed they wanted to "give up" the anorexia yet both also asserted that they still felt attached to, and only comfortable in, their emaciated frames, explaining they "*feel* overweight" any time they come within the normal weight range.

Standing at 5′9″ and 114 pounds, Carolyn listed herself as "tall" and circled both the "overweight" and "average" categories on a preliminary one-page questionnaire, adding the note: "Depending on the day. I always *feel* overweight, despite how I look at present or have looked [in the past]." Similarly, Tessa at 5′2″ and 92 pounds, listed herself as "short" and "average weight," although she was on medical leave from her work for having lost "too much" weight and was still considered too thin by her loved ones and psychiatrist. Thus, in the summer of 1997, Carolyn and Tessa each still struggled to feed herself adequately and to feel comfortable inside her body. As their narratives reveal, Carolyn and Tessa's struggles to recover are rife with ambivalence, as they find their condition a default instrumental rationale for perceived life failures, and explicitly use it as an alternative communicative mode to express their desires and fears. For example, when Tessa talked of a recent relapse, she explicitly implicated her use of the anorexia as an excuse for perceived incompetence, introducing her analysis with the conjunction "whenever" to index her rationale as routine:

Tessa: So like **whenever** I feel like the expectations [. . .]
So if I'm in the eating disorder, it's an excuse, [. . .]
If I'm nourished, there's no excuse, you know?[12]

Similarly, she uses summary rationale statements such as "that was my way out" to depict the eating disorder as her way of bailing out of medical school:

Tessa: And (.) and . . . **that was my way of sort of . . . getting out of it.**
'Cause I became sick, so I *couldn't* go to medical school.
So it wasn't that "Tessa *can't* do it," or "doesn't want to do it,
it's that . . . she's *sick*. The *illness*. . . . It's the *anorexia*, the *eating disorder*."
So that was my way out, I think.

Carolyn likewise describes a past relapse episode that landed her back in the hospital for the summer as having been her nonverbal means of communicating

her reluctance to go to a precollege summer camp far away from home. Like Tessa, she casts her communicative mode as a recurring practice, using conjunctions such as "again," "always," and "not coincidentally" to frame her narrative:

Carolyn: That was **again,** going away from home.
And it wasn't conscious,
but I think it was like, "Let's"—sort of a self-sabotage thing,
[. . .]
I mean, I would **always** have these crises.
These crises **always** happened before leaving home,
you know, **not coincidentally.**

Paradoxes of Insight

The notion that people—and, especially, women—develop psychological disorders such as anorexia in part as an attempt to resist, avoid or repair threatening and undesirable situations or relations is hardly new (Bruch 1973; Freud 1977; Geist 1989; Lee 1995). Anorexics' heightened metaconscious awareness of such internal conflicts, however, may contribute to the difficulties clinicians face in treating them because insight in this case at best only partially motivates change. As the narratives told by Tessa and Carolyn demonstrate, it is not uncommon for anorexic women to correctly perceive and take advantage of the fact that in embodying illness they are able to retain others' sympathetic stances toward themselves. Their use of conjunctions such as *whenever* and *always* to frame their narratives' introduction and conclusion implies that Tessa and Carolyn consider their eating difficulties as at least in part habitual and valuable, if manipulative, resources for shirking moral responsibility for their actions, feelings, and decisions. In this sense, if a return to permanent health entails relinquishing these strategic means of controlling one's projected self-image, then recovery may well present particular challenges both to the anorexic and her clinicians. To illustrate processes by which "full" or "struggling" recovery realities are discursively enacted, I discuss in the remainder of this article the four features along which the FR and SR genres differ, that is, their degree of epistemic certainty, affiliation with master narratives and clinical typifications of the disorder, continuity of self through time, and overall linearity.

Epistemic Certainty

FR Narrative

Throughout her narratives, Emma constructs an epistemically unequivocal account of her experiences. She uses cognitive verbs of certainty such as "know" and "realize" and intensifiers such as "completely" and "obviously" to render the protagonist as one who has discovered what is evident and true about her past and present life, and does not undermine this narrative reality by embedding her certainty markers in mitigating constructions such as "sort of" or "I guess" (zero occurrences across her interview).

In response to challenges to her perspective, Emma does occasionally concede having experienced doubts about interventions, but these doubts are minimized and then retracted to confirm the stance of the new enlightened self. For example, when Emma cast her mother as a savior for having pulled her out of school and placed her under 24-hour surveillance and treatment in a clinic, I asked her (to the point of suggesting) whether she resented this intervention. Emma concedes having some negative feelings but (1) minimizes them through cutoff utterances, the qualifier *a bit*, and hesitations; (2) denigrates them because they arise from the false consciousness of food refusal ("subconscious suicide"); and (3) claims that they were also countered by a deeper, truer self that did not like her precrisis self and who "in the back of my head *knew* I was happy they were helping me":

Interviewer:	And at the time, did you . . . resent it, that she (.) you know, *pulled* you out, and *moved* in, and everything?
Emma:	**A bit. Well, . . . a bit,**
	because . . . **I wasn't—I was never *sure*** I wanted to give up the eating disorder.
	But, 'cause, at one point *all* my life was **(.)** was the eating disorder.
	I **knew *nothing* else** and **what I *did* know I didn't like,**
	I **didn't like** where I was before,
	so . . . I really was **committing sub-conscious suicide** basically. [. . .]
	But in the back of my head I *knew* . . . I was happy that they were helping me.

In this manner, Emma contains uncertainties introduced by my impertinent question. We see here a narrative glimpse into internal conflict, with two possible selves vying for mastery. Rather than being an elaboration of alternative ways of thinking and being in the world, however, the outcome of the conflict is rendered as a fait accompli, and Emma delegitimizes the feelings of her past self through her present, ratified self. Interestingly, the present, positive self is recounted as existing alongside but subordinate to a past, destructive self. In taking the moral high ground of deferring to her mother's wisdom and repudiating the lifeworld associated with her disorder, Emma privileges an enduring, virtuous, health-oriented self in favor of a misguided and even recalcitrant anorexic self.

SR Narratives

Carolyn and Tessa's SR narratives, in contrast, are characterized by discursive practices that index their lack of certainty and complete affiliation with one unchanging point of view. Verb constructions such as "I *don't* know" and "I think" pervade their narratives, as do verbs and adverbs of uncertainty ("maybe," "I guess"), mitigations ("in a way," "sort of"), pauses, cutoffs, hedges, retractions, and reflexive questions. For example, unlike Emma, who asserts, "I *know* that recovery is possible," Tessa uses questions and qualifiers to formulate a stance of doubt in relation to recovery:

Interviewer:	So what is recovery?
Tessa:	I **don't know!**
	I **mean, is** recovery **maybe** . . . **just** moving to a different place**?**
	Not necessarily giving this up, **but** putting it in a place in your life
	—like *incorpo*rating it into our lives in a more healthy way**?**

Similarly, in trying to explain what anorexia is, Carolyn does not have a ready slogan at the tip of her tongue. Her discourse is filled with clarifications ("I mean") and pauses ("it is . . . "), and she seems flustered as she charts anorexia as a phenomenon whose meaning for her changes with time, an entity with which she used to be able to identify but that now confronts her as an unknown:

Carolyn:	Yeah, I **mean,** it used to be, I **mean,**
	if you asked me that last year, I would say, "It is *me*.

It is—it is . . . I am . . . I am—without it" [. . .]
Um, . . . I **don't think** I ***quite*** feel like that anymore.
. . . Um . . . ***what is it?***

Affiliation with Master Narratives and Typifications of the Disorder

The two genres also differ in the degree of the narrator's affiliation with and integration of a clinical master narrative to explain how and why the disorder came about, and what the contours of a recovered life might look like. In this section, I first trace the correspondences between Emma's empowerment FR narrative and institutional accounts of (Western) anorexics and later provide examples of the characteristic lack of complete affiliation with and even subversion of such accounts in the equivocal SR narratives told by Carolyn and Tessa.

FR Narrative

Emma's account embraces two institutional paradigms, the psychoanalytic and the feminist, to explain her descent into anorexia and to promulgate her success in recovery. Her discourse is peppered by these paradigms' typifications of sufferers' family background, personality traits, social pressures, and acquired coping skills, telling a coherent tale that has appropriated features from each of the two institutional master narratives about anorexia and its sufferers.

According to psychoanalytic accounts, those with anorexia tend to be perfectionist women who have grown up in a troubled family environment where "mutual difficulties in intimacy and trust [are] masked by a façade of smooth functioning, family loyalty and solidarity" (Gordon et al. 1989:30). The mother in such families is described as an overinvolved self-sacrificing nurturer masking her narcissism and fragility while the father is portrayed as a distanced and detached, highly successful and hardworking autocrat masking his own low self-esteem, dependency, and misogyny. Self-starvation in these accounts is seen as a girl's response to the family's pathology, her misguided attempt to repair or uphold an image of family unity and harmony, and her effort to simultaneously affirm and resist familial and societal pressures for girls to become self-denying women occupying a subordinate position in relation to men (Bruch 1978; Gordon et al. 1989).

Emma's portrayal of herself and her "family dynamics" aligns with this clinical paradigm. In the excerpt that follows, for example, she identifies her personality and the circumstances that she believes led to her anorexia as a "typical case scenario" and explains her behaviors in the terms used by the above-cited clinicians:

Emma: Umm, **my personality,** my behaviors always (.) focused on (.) umm, (.)
being perfect,
overachieving,
very typical case scenario,
and that was because my family was (.) having those **dysfunctions.**

Consistent with psychoanalytically oriented accounts of prototypical anorexic families, the "dysfunctions" to which Emma alludes involve a lack of affective expression within her family, her parents' unhappy marriage, problematic personality structures, and stereotypical roles played. In staccato-like sentences that sound well rehearsed, Emma liberally employs clinical diagnoses and idioms of addiction to describe herself and her father, and even more explicitly locates herself within the clinical lexicon of anorexia when toward the end of the interview she identifies herself as a "prime candidate" for the illness:

Emma: But I know the nature of my . . . *be*ing, being . . .
obsessive compulsive disorder,
perfectionist nature,
divorced family,
alcoholism,
addiction,
all that
Interviewer: Um-hm?
E: I was a ***prime*** **candidate.**

At the same time that she adopts a psychoanalytic model of family dynamics to explain her own descent into illness, in describing anorexia's widespread prevalence Emma also relies on the explanations of feminist clinicians and theorists who consider self-starvation to be girls' understandable response to what they call our "weightist" and "patriarchal culture" (Bordo 1993; Chernin

1981; MacSween 1993; Orbach 1986; Steiner-Adair 1994). Unlike Carolyn and Tessa, who as we shall see later are ambivalent in their stance vis-à-vis the meanings of media portrayals of eating disorders, Emma's grammatical and lexical choices, including moral assessments, broad inclusives, and the term *weightism*, help her build a coherent indictment of the media for "validating" and "encouraging" eating disorders, which aligns her with feminists' and cultural theorists' views, as excerpted here: "**Weightism** is a **very bad** thing in this world [. . .] **all** of it's **wrong.** [. . .] I *do* believe that the media *validates* eating disorders. They don't necessarily induce them [. . .] so I think what they do is, they can *encourage* insecurity."

In line with the feminist model, Emma's vision for recovery advocates going beyond a mere critique of the fashion industry or media norms to call for deeper structural changes in how girls and women are viewed and treated in this culture so that they are positioned not as passive victims but as empowered agents of social change who can exercise choice (Katzman and Lee 1997; Sesan 1994). Thus, unlike clinicians who expect the anorexic merely to "grow up" or "mature" and give up her "irrational" and "infantile" obsessions (Bruch 1988), feminists emphasize that they consider self-starvation to be a comprehensible but paradoxical coping mechanism in reaction to social pressures. According to this model, recovered women are those who choose to give up self-starvation and who assume more assertive stances, voicing and communicating their distress as well as desires in less self-destructive ways (Kearney-Cooke 1991; Sesan 1994; Thompson 1994). Emma's definition of recovery fits in with this model, sounding almost like a sloganed battle cry about "choice and voice" and her new ability to feel comfortable with herself and place her rather than others' desires and expectations at center stage. As the following passage indicates, Emma liberally uses parallel list structures and nominalizations ("my terms, my beliefs, my values") to express her sense of ownership and control over her post-illness life:

Interviewer:	What does umm, being recovered mean?
Emma:	To me?
	It means that I don't obsess about food, weight, exercise, diet.
	I live a life based on **my** terms, **my** beliefs, **my** values . . .
	I express **my** feelings of anger . . . on one spectrum,
	to feelings of happiness on the other spectrum.

. . . Umm, I'm very comfortable with **my** size, **my** shape, and how I appear,
and . . . I **completely know** that the experience was uh,
was something that almost *took* **my** life, but what it did also was
it gave me a different life . . . and it's the one about me,
and . . . respecting others, but respecting myself first.

Emma's assertion echoes the kind of self that feminist therapists envision: a self at once autonomous and relational and connected, who accepts itself and its body in whatever shape or form.[13]

Also in line with her feminist mentors, in discussing the new life of her recovered empowered self, Emma underscores the importance of accepting and expressing oneself as a whole being. Her sustained use of parallel structure and repetition adds rhetorical force to her message, and continues to give it the quality of a sermon: "It's a *true* not only acceptance of yourself, as a whole being, but *expressing* yourself as a whole being, [. . .] and you should value it [. . .] and . . . allow the voice." Emma continues this sermon, using the construction "I can" no less than six times in one sentence to further preach the virtues of finding one's own voice and exercising one's own choice, again to accentuate her sense of ownership and control over her life:

Emma: I always think that there're two things that I have
that no one can take away from me,
and (.) that's **my choice—**
I can *choose* to do something,
I can choose to eat something,
I can choose not to eat something,
I can choose to go out with someone, or not . . .
and **my voice—**
I can *tell* you how I feel,
and **I can tell** myself.

Emma concludes, "So that's what I didn't have before the eating disorder," a remark emblematic of yet another feature of the FR genre, in which a sharp

break is demarcated between past and present selves (for similar delineations of empowerment narratives for anorexia, see Garrett 1998; Lock et al. 2004).

SR Narratives

In contrast with Emma's FR narrative, Carolyn's and Tessa's narratives only partially affiliate with clinical and feminist versions of anorexia's causes and visions for recovery. They recount alternative, subversive plots in which the official diagnosis and the practices associated with it are framed as mechanisms that perpetuate their symptoms. For example, whereas Emma fully embraces psychoanalytic accounts to explain her disorder in terms of a faulty personality structure embedded within a problematic "family dynamic," Carolyn equivocates, attributing her problems instead to a strange, inexplicable feeling of anxiety that then took on a life of its own once she entered the culture of treatment and was diagnosed with an eating disorder:

Carolyn: It was just **this weird anxiety** about people.
And then it just became like, I can't really eat with people around,
like **this anxiety.**
And then **it got *named*,**
and then **there were expectations**
that came with (.) **that diagnosis,**
and it was like, so I don't really know
when **my own obsession** began,
and then **the whole obsession with treatment**
and **that whole knot of** . . . *((trails off))*

Using the demonstratives *this* and *that* as deictic markers of proximity and distance, Carolyn narrates both the nearness of her psychological state of anxiety ("this weird anxiety"), and her psychological distance and disaffiliation with treatment ("that diagnosis," "that whole knot of"). Similarly, she conveys her negative affect toward and distancing from her clinical encounters by using the impersonal pronoun *it* and the passive voice of the verb *get* when describing the process of diagnosis ("and then it got named"). She implies a contrast between her "obsession" as a particular and limited case using nominalization ("my own obsession") and the more generalized imposition of external

"expectations." She further uses the universal adjective *whole*, the predicate of uncertainty "I don't really know," and trails off in midsentence to amplify her expression of negative affect toward treatment.

More generally, throughout their narratives Carolyn and Tessa use such linguistic resources as deictics and conjunctions of contrast and doubt to represent experience as enigmatic and open to (re)interpretation rather than as coherently aligned with clinicians and, therefore, resolved. Contrary to clinical explanations (Bruch 1978; Vitousek et al. 1998), SR narratives locate the protagonist's problem not just in internal, faulty psychological mechanisms but also in the intersubjective space of interaction with socializing others whose expectations each feels she had to live up to. In discussing treatment, Carolyn and Tessa equivocate between a position that (like Emma's FR narratives) lauds clinicians for their well-meaning efforts and philosophy, and a position that indicts institutional treatment for its failure to cure, or even for perpetuating and aggravating the condition. Equivocation is marked through:

1. Irony (e.g., Tessa: "Interestingly the bad anorexic really and bulimic type behaviors began after I started getting treatment. Which always baffled me.");
2. Mitigating and deintensifying adverbs and verbs that express hesitation and ambivalence:

Carolyn:	I (.) **sort of—I guess** had gained (.) **sort of** an identity as an eating disorder
	And I um **felt like** I had to live up to that.

3. Semantic roles that alternately cast protagonists as sometimes actor or agent, sometimes experiencer, patient, or benefactive:

Carolyn:	**things happened** fairly quickly after that.	*Implied patient*
	I saw a therapist like really	*Actor*
	—like, **they sent me** somewhere with my mom [. . .]	*Patient*
	that was the best thing that **school did for me** was	*Benefactive*
	—**I found** my therapist	*Actor*

4. Mixed idioms of fortune and distress and affiliation or disaffiliation with clinicians and other relational partners who function as both benefactors and misunderstanders, targets to outsmart or evade:

Carolyn:	**I was *dumped*** into treatment fairly early [. . .]	*Distress*
	—I found my therapist—**it was such a lucky chance,**	*Fortune*
	So . . . **'ts weird.**	*Ambivalence*
Tessa:	That was ***not* a good experience** [. . .]	*Distress*
	I like their umm—**their philosophy is good.**	*Affiliation*
	It's **about women being empowered** [. . .]	*Distant affiliation*
	In some ways it was a **good thing**	*Partial fortune*

and

5. Subversive metaphors for treatment (e.g., clinic as "sorority," place to play games and learn subterfuge):

Tessa:	it was too loose of an environment? where . . . where,—that you could **play games.**
	And **everybody was learning from each other.** . . . **I learned** so much there.
Interviewer:	What did you learn? What do you mean by "games"?
T:	Like, how to **hide the food,** [. . .]
	—it was like, my mother (.) called it a **sorority.** [. . .]
	and I would do things like I would figure how to **break the rules.** [. . .]
	And I would ***fool* them.** [. . .]
	I would **do certain manipulative things,** [. . .]
	I got away with a lot there.
	Hiding food, giving . . . you know, **we would all do it, together.**
	It kind of ***was* like a sorority.**

Rather than narrate a quest toward self-discovery and growth, Carolyn and Tessa use these linguistic structures to narrate how they learned to become clever patients, telling as well of wasted months in which the protagonist was at best only partially enlightened, leaving the hospital still symptomatic, unhappy, and ready to resume her self-destructive behaviors.[14] They do not completely disaffiliate from clinicians, however, but maintain a stance of ironic curiosity, as dramatized in the following story of disaffiliation in which Carolyn narrates

waiting for clinicians and other patients to provide her with a set of meanings to make sense of her experience of emotional distress and struggles with food. Like Emma, Carolyn uses clinical slogans (bolded below), but rather than embrace them, she takes distance and sustains a subversive, suspicious attitude. She casts clinicians as anonymous others ("that was **their** big thing") and treatment as a foreign culture ("I entered this culture that was just so . . . different"), and summarily dismisses institutional concepts ("emotions or whatever that meant"):

Carolyn: I entered this culture that was just so . . . *different.*

It introduced a *whole* . . . cause I didn't know that this was . . . anything like it, [. . .]

—my understanding of why I was in the hospital was to (.) you know, **stabilize me** in (.) in different ways

—**in terms of emotions** or whatever that meant,

figuring out what was driving this, that was their big thing,

We will **identify the necessary issues** or whatever,

so I was curi*ous*, I was like, "Wow, what are they going to find out?"

((almost laughs)) Like, "I have no idea what they're talking about,"

and so there was a lot of like, **family-work** and all that and . . .

I don't know, I left pretty clueless.

I mean, *((chuckles))* I don't think there is . . .
it was kind of (.) a wasted month.

In contrast to Emma, who has assimilated clinical plots and uses one voice to tell one story of growth, discovery, and recovery, Carolyn here, and Tessa elsewhere, contrapose multiple, conflicting voices and interpretations about self-starvation and multiple hospitalizations, narrating polyphonic experiences of struggle rather than harmony.

Continuity between Past, Present, and Imagined Future Selves

Another dimension along which the FR and SR genres differ is the degree to which protagonists portray past, present, and imagined future selves as continuous. This dimension relates to overall linearity and the degree of affiliation

with master narratives of anorexia, which stipulate that anorexics disavow an old, problematic self in favor of a transformed, ratified self who is better able to handle life's contingencies and withstand the onslaught of family or societal pressures facing women. Whereas Emma's empowerment FR narrative—like the narratives of nondrinking AA alcoholics (Cain 1991), recovered anorexics (Garrett 1998), and rehabilitated school dropouts (Rymes 2001)—displays a break between past and present, devaluing the former in favor of the latter, SR narratives struggle with this mission, highlighting continuities and convergences between their past and present selves.

FR Narrative

Throughout her discourse, Emma explicitly distinguishes between her old, preanorexic negative self and her present, recovered, positive self, narrating the period of illness, treatment, and recovery as the transition turning-point phase that led to her present and anticipated future. Emma's two selves differ along what she portrays as dimensions of knowledge and perfectionism, and self-determination and authenticity.

In line with clinical accounts (Beresin et al. 1989; Reindl 2001), Emma's narratives are filled with idioms that equate her old self with lack and that oppose this old to the new, fully recovered self who has come about through her battle with anorexia. Asked toward the beginning of the interview how her condition began, for example, Emma immediately contrasted her present, aware self with her past, confused and unknowing self, pairing the subject *I* with the evidential verb *know* in asserting, "*Now* I know why it began, and I could tell you in a very analytical way why it began, but when I was *in* eating disorder—no idea what was going on." Emma discursively accomplishes the differentiation by emphasizing the temporal marker "now" when affirming her present ability to explain her condition and contrasting this expert self with her former unknowledgeable and distressed self, an invisibilized, elided subject ("—no idea").

Similarly in line with clinical accounts (Bruch 1978; Chernin 1981), Emma narrates her past, preanorexic self as perfectionist to the point of obsession and addiction, her actions motivated by a valiant if misguided attempt to make everything look perfect. Repeatedly, she explains, "to *me* it was important to make it look perfect, so I made the family appear perfect." She casts this past

drive in heroic terms, using the verb *strive* and intensifiers such as *real* and *true* to elucidate her past logic, which equated the appearance of perfection with happiness:

Emma:	So I **strove** for perfection not for uh, (.) superficial reasons,
	but for **real true** reasons
	and the fact that I believed that if someone were perfect they *had* to be happy.
Interviewer:	I see.
E:	So it was more a **strive** for **true** happiness

At the same time, she implies that this quest for perfection was ultimately doomed, continuing, "so I was trying to fulfill a void, but the void never got filled." From her present vantage point, Emma dismisses the quest for perfection as illegitimate and unworthy. She portrays the old self as misguided and full of sorrow and frustration fostered by her faulty mission and suggests that false knowledge coerced her ("I *had to be*") to pursue unattainable goals at the expense of being "true to myself":

Emma:	I felt like I wasn't being true to myself?
	But, . . . I **still believed** (.)
	I ***had to be*** the most popular, the most perfect
	and that, so therefore I uh,
	I would (.) *sit* with this sorrow, and (.) and the frustration

But as we already saw earlier, Emma again hints that alongside the deluded self, there was already a more self-caring side of her that because of fear was not yet ready to come out, continuing, "because I knew that if I didn't do that, the other choice was (.) *not* to be popular and *not* to be perfect and *((long pause, voice seems full with wonderment))* I didn't know what that was about. And that was too scary."

In these passages, Emma foreshadows a transition away from an unknowing and afraid self to a truer, more aware self. Her use of the past tense of the evidential verb *believe*, which contrasts with more certain verbs such as *know* and *realize*, and her modification of this construction with the adverb *still* ("I still believed"), serve to disavow a faulty, former belief system and highlight that a better pattern of thought and knowledge has since been adopted. Lest such grammatical subtleties are lost on her audience, later in the interview Emma

also goes on to aver that as a recovered anorexic, she has adopted a "new" stance toward perfection. Again using the temporal marker *now* to separate present from past, she stresses that perfection now projects into her present pursuits in a morally acceptable way ("under control"), and she uses a series of negations (bolded below) associated with it further to help her reject her old problematic equation of happiness with the appearance of perfection:

Emma: now I say that I have my perfection under control,
because nothing—**not everything has to be perfect.** [. . .]
perfection doesn't exist, it's **not human,**
and I'm human, so therefore, I **can't be perfect.**
I **don't want to be perfect.**
. . . It's **not important** to me.

Additionally, Emma identifies "choice" and "voice" as the two vital qualities that make her postrecovery self a full rather than lacking person. She highlights the contrast by recounting that before the eating disorder, she lacked both qualities, acting under the influence of a faulty belief and desire system: "So . . . that's what I **didn't have before** the eating disorder. I made choices because of perfection and popularity and I **didn't have** a voice because I **didn't wanna** express it. And **now** it's the two things that allow me to live." Asked, "What did being popular and being perfect entail?" Emma replied, "Being . . . fake. Not being . . . true to myself" and then elaborated, "I *had* to—I was nice to everybody? Umm, I could not express *bad* feelings." In repeatedly using temporal and tense markers to distinguish present from past, Emma implies that whereas her former life was governed by disability, frustration, and repressed desire, a life devoted to keeping up appearances rather than embracing needs and wants, her new life is one in which authenticity is the governing idiom, as she proclaims:

Emma:	**before** my anorexia I **was a façade,** I **masqueraded** a life.	*Old inauthentic self*
	And then the eating disorder happened, was devastating, and I almost died, and *but*,	*Turning point transition phase*
	when I came out I was a real person, you know, **I'm *not* a façade,**	*New authentic self with full range of feelings*
	I'm true to my feelings, whether they're positive or negative.	

As in her account of how her anorexia began ("*Now* I know [. . .] but when I was in"), Emma emphasizes the break between her past and present self, identifying her recovery as the transition period at which the transformation occurred. In this sense, Emma's story takes on the form of a turning-point life narrative (Bruner 1986), a self-story in which illness comes to be defined not only as a threatening and unwelcome interruption but also a crisis that becomes the source and opportunity for moral growth and transformation. Although somewhat reluctant to cast the anorexia in this positive light, as the necessary crisis that allowed her to grow, Emma explicitly draws this connection. Lest one get the wrong impression that anorexia is something to strive for, an experience that allows girls to grow and develop an authentic self, Emma first emphasizes the undesirability of the disorder, using intensifiers, repetition, and emphatic stress to add dramatic effect: "I would **never** bless an eating disorder on anybody, it's an ***evil*** thing, it can rob you of your life, either literally, or for a period of time. And it's horrible, I **hated** myself, I **hated** everybody, it was the ***worst*, worst worst worst!**" Having cautioned against the experience, however, Emma next acknowledges the illness' "remarkable" result. Perhaps harkening back to sentiments characteristic of the SR genre, she signals her difficulty imagining an alternative route to this result by resorting to more pauses and qualifiers: "**But, . . .** what the result was, was remarkable. I . . . I am . . . **I don't know.** ***Maybe*** another crisis **could have** happened that wouldn't have been as painful, . . . **umm, I don't know.**" Yet as discussed earlier, in her role as a recovered expert Emma does not tolerate doubt and ambiguity in her narrative for long. Quickly, she returns to statements that convey moral certainty ("obviously") and determinacy ("had to") to emphasize the extraordinariness of her transformation as also a necessary and foregone conclusion:

Emma: But, **obviously** some crisis **had to** occur for me to do the analytical growth,
ummm, and to let myself (.) explode and . . . and come out,
and (.) and be who I **needed to** be.

SR Narratives

Although conjunctures in which alternative possibilities are minimized in the FR genre, as Emma races to foregone, felicitous conclusions, such junctures

are amplified in the SR genre. Carolyn and Tessa cast anorexia as a temporally continuing, morally acceptable means of shirking certain responsibilities, obtaining attention and care, and marking oneself as different from other women. These uses of the illness reoccur, presenting a cyclical self that habitually displays critical behaviors across autobiographical time. Tessa, for example, explicitly points out not only that she sees anorexia as an attention-getting device but also that part of her loves it, even as another part of her feels guilty and wants to give up the illness:

Tessa:	Like I feel really kind of confused and stuck.
	I feel uh . . . **parts of me want to stop** this whole night*mare*,
	. . . **but part of me loves it,** you know?
Interviewer:	Loves the . . . ?
T:	Loves the attention, um, the feeling of being in control,
	. . . the having *not* to take responsibility for anything? in life?

Clinical and feminist master narratives (Beresin et al. 1989; Brumberg 1988; Chernin 1981; Pipher 1994), in which the starving self is cast as defective or maladaptive, may remain unpalatable for SR anorexics so long as there is no guarantee that an alternative nonemaciated self would still be successful in obtaining the kind of moral and material support that patients receive while in treatment. SR narratives foreground this dilemma, casting protagonists as unable or unwilling to fully disengage from the self who through food refusal has been able to get—and continues to desire—pathos from others.

Earlier, it was shown that Carolyn and Tessa frequently use such adverbs as *always*, *still* and *whenever* when discussing their life circumstances, blurring some of the boundaries between past, present, and future by describing events as habitual through time. Their stance toward anorexia and affiliation with fellow patients is likewise conflicted and continuous through time, narrating both intrigue and fear at becoming a chronic patient and, thereby, also a "legend." Not immune to probes by the interviewer, Carolyn and Tessa retract positions or equivocate about the kind of self-image they want to project to the world rather than narrate a constant and coherent self. Thus, in the midst of discussing some of the dire consequences facing chronic anorexic patients she encountered in the hospital (e.g., women forced to rely on Social Security benefits, or who have lost marriages and careers), as though in an effort to disavow

the "mystique" that she had said had "intrigued" her early on in treatment, Carolyn admitted in response to a challenge that despite the loss of choices and scary consequences, a part of her still wants to remain—and become "better"—at being anorexic:

Carolyn: Yeah, I mean, **part of me** *does* want that, I guess.
. . . Umm, cause I **still** buy into the whole like,
"the best anorexic" thing, like "I haven't done it well enough,"
and I *know* I haven't done it well enough,
but I don't . . . I don't know.
I think I'll **always** feel like—
I *worry* that I'll **always** feel that way.
And but **as long as** you feel that way,
it de—recovery is **always** gonna be a defeat.
It's **always** going to be something . . . a *failure* to get better,
So I guess I *do* need to change that.

In this subversive narrative, Carolyn nevertheless leaves the possibility open that her feelings may—or at least ought to—change. Her switch to the second-person pronoun *you* ("as long as you feel that way") may be an attempt to distance herself from a destructive self who hangs on to the illness, considering recovery to be a defeat. Switching back to the first person pronoun ("I guess I *do* need to change that"), Carolyn does not fully separate from the institutionally nonratified self who remains part of her, yet at the same time she reluctantly accepts the normative charge to change.

Tessa likewise only partially accepts the charge to change and, instead, defiantly asserts, "as far as I'm concerned, my weight's fine, . . . I *feel* fine, why do I have to be on medical leave? Like, . . . then it makes you feel pressured to get worse." Tessa considers her problem to be not just the result of socialized interaction with others, but, like Emma (and the clinical master narrative), she presents anorexia as also emblematic of her feelings about her body and personality structure. Having early in the interview asserted that she had "always had some issues about body image" and later elaborated that she always hated her hips in particular, Tessa next extends the discussion to her deeper personality structure: "I've always been . . . gone to the extreme with things. Like I always had low self-esteem, so I'd always try to prove myself with everything

I did—growing up, school, whatever. And it would always have to be—I'd have to be extreme." Using the present tense and emphasizing the continuity ("all my life, and still now") Tessa, unlike Emma, does not imply her personality or sentiments have substantially changed or could change:

Tessa: And the way I **see** myself, yeah, you asked me who's the real Tessa?
I **don't know,** because **the way I've always defined** myself **is** from the outside. How I **think** other people **perceive** me. So I **always** . . . felt . . . **all my life,** and **still now,** that in order **to be** (.) a good person or . . . **to like** myself, I **need** good feedback.

In rejecting a discontinuity between their past and present selves, Tessa and Carolyn's narratives highlight the dilemmatic nature of experience, so that the patent closure found in Emma's narratives remains an unrealized, and not necessarily desired, possibility.

Linear, Deterministic Progression of Events

The final dimension along which the FR and SR genres differ is their overall and intrasentential temporal and causal linearity. As explicated in Ochs and Capps (2001), narratives that strive for "coherence" tend to be highly linear, employing the techniques of "foreshadowing" and "backshadowing" to achieve a sense of unity: foreshadowing or anticipating events to follow and backshadowing or casting prior events as "a consequence of events to come" by framing the past in terms of present knowledge and implying "backward causation" (Bernstein 1994; Morson 1994:7). Alternatively, nonlinear narratives use the technique of "sideshadowing" to cast "events as ambiguous, conflictual, unstable, subject to constant revision, perhaps even unknowable" (Ochs and Capps 2001:5) and to express "the ever-changing nature of [an otherwise unfathomable] truth" (Bernstein 1994:3). While both the FR and SR genres rely on foreshadowing and backshadowing to create structured tales with steplike progressions, they differ in the extent to which events are also cast as open, chaotic, even unknowable. In other words, FR and SR narratives differ in their use of sideshadowing to tell alternative, even subversive and morally ambiguous tales.

FR Narrative

From the beginning of the interview to its conclusion, Emma consistently uses foreshadowing and backshadowing to project a relatively linear life story in which one event led to another, her knowledgeable expert present self reflecting backward to chart out her transformation through time and treatment. Although I intended to conduct an open-ended discussion, Emma wasted no time linking the questions to one central plotline that culminates in complete empowered recovery, as follows:

1. A problematic past psychological and physiological (private) **Setting** (i.e., dysfunctional family dynamic) that foreshadowed her illness;
2. A **Response** to this Setting (i.e., striving for perfection through nurturing others, then substituting this attempt at repair by nearly starving herself to death);
3. **Interventions** (i.e., mother pulled her out of college and sent her to a treatment program);
4. Her **Realization** (i.e., treatment is for her own good);
5. Her **Positive Present,** sporting a transformed visionary self who is not only theoretically capable of, but actively *is* confronting life's contingencies and advocating for others to also get better.[15]

Across the interview, Emma peppers her narration with steplike expressions to indicate temporal and causal progression and recounts her illness as a logical and inevitable outcome of a constellation of events. She identifies key life turning points of action and cognition and provides a number of interpretive glosses about what her behavior signified. Framing her entire discussion of treatment as a series of benefic guided steps, Emma begins with this metaphor to depict her mother's intervention: "so it came about when someone stepped in. And that was my mother." Continuing to backshadow, she aligns with clinicians in casting treatment as the propitious stabilizing force that by refeeding her, allowed her to grow into the full person whom she believes she embodies today. In other words, Emma relies on insight gained through hindsight to morally frame and disaffiliate from facets of her illness and, instead, emphasize measures that helped her "realize" and "take the step" to overcome the eating disorder and recover.

Emma likewise casts turning point realizations as a sequence of steps that she took to "get better," for example when she says, "Admitting that I needed help

. . . was the first step. Uh, saying that I'd let someone help me." Probed whether she ever doubted treatment, Emma remains steadfast in her stance, clarifying by narrating a lock-step sequence of cause–effect events that reinforce the moral force and rectitude of the therapy she received, leaving no room for doubt or the possibility that things could have, or should have, proceeded otherwise. When I try to bring Emma closer to her treatment experience ("And how did the . . . the gaining weight, **at the time,** feel?"), she overcomes a brief moment of hesitation in which she sighs, gulps, and seems almost at a loss for words, admitting to a morally questionable narrative strand characteristic of the SR genre, as she pauses to say, " . . . Pretty bad . . . pretty . . . awkward. I didn't want it, it meant that I was gonna get better." Rather than dwell on this painful moment, Emma instead rushes to tell a narrative filled with the features of the FR genre, signposting a turning point and relying on markers of epistemic certainty, parallelisms and repetitions, and an agentive voice to paint her experience not as unique but as a genericized, typical, and causally necessary outcome toward which she was striding all along:

Emma: **But I came to a point** that . . . the weight started coming on,
And I **knew, at that point,** I couldn't go back any further.
Like, I **started** gaining weight
and . . . I **thought,** "It's gonna be so much work to lose this again!"
And **at that point I realized** . . .
I'm gonna go forward, I'm not gonna go back.

As a final step in her recovery trajectory, Emma recounts her present status as a public speaker and services coordinator working to prevent eating disorders. This work reinforces her identity as a cohesive self who, having concluded the quest of full recovery, now actively works to help others fight to achieve the same end. Emma explains her work as motivated and governed by moral reasoning: "Once I fully recovered I really wanted to give back." She continues this line of reasoning, relying on a language that marks epistemic certainty and that uses her personal experience as evidence: "and, umm, to be able to help people and give them hope that one, **full recovery exists, I've done it.** Not to say that my way work—will work with everyone, but that it is . . . **it *does* happen,** and that people can fight to get better." In this way, Emma propagates a narrative through which she believes she helps some young women avoid the pitfalls that

led to her anorexia. The rhetoric of "giving back" and "giving hope" perpetuates her sense of linear progress and completion. Reflecting on the future, Emma conveys confidence in the unidirectionality of her achievements:

Interviewer:	So you don't see yourself going back again?
Emma:	**Never!**
I:	Ever?
E:	**Ever.**
	I'd have to give something up now, and **I'm not willing** . . .
	I . . . I'd have to push all this identity back in, and **it's out!**
	You know, **it's not coming back in.**

While Emma's empowerment FR narrative minimizes less fortuitous possibilities that could have materialized were she less certain about the completion and cohesiveness of her trajectory, such multiple plots prevail in the equivocal SR genre.

SR Narratives

Linearity is not entirely absent in Carolyn and Tessa's narratives; nevertheless, they focus less on a teleology of the illness and how it led to recovery and more on connections forged with therapists, and contradictions and indeterminacies that render episodes in their lives as ongoing enigmas rather than completed autobiographical stages. Carolyn, for example, at first attempts a linear empowerment narrative, using temporal and tense markers to present a break between a past, defective, vacant, and nonvolitional self and a new, active self whose present desires and actions are morally appropriate: "**Before I felt** vacant. It cleared me out of *every*thing. [. . .] **I didn't want** . . . anything to do with people? And . . . **I *do* now. I want** to be at school." Yet, unlike Emma, Carolyn is not able to sustain this distinction and fully leave the past behind. Past habits invade her present desires, as reported in a confession that her difficulties with food are far from over: "and it's *still* hard to eat with people. I mean, I find . . . um, it's just awkward."

Like Tessa and other chronic patients, Carolyn intimates feeling pressure to keep up appearances and maintain her identity as a self-starver, and, as shown earlier, it is often around this failure to transition from a sick to a healthy self that narratives center. Giving voice to an ongoing immediacy of experience through lavish

use of progressive tense verbs and direct reporting of (past) thoughts, feelings, and the words of others, at a number of junctures Tessa and Carolyn admit that the connection they desire with people is an asymmetric one, envisioning themselves as persons who need others to be concerned about and forgiving toward them. They openly take pride in the diagnostic label they have earned, and unlike Emma, who views anorexia as an unfortunate but, perhaps, necessary transition phase, their plots validate rather than dismiss the moments and attributes of their selves that have led them to this life course, leaving them unable or unwilling to fully relinquish the symptoms and life stories that make sense of these symptoms, even as they give lip service to the notion that their actions are "bad."

Similar to Dostoevsky's characters as discussed by Mikhail Bakhtin (1981) and Gary Morson and Caryl Emerson (1989), Tessa and Carolyn often give voice to the uncertainty of the moment, representing events not so much as completed stages in a linear trajectory through illness and recovery but, instead, as dramas whose conclusion—or cause—may not be wholly determinate. Employing subjunctive verbs, qualifications, mitigations, ironic tone and statements, direct quotes, and reflexive questions and answers, these narratives often meander and muse, voicing internal as well as external dialogues. Carolyn, for example, frequently revises and retells her narratives in situ, her monologues underscoring the conflicting desires and ambivalence she feels about the pressure to part from her anorexic self if she is to fully recover. She begins by partially aligning with her therapist's insight that "people are the cure for eating disorders," asserting, "I guess I'm tired of feeling completely *alone* or *lonely*, I want people . . . " Yet she does not carry this orientation to its logical conclusion (e.g., *so I shouldn't starve myself anymore and I should be more social*) but, instead, backtracks to voice a contradictory sentiment: "and I can only take people in you know, yeah, small amounts." Note her report of fatigue with social isolation seems half-hearted, as she prefaces it with the weak evidential verb *guess*, and then proceeds to explain that she is "very selective" and "critical." When I probe how she "feel[s] about being selective and critical," Carolyn does not disavow this faculty, as would Emma in the name of complete recovery. Rather, she partially reaffirms what she believes could be a felicitous quality she possesses: "I mean, sometimes I feel glad, like I **would rather be** (.) lonely [. . .] 'cause I almost feel like I have an advantage . . . "

The frequent use of conditional verb constructions reflects—but also creates—an experiential world in which multiple partial selves are entertained and

morally evaluated. These possibilities may undermine the telling of linear narratives that posit a progression from a maladaptive self to a transformed new identity that does not equivocate or yearn for the self who potentially could manifest life-rejecting acts. Further, in entertaining a notion of anorexia as a game in which options such as not playing by the rules or quitting are possible, Carolyn and Tessa struggle to imagine themselves without the disorder. They highlight points of drama and connection with their therapists as salutary and significant, but unlike the turning points narrated by Emma, their dramatic encounters do not lead to "healing" or a complete change in their life course, so that recovery is narrated not as sure-to-happen but as a slim possibility. Hypothetical formulations and conditionals such as in the following example (and rarer in Emma's narratives), finally, lend the SR genre its quality of struggle and lack of closure:

Tessa:	David *((her husband))* says to me,	
	"**Suppose** we had just moved to California?	*Hypothetical*
	Do you think you would have just gotten better?"	*Sideshadowing*
	I don't know!	*Uncertainty*
	This whole treatment has just turned into a circus. . . .	*Irony*
	If I didn't have the label, . . .	*Hypothetical*

Tessa's awareness of the damaging power of diagnostic labels echoes Carolyn's earlier equivocation ("I was dumped into treatment/that was the best thing that school did for me"), and has been well articulated by such sociologists as Erving Goffman (1961), Thomas Scheff (1966), and others. Again, what makes the women's narratives interesting is that they give voice to their conflicting assessments rather than reframe their stories as either affirmations or condemnations of their clinical encounters. Perhaps because current literature and clinical practices do not really have a plot for the contours of a recovered life other than the cessation of symptoms, a return to "normal" thought patterns and body functions, and an abstract finding of one's "choice and voice," self-starvers reluctant to dismiss or make a clean break with their past self who also led them to their present relations with therapists and friends may remain suspended in a struggling to recover narrative of present drama, unable to replot their lives along the cleaner, straighter line told by fully recovered women such as Emma.

Conclusion

If, as Václav Havel writes, "human identity . . . is not a 'place of existence' where one sits things out, but a constant encounter with the question of how to be, and how to exist in the world" (1989:355), then examination of the narratives told by individuals can be a rich arena to explore how ill and recovered identities are formed and lived out in the process of being told. I have argued that Emma's, Carolyn's, and Tessa's narrative practices in interviews about their life experiences with anorexia reveal two distinct narrative genres of recovery, the FR and SR genres. Whereas Emma tells both me and her circuit audiences a relatively stable and coherent story of a mostly unitary self who has survived a quest and come out healed, Carolyn and Tessa regularly tell stories of selves suspended in the midst of experience, unable to relinquish multiple possibilities in favor of one unified plot.

These two genres are consequential for the women's experience of recovery, since it seems that the telling and retelling of an empowerment FR narrative, with its clear beginnings, turning points, and felicitous, institutionally condoned endings may well be critical for recovery to remain a stable condition in life. Perhaps in similar fashion to the telling of spiraling agoraphobic stories (Capps and Ochs 1995) or AA alcoholic drinking stories (Cain 1991), such narration articulates, but also facilitates, the teller's consistent affiliation with and appropriation of institutional master narratives. Alternatively, the telling and retelling of equivocal SR narratives, in which protagonists question received wisdom, ponder hypothetical life paths not actually pursued, and envision self-starvation as both good and bad, may perpetuate a cyclical life course in which anorexia recurs and permanent recovery eludes the narrator as protagonist. To be clear, I do not argue here that narrative alone gives rise to experience, but that differential narrative practices, in consistently articulating feelings and understandings about one's lifeworld in particular ways, may lead the women portrayed here and potentially others like them to adopt, reinforce, and perpetuate divergent visions of their self-commitments and experiences of the possibilities of illness and recovery. My argument goes beyond simply highlighting the notion that recovery from anorexia is not just an outcome to be measured in terms of symptoms but entails a narrative process that links past, present, and future visions of the self in relation to others. I show also that even when an empowerment FR narrative is available, it is not necessarily the one

adopted or desired, and that this may be related to the kind of narrative practice habitually preferred. Finally, my analysis of the SR genre suggests that when some humans employ narrative to confront illness as open-ended and multiply interpretable, then the therapeutic qualities attributed to narrative practice may paradoxically make complete recovery an elusive reality.

Appendix A: Transcription Conventions

((comment))	Description of scene
—	Self-interruption
(.)	Short pause
. . .	Long pause
?	Rising intonation
[. . .]	Text cut out
Italic	Emphasized word or syllable
Bold	Item of analytic focus

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Notes

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1. "Anorexia" and "anorexic" are themselves contested illness categories; however, I bracket this dispute to focus on the relations among narrative, recovery, and illness experience for women who

have at least partially accepted the clinical content of these terms as pertaining to them. See *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (American Psychiatric Association 1994).

2. Eugene Beresin and colleagues (1989) is one of a handful of exceptions in which clinicians approach recovery from anorexia as a process rather than an outcome, taking into serious consideration the insights of recovered and recovering women. See also the study by Federica Tozzi and colleagues (2003). Yet even studies that claim to take self-starvers' perspectives into account continue to frame the illness in terms of internal motivational states and personality structures rather than an interactive, narrative process (Vansteenkiste et al. 2005).

3. It is beyond the scope of this article to enter debates into what constitutes "a self," and it is not proposed here that the self is ever merely a text. Yet I draw on Bakhtin's (1981), Linda Garro's (2003), Douglas Hollan's (2000), and Marilyn Strathern's (2004) analyses (among others) in envisioning persons as experiencing their self as partial and multiply committed and displaying various aspects of these potentially multiple, partial selves in sociocultural interaction with others. Narrative, in verbalizing and bringing experience into conscious awareness, may highlight and reinforce certain aspects of the self while leaving other parts less explored.

4. The genres also subtly differ from the AA alcoholic genre identified by Carole Cain (1991) in that discourses on anorexia adopted by women in this study reject the forever diseased model of self mandated by 12-step programs.

5. I fully transcribed the recordings within three days of each session, noting the women's words, pauses, and changes in voice quality and intonation. All quotes are drawn from these transcripts, using pseudonyms for all individuals and treatment facilities appearing in the text. All subjects in this study are women.

6. I define "progressive eating disorders programs" as programs that have sought to address not only the eating and weight concerns of their patients, but also the psychological and cultural issues that are presumed to be involved in the genesis and maintenance of eating disorders (see Hornyak and Baker 1989; Sesan 1994; Shohet 1998).

7. Carolyn had been hospitalized six times between summer 1992 and spring 1996 for approximately two months each time; Tessa had been hospitalized four times between fall 1995 and summer 1996, for periods of two weeks to two and a half months.

8. Clinicians disagree over what constitutes "recovery" and how to measure it, but, generally, group patients as "treatment-resistant," "reluctant," "in remission," "ready to change," or "recovered," neglecting to account for the contours and process of struggle (see Jarman and Walsh 1999; Pike 1998; Rieger et al. 2000; Vitousek et al. 1998).

9. Words and phrases alone, however, should not be taken out of context: I argue that recovery is conceptualized, represented, and lived in the practice of weaving one's narrative of personal experience in a particular social milieu. The various linguistic features together constitute narrative dimensions that work to differentiate genres of recovery.

10. As a spokesperson for recovery, Emma has had many opportunities to relate and crystallize her story, likely leading her narratives to sound exceptionally conventionalized and, thus, to represent a full-fledged genre of recovery that approximates a Weberian ideal type. This renders her narrative particularly illustrative of the genre's component discursive features. While there are no statistics that I could find on the frequency with which recovered anorexics attempt, like Emma, to help others by publicly recounting their tales, anecdotally, this undertaking appears not uncommon (see, e.g., Garrett 1998 and the memoirs cited above, which ultimately insist or imply that full recovery entails a coherent narrative of growth in which a clear break between past and present selves must be achieved and retold).

11. Although I talked extensively with both women (1996–2002), this article draws only on conversations tape-recorded with Carolyn for two and a half hours over two sittings, and for four and a half hours with Tessa in one sitting in July 1997. The larger study also involved six months of participant-observation at Boston-area eating disorders treatment facilities.

12. Please refer to Appendix A for transcription conventions used throughout this article.

13. For example, feminist therapist and critic Robin Sesan calls for treatment programs that help eating disorders patients "explore the costs and consequences of consistently **choosing** other-care over self-care," to guide them "toward a more integrated focus on self and other" and to give them the "opportunity to define themselves and their bodies in **whatever shape or form** they may come" (Sesan 1994:263, 257, emphasis added).

14. This subversive view is consistent with Scheff's (1966) classic critique of psychotherapeutic institutions in general, as well as with fictional and memoir accounts of anorexic patients' experiences in treatment institutions in particular.

15. Because of space constraints I limit illustration of these points. See Merav Shohet 2004 for a fuller discussion.

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