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Abstract
Interpretive approaches to the study of eating disorders are scarce due to a medical bias for positivist epistemologies. Insights into how eating disorders are experienced are therefore lacking. Narrative theory, which emphasises that experience is constituted through narrative (Somers, 1994) and that a life as led is inseparable from a life as told (Bruner, 2004), provides an attractive means to address this shortfall. This study therefore applied principles of narrative analysis to the life story of Beth, a former elite athlete with experience of anorexia nervosa and, as she revealed, sexual abuse. 6 unstructured life history interviews took place over a period of 12 months yielding more than 9 hours of interview data. Due to a lack of previous narrative opportunities, the story Beth told was in many ways embryonic. Throughout our conversations Beth constructed multiple, fragile and sometimes contrasting narrative coherences indicative of a fragmented and uncertain understanding of her life. Practitioners should promote narrative understanding by encouraging opportunities for individuals with eating disorders to tell their story. Beth's atypical story helps create a more complete understanding of eating disorders in sport and serves as an additional narrative resource from which others might draw to story experience.

Narrative Constructions of Anorexia and Abuse: An Athlete's Search for Meaning in Trauma

This study began as a narrative analysis of the life history of a female athlete's experiences of anorexia nervosa. It became apparent early in the investigation that a period of sexual abuse was as central to the participant's life story as her eating disorder struggles. Rather than focus analysis on our original objective we have widened our lens to encompass the emergent issue of sexual abuse. This study has therefore evolved from one centred on understanding athlete experiences of eating disorders to a study that addresses athlete experiences of eating disorders and sexual abuse. The decision to broaden the scope of the investigation in this way was one of many methodological issues that, over the course of the study, required consideration and resolution. Drawing on principles of the confessional tale (Van Maanen, 1988), whereby a researcher details the methodological tensions that underline the research process (Sparkes, 2002), at various points in this study we look to make transparent key factors that have contributed to the narrative that is represented.

Eating Disorders in Sport

Implicated through a large and growing body of research, the world of competitive sport is considered a risk factor for the development of disordered eating behaviours and, in some cases, clinical eating disorders (Beals, 2004, Dosil, 2008; Petrie & Greenleaf, 2007; Thomspon & Sherman, 2010). It is suggested that the sporting environment presents a number of pressures to be thin, which can promote a dangerous preoccupation with body weight and, duly, disordered eating (Reel, SooHoo, Petrie, Greenleaf, & Carter, 2010). Examples of these weight-based pressures include an emphasis on leanness for success in sports such as distance running (Hulley & Hill, 2001) or figure skating (Monsma & Malina, 2004),

disparaging comments from coaches and peers (Kerr, Berman, & De Souza, 2006, Muscat & Long, 2008) and unnecessarily revealing sporting attire (Thompson & Sherman, 2009). Ultimately, athletes considered most vulnerable to these pressures, and therefore to disordered eating development, are elite females competing in sports with an aesthetic or lean focus (Smolak, Murnen, Ruble, 2000). Prevalence studies support these general contentions with one recent example claiming twice as many athletes than non-athlete controls possess a clinical eating disorder (Torstveit, Rosenvinge, & Sundgot-Borgen, 2008).

Despite intensified interest, in the popular as well as the academic press, there is much that is unresolved in terms of our understanding of disordered eating in sport. Athletes from 'non-lean' sports, where a low body weight is not considered central to performance, have rarely been the focus of study yet isolated examples suggest these sports may also present disordered eating risk (Papathomas & Lavallee, 2006). More broadly, if athletic samples are at greater risk, the proposed mechanisms by which this is the case are speculative at best due a lack of longitudinal studies capable of identifying causal risk (Petrie & Greenleaf, 2007). In terms of strategies for treatment of athletes, suggestions are often anecdotally derived (e.g. Sherman & Thompson, 2001) or drawn from practices employed within the general population (e.g. Currie, 2007). These struggles with identifying risk and effective treatment are not new and the mainstream eating disorders literature has previously encountered, and continues to encounter, similar problems, with current incidence and prevalence rates showing no sign of decline (Hudson, Hiripi, Pope, & Kessler, 2007) and treatment outcomes often proving unsuccessful (Wilson & Fairburn, 2002).

Given the aforementioned critiques, the relative absence of other ways of knowing, namely interpretive work, as a possible means for advancing the knowledge

base is somewhat surprising. Although there have been various calls for more qualitative, experience focused work in the area (Byrne and McLean, 2001; Petrie & Greenleaf, 2007) very few scholars have answered these calls. In contrast, the currently dominant medical perspective on eating disorders, emphasising risk factors, clinical features and recovery outcomes, is born out of positivist epistemologies that shun explorations of personal experience (Botha, 2009). Rich (2006) claims this insensitivity to personal accounts of experience is dehumanising and that anorexic girls long to be understood in terms of their emotional plight rather than through clinically defined physical problems. The detachment from individual life experience, which Frank (2007) suggests is typical of medical science generally, is true of much of the extant eating disorders in sport literature and this impacts negatively on the degree to which athletes are understood. For example, some athletes with eating problems have aired their dissatisfaction at health professionals' lack of appreciation for their specific illness circumstances (Sherman & Thompson, 2001). This perspective concurs with that of Johnson (1994) who stated that knowledge of the specific sporting context is important for therapists to provide effective support for disordered eating.

All this considered, athletes' personal accounts of disordered eating are a crucial means by which understanding of the phenomenon can be increased. Papathomas and Lavallee (in press) offer a rare example of how an interpretive approach to athletes' subjective views can provide alternative insights to traditional conceptions of disordered eating in sport, shaping a more textured understanding than that which currently exists. The study, an interpretative phenomenological analysis on the disordered eating experiences of 4 elite female athletes, highlighted a range of experiential features previously not discussed within the eating disorders in sport

literature. The athletes spoke of perceived stigmatisation, isolation from support mechanisms and troubling identity conflicts as well as ongoing concerns with food and weight long after athletic competition had ceased. These issues represent a move away from measuring or describing disordered eating behaviours towards understanding what the wider implications of such behaviours might be for lived experience. The focus on the athletes' perspectives provides a sense of some of the struggles that constitute an athlete's life with disordered eating.

Narrative and Eating Disorders

A succinct and agreed definition of narrative has proved elusive though it is usually recognised to possess a sequential plot providing an explanation of consequence (Smith & Sparkes, 2009b). Narrative psychologists purport that our life experiences, and duly our identities, are constructed in the stories we tell of ourselves, our personal narratives (Bruner, 1986, 1990; Polkinghorne, 1988; Sarbin, 1986). Narrative is, according to the much-cited declaration by Donald Polkinghorne (1988), "the primary form by which human experience is made meaningful" (p. 2). Consequently, for scholars seeking to explore meaning, experience and identity, analysis of narrative is a useful method. This is particularly evident within health psychology where there is great interest in how individuals make sense of serious illness. Numerous works have shown that the process of narrative construction is essential to bringing order, a sense of coherence and meaning, to a life story that has been disrupted by illness or trauma (Carless, 2008; Crossley, 2000; Neimeyer, Herrero, & Botella, 2006). These ideas also transfer to certain forms of narrative psychotherapy, which can be defined as the re-framing of experience, re-biography and narrative reconstruction (Hiles & Cermak, 2008). As well as finding new stories to succeed narratives broken through illness, therapy might also involve constructing

alternative narratives to replace life stories that are destructive and debilitating though firmly intact (McLeod, 1997). The goal in both cases is to find acceptable meaning in experience, although in the former meaning is absent and in the latter it is present but intolerable.

Broad commentaries on the aetiology of eating disorders argue that existing approaches to understanding constitute a culturally dominant medical narrative. These analyses usually adopt a critical perspective, implying that the clinical model of eating disorders is essentially an encompassing story that has resulted in a restricted understanding of the illness (Bordo, 1982). In effect, the medical narrative, to which psychology is a major contributor, precludes the exploration of meaning and portrays eating disorders as a purely individual psychopathological phenomenon (Botha, 2009). Such an understanding implies that eating disorders occur due to personal deficiencies and individual vulnerabilities such as perfectionism and low self-esteem (Rich, 2006). Consequently, according to Lock, Epston, and Maisel, (2004), modern psychology wrongly conflates the person with the eating disorder.

The work of Lock and colleagues (2004) has been instrumental in outlining how an eating disorder, in particular anorexia nervosa, is narratively experienced. Their narrative therapeutic position suggests that an eating problem is a story told of oneself as influenced by cultural resources. Making sense of an eating disorder through the resource of the popular medical narrative, for example “I starve myself because I’m vain”, can lead to an understanding of oneself as inherently flawed and helpless. This ‘person-as-problem’ outlook is disempowering and promotes a more troublesome experience than if an individual could somehow make sense of eating issues differently in a way that separated person and problem. On this issue, Lock et al. propose that what is needed is a counter-narrative, an alternative story that can

resist the dominant one, though they acknowledge that these are perilously few and difficult to uphold. Finally, they assert that the only way for more counter-narratives to be available is to tease out "individual stories as landscapes within which effective counter-narratives can be constructed" (p. 278).

Despite specific narrative analyses within eating disorders research being scarce, a number of autoethonographic accounts exist (e.g. Axelson, 2009; McMahon & Dinan-Thompson, 2008; Saukko, 2008; Tillmann-Healy, 1996), whereby scholars write deeply personal accounts of experience and situate these accounts socially and culturally (Ellis & Bochner, 2000). Although autoethonography is very much a methodology in its own right, the biographical stories that typify such work are essentially narratives. Tillman-Healy's (1996) moving prose on her experiences with bulimia nervosa is motivated to help the reader "engage how bulimia feels" (p. 104). She expresses dissatisfaction at the medical narrative's understanding of her experience and her writing, which contains artful descriptions of various subjectively meaningful moments in her life, is in part an attempt to shape a counter-narrative: "I wrote a sensual text to pull you away from the abstractions and categories that fill traditional research on eating disorders" (p. 104). She is not alone in this endeavour and Saukko's (2008) autoethonographic account of anorexia nervosa is fuelled by a similar goal, namely it serves as "an attempt to find a way of communicating about eating disorders that dos not simply validate diagnostic notions" (p. 34). These autobiographical narratives illustrate the utility of personal stories in elucidating the eating disorder experience.

Shohet (2007) produced a rare example of a detailed narrative analysis of interview data drawn from 3 females with experiences of anorexia nervosa. Sohet identified two narrative genres referred to as 'fully recovered' and 'struggling to

recover' narratives. Shohet drew on work by Ochs and Capps (2001), who propose that narratives serve two fundamental, though potentially conflicting, needs – the need for a *stable* reconstruction of past experience and the need for an *authentic* reconstruction of past experience. Stable narratives are *coherent*, characterised by an orderly, linear sequence of causal events providing a clear sense of resolution of the experience. In contrast, authentic narratives feature a relative lack of coherence in place of ambiguous and contradictory musings on an evolving and uncertain understanding of past experience. Shohet maps the eating disorder narratives constructed in her own research onto these conceptual ideas and suggests that the identified fully recovered narrative resonates with a stable and coherent narrative, whereas the struggling to recover narrative parallels the authentic. The fully recovered individuals gain their narrative coherence and stability through internalising the set scripts of popular master narratives of eating disorders. In contrast, those demonstrating a struggling to recover narrative are much more critical and questioning of any given explanatory model and, perhaps in a bid for authenticity, ponder the nature of their experience. The result of these reflections is a less coherent and less concrete understanding of the illness.

Shohet (2007) concludes her paper by suggesting that the type of narrative that is constructed also plays a contributory role in shaping experiences of recovery; it is "reflective and *constitutive* of the type of recovery processes they have undergone" (p. 350). Specifically, the certainty associated with the fully recovered narrative breeds commitment to recovery and thus helps maintain it. In effect, there is no room to deliberate some of the perceived benefits of an eating disorder or to critique recognised recovery routes, as is the case with the struggling to recover narrative, which, it is claimed, perpetuates the recurrence of anorexia. Such an interpretation is

insightful and informative and concurs with the narrative standpoint that our personal stories shape our future actions and experiences. In linking narrative constructions to recovery it is apparent that stories, in particular stories of eating disorders, matter enormously to understanding the experience and how those who suffer them might best be supported.

In summary then, the aim of this study is to expand understanding of eating disorders, and specifically eating disorders in sport, beyond traditional, dominant medical conceptions. The chief objective is to explore the experiential features of an eating disorder that, largely due to psychology's preference for positivist research, have often been neglected. Given the assertions that personal stories are important in the study of mental illness (Carless, 2008; Roberts and Holmes, 1999) and that individuals understand experience and construct identity by constructing narratives, narrative inquiry is considered a useful approach to achieve these broad goals. The life history stories of a former competitive tennis player with experiences of anorexia nervosa are therefore interpreted through a narrative analysis. Particular concerns include the meaning given to eating disorder experiences, the narrative processes involved in constructing these meanings and the implications of constructed meanings for identity, experience and action.

Methodology

Philosophical Positioning

The approach to narrative inquiry adopted here is underpinned by the philosophical principles of interpretivism. This runs counter to what Gergen (2001) describes as one of the mainstays of psychological science – that there is an objectively knowable world. In contrast, embracing postmodern thought, interpretivism assumes a constructivist epistemology, and a relativist ontology. The

former contends that claims to knowledge are always dependent on the perspectives and experiences of the person making the claim; irrespective of the methods employed there can be no theory-free knowledge or God's-eye view (Smith & Deemer, 2000). The latter infers that accordingly, with reality unknowable independent of observer perspective, all knowledge and our understanding of it, is therefore *relative*. Ultimately, there is no accessible external referent of reality from which one account can be verified over another. Relativism however, contrary to popular critique, does not imply that judgements on quality do not or should not occur, as Gergen (1985) explicates with reference to a relativist standpoint in the study of psychology – "this does not mean that 'anything goes'. Because of the inherent dependency of knowledge systems on communities of shared intelligibility, scientific activity will always be governed in large measure by normative rules. However, constructionism does invite practitioners to view these rules as historically and culturally situated–thus subject to critique and transformation" (p. 273).

Reflexivity and Confessional Writing

A confessional approach is synonymous with reflexivity in research and the notion that researchers should be critically aware of their own role in constructing knowledge. As stated by Altheide and Johnson (1998) "*how* knowledge is acquired, organised and interpreted is relevant to *what* the claims are". In considering these "hows" of methodological practice, and confessing these considerations as part of the research report, the reader is provided with greater context as to how knowledge claims are formed. Plummer (2001) articulates the value of reflexive writing well when he states "research knowledge only makes sense if we can acquire understanding about the active processes through which such knowledge becomes produced" (p. 208). Attending to these active processes requires a distancing from the

author-evacuated style of traditional scientific writing towards a style that acknowledges the presence of the author/researcher as a key figure in what is presented (Sparkes, 2002). The ensuing study embraces authorial presence by intersecting data analysis with reflexive ruminations on method, producing what Marcus (1994, p. 567) describes as a “messy text”.

Writing in a confessional/reflexive way, although popular across much qualitative research (Pillow, 2003), is particularly in tune with the fundamental tenets of narrative inquiry. Critically, narrative construction is regarded as a relational feat with narratives not pre-existent in the minds of individuals but rather composed within interactional and discursive contexts (Reissman, 2008). The interactive interview common in narrative studies represents one such discursive context in which narrative can be constructed or, more aptly, co-constructed. It is this emphasis on socially constituted reality, and the pivotal role of the researcher/interviewer in this process, that makes narrative inquiry and reflexive practice so compatible. For example, a researcher’s framing of questions, reactions to interviewee responses, personal disclosures, and the broader interviewer-interviewee relationship dynamics all influence the construction of a particular narrative account (Manderson, Bennett & Andajani-Sutjahjo, 2006). It is therefore important to reflexively consider how narrative meaning is collaboratively shaped in these ways (Gubrium & Holstein, 2009). In addition to interview nuances, all narratives are considered essentially performative (Gubrium & Holstein, 2009, Reissman, 2008) in that they are constructed differently for different audiences and contexts. A story told to a researcher may alter significantly when told to a friend or a family member. Again, addressing how a participant’s narrative is tailored towards oneself as the listener is a matter worthy of reflexive deliberation.

The Participant

Beth (pseudonym) is a 24-year-old postgraduate student in England who formerly competed to a national standard at tennis. Her various tennis endeavors, she also attended a full University scholarship in America, have since been replaced by an involvement in competitive distance running. She volunteered to partake in this study by answering recruitment materials that sought athletes with experiences of disordered eating in sport. Beth's eating disorder was particularly severe. At the age of 19, towards the end of her first year of University, she weighed just over 40kg and was clinically diagnosed with anorexia nervosa. At the time of our interviews Beth's eating habits and attitudes were still troubled although she maintains that she now manages this to a point: "*my eating habits are horrendous and I just don't know if I'm ever going to be able to become normal as such…I control it so it's not going to affect my life and my weight so much*".

During our first meeting I (first author) tried to ascertain the role sport had played in her illness in order to assess her suitability for a study investigating experiences of eating disorders in sport. Beth's responses were hesitant, uncertain and unforthcoming. She skirted around several issues and made repeated vague references to what she termed "*structural pressures*". Eventually she confessed to having been sexually abused by her tennis coach. I thanked Beth for finding the strength to disclose this information and reassured her that, if we went ahead with the study, she would not be asked to discuss anything she felt uncomfortable with. Immediately after this meeting, I telephoned my PhD supervisor (second author) with a range of concerns. I was primarily concerned that Beth's experience differed to that typically portrayed in the eating disorders in sport literature. I sensed her story was fundamentally different to that of the athlete who makes body comparisons with other

athletes, whose weight is criticised by coaches and who essentially diets to improve performance. Like any audience to a story, I possessed preferred plots and themes (Holstein & Gubrium, 2000). After much discussion with my supervisor, it was decided that to not conduct research with Beth because she didn't fit a highly prescribed criteria was against the spirit of qualitative research, which actively seeks diversity and complexity. My goal was not to purely verify what the literature already tells us, reinforcing the existing medical narrative in the process, but to explore new terrain by researching personal, idiosyncratic understandings of experience. My supervisor and I agreed fervently that it was a moral obligation to honour, rather than silence, Beth's divergent narrative. In so doing, an alternative tale, a possible counter-narrative, to the traditional athlete with an eating disorder tale is witnessed, which as well as enriching knowledge of the phenomenon might also resonate with the lives of others, whose experiences, perhaps until now, have not seemed to fit with the dominant story. As the story of an athlete with an eating disorder Beth's story warrants study. As a story distinct from others, it demands it.

Narrative Interviewing

In line with other narrative studies (e.g. Carless, 2008; Smith & Sparkes, 2008) I conducted life history interviews that emphasised allowing Beth to talk freely and extensively on the issues she deemed pertinent to her life. In total, a series of 6 unstructured life history interviews took place over a period of 12 months yielding more than 9 hours of digitally recorded interview data, all of which was transcribed verbatim. Each interview lasted between 60 and 130 minutes and took place at my university office. As stipulated by the university ethical advisory board that approved the study, Beth received a participant information sheet detailing the nature of the study and her involvement in it prior to interviews taking place.

In the first instance I conducted a less formal “intake interview” as a means to introduce Beth to the interview setting and accustom her to the experience. From the outset, I informed Beth that she could withdraw from any interview, or the whole study, at any point and that she need not discuss topics she did not feel comfortable with. It was also a chance to begin to build rapport and feelings of respect and trust that are necessary if an individual is to share intimate details. Facilitating this process, principles of relationality, mutuality and empathy (Cole & Knowles, 2001) guided the intake and all subsequent interviews. In addition, drawing on recommendations by Rapley (2004), I looked to talk in a relaxed and informal manner, establish mutual interests and, where appropriate, self-disclosed. I was able to quickly and easily form a bond with Beth due to several commonalities; amongst other things we were both postgraduate students, we enjoyed similar sports and supported rival soccer teams, all of which provided plenty of scope for conversation. Beth appeared relaxed and at ease during the intake and unprompted she began addressing issues regarding anorexia nervosa, and to a lesser extent sexual abuse, far earlier than I had anticipated.

Plummer (2001) states that interpretive approaches to life history and narrative often deploy interviews that are largely open, interactive and conducted with very general guides. In support of this view, Atkinson (1998) states that “the less structure a life-story interview has, the more effective it will be” (p. 41). That said, the aims of the study provided an implicit structure to our conversations. Beth and myself were acutely conscious that my research was broadly focussed on the experience of disordered eating and as a result Beth’s reflections on her life experiences, as well as my probes for further detail, were framed in light of this. Beth’s leading of the intake interview would prove characteristic of subsequent interviews. I encouraged Beth to dictate topics for discussion and I would ask her to describe, expand on, and provide

examples of issues of interest. Although digressions were welcomed their frequency and sheer scope was at times unsettling. It was important to relinquish control in this way and remind myself that discussions not obviously relevant can provide important contextual information for interpretive work. When pertinent issues did surface, probes such as “how did/do you feel about that?” and “what did/does that mean to you?” encouraged Beth to reflect and engage in narrative construction. On completion of each interview, I conducted a preliminary reading and noted topics of interest to be discussed in subsequent interviews. Beth was forwarded full transcripts for all interviews.

Narrative Analysis

Approaches to narrative analysis abound and this is considered a fundamental strength (Coffee & Atkinson, 1996). Most narrative methods however share an emphasis on keeping participants’ stories intact, as opposed to fracturing data into discrete themes, and therefore incorporate extended interview extracts into analysis (Reissman, 2008). It is within longer segments of data that essential narrative features such as context, plot and sequence over time, can be preserved. These narrative features are telling and enable the researcher to embrace the complexity and ambiguity of experience. The interviewing strategies discussed in the previous section ensured that appropriately extensive narrative accounts were in place, on which analysis commenced. From a broad perspective, I adopted the position of what Smith and Sparkes (2009a) term a “story analyst”, which they define as a researcher who “steps back from the story generated and employs analytical procedures, strategies and techniques in order to abstractly scrutinise, explain, and think about its certain features. They also theorise it from a disciplinary perspective to develop theoretical abstractions”. My work as a story analyst was primarily informed by the ideas of

Holstein and Gubrium (2000) and Gubrium and Holstein (2009), whilst also drawing on specific techniques profiled by other prominent narrative theorists (Lieblich, Tuval-Mashiach, & Zilber, 1998; Reissman, 2008).

Holstein and Gubrium (2000) and Gubrium and Holstein (2009) offer a form of analysis that suggests orienting towards the *whats* and *hows* of narrative reality. The *whats* of a narrative concern the environmental circumstances of narration, whereas the *hows* concern the processes through which an individual creatively accomplishes a narrative. To emphasise, it is considering the role of descriptive resources and institutional constraints as well attending to the artful, performative element to narrative construction. These two aspects form the crux of what is termed "narrative practice" whereby individuals "actively craft and inventively construct their narratives" while also drawing from "what is culturally available, storying their lives in recognizable ways" (Holstein & Gubrium, 2000, p. 103). Working to these principles, in trying to interpret Beth's eating disorder experiences and the processes by which they are constructed and made meaningful, the *whats* and *hows* were integral. Gubrium and Holstein recommend a continuous and fluid shift back and forth between these *hows* and *whats* in a process coined *analytic bracketing*. This important technique ensures primacy is not granted to one element of narrative practice over another but rather recognises that each component is "mutually constitutive; each reflexively depends upon and incorporates the other" (p. 29). Essentially, neither the independent individual nor the cultural environment fully determines narrative construction and this, therefore, should be reflected in analysis. In view of these recommendations I read the transcripts multiple times, sensitising towards the *whats* and *hows*. In the first instance I made frequent and loose analytical observations and annotated these besides the relevant segments of text. As the reading

became more focused I oriented towards the thematic content and structural form of the narrative (Lieblich, Tuval-Mashiach & Zilber, 1998; Reissman, 2008) allowing interpretations as to the social and cultural determinants of the story told – the *whats*. In turn, I attended to the performative qualities of the narrative and the artful, creative and selective choosing from given experiences to form linkages that construct meaning – the *hows*.

Interpretations and Discussion

Throughout the subsequent analysis, I discuss Beth's narrative constructions with reference to principles of narrative theory as well as to existing literature on eating disorders and sexual abuse. Firstly, the reader is given the opportunity to 'meet' Beth through the provision of broad contextual information on her life. The biographical synopsis presented, supplemented with direct quotes from interviews, serves as a necessary preface to the formal analysis that follows.

Meeting Beth

Beth grew up in a quiet and isolated village in England where she suggests there is "*not a lot happening…not much going on*". Through her childhood years both her parents earned their living in caring professions. Her younger brother, with whom she is close, completes the family unit. Family life was often turbulent and mum and dad would regularly clash over work stresses, financial pressures and other deep-rooted relationship issues. It was a "*very unsettling environment*" which has had a enduring impact on Beth's life: "*I've always taken anxiety on from my parents' problems and that's as far back as I can remember*". Theirs is a marriage that continues to puzzle Beth: "*I don't know how they've been together so long because they are just so awful together*".

Beth remembers herself as a sensitive, nervous, self-conscious child. Worry and anxiety pervaded her life from very early on: "*I've always had this thing where I've felt people don't like me or worried that they don't like me or worried if I've done something wrong*". With other children she would be "*worrying about being noticed… being bullied*", scared that she was different, that she did not fit in. Beth attributes much of these troubling experiences to her mother, whose eccentric tendencies led to Beth sporting unconventional clothes and an unusual haircut. Beth was often teased. This was just one of many issues she had with her mother, who she describes as temperamental and whose mood swings and marital conflicts were often projected onto Beth during heated arguments. The consequences of these outbursts were devastating: "*I grew up believing everything was always my fault and that I was really selfish*".

Interestingly, this unassuming child also possessed a fierce competitive streak: "*I was always quite competitive…I just wanted to be winning*". Beth applied her competitiveness to sport, particularly football, and she excelled at it: "*I was always playing football from the word go really…that was my passion*". As Beth got older the opportunities to play football were fewer and by the age of 11 she had started playing tennis. Once again she excelled and her participation swiftly progressed from an informal weekend activity with friends to representing her local club and soon after her region. At 12 years of age Beth played tennis 4 times a week, had a personal coach and was competing in tournaments. Her sporting endeavours were not immune to the turbulent relationship she had with her mother. Although her mother encouraged tennis, she resented the strain it placed on the family in terms of money and time. Arguments would surface regularly and Beth was often made to feel guilty

by her mother for pursuing the sport: "*in one way she was driving me, in the other way she was bullying me for doing it*".

Beth's tennis career managed to develop despite inconsistent attendance to tournaments and the disruptive backdrop of her family life. Her mother was proactive in seeking out effective coaches and would move her daughter elsewhere if she felt the current coach's skills did not match Beth's needs or even if she perceived the coach to favour another player. After Beth suffered successive losses to her closest rival, she was moved to her third coach inside a year. These changes were awkward for Beth who despised the conflict and just wanted to please people. She arrived at the new coach feeling vulnerable: "*my confidence was extremely low, especially in tennis terms, I was really not confident anyway in any aspect of my life*". This vulnerability was amplified by the worsening arguments at home caused by the escalating demands of Beth's tennis career. Beth sought solace in her new coach, with whom she had established a good relationship: "*I turned to him to ask for help and advice*". He seemed caring, considerate and trustworthy. Tragically, the coach abused this trust and exploited Beth's troubled situation, coercing her into a sexual relationship that would last 3 years. Beth was 13 when the abuse started. This critical episode in an already troubled life was compounded by the onset of anorexia nervosa 5 years later. At the time of this study, despite previously receiving psychiatric support, Beth struggles to make sense of these life experiences.

Resistance of Narrative Opportunities

Narrative opportunities or 'occasions for conveying selves' occur in an abundant array of relational and institutional contexts, such as counselling sessions and self-help groups, and serve the important role of inciting individuals to construct the narratives needed to understand their lives (Holstein & Gubrium, 2000).

Essentially, narrative opportunities prompt the act of "emplotment", the organising of life events in to an order that makes explanatory sense and provides meaning to experience (Ricoeur, 1984). Critically, throughout our conversations together it was evident that Beth had seldom accepted an opportunity to tell her story, either in terms of anorexia or sexual abuse.

With regards to the former, Beth recalls an inability to acknowledge her issues with food stating "*there was nothing that would have made me admit it and I thought that everybody else was just being stupid and that I just wanted to be healthy*". Denying her illness in this way, a common diagnostic feature of anorexia nervosa (American Psychiatric Association, 2000), inhibits the integration of the experience into a narrative plot, as there is, according to Beth, no significant experience to integrate. Similarly, when discussing her experience in a professional setting, Beth also stated: "*with the psychiatrist I wouldn't speak at all. I used to hate it so much, I used to dread going there*". From this I suggest that attempting to narrate the problem is so painfully difficult for Beth that the very prospect fills her with such "*dread*" that she is forced to resist obvious narrative opportunities.

Beth's previous narrations of her sexual abuse experiences have been equally sparse as is clearly emphasised by the following quote: "*for years I just kept it to myself…I still find it really impossible to talk about*". The shame, guilt and self-blame that she experienced, typical responses in victims of abuse (Neumann, Houskamp, Pollock, & Briere, 1996; Putnam, 2003), conspired to ensure disclosing her experience to another was extremely difficult for Beth (Tang, Freyd, & Wang, 2008). Although the burden of secrecy was likely psychologically problematic in itself (Pachankis, 2007), in terms of narrative it prevented Beth receiving the support necessary to construct a story to make sense of such traumatic experience. Beth's

claim that the issue is "*still*" difficult to discuss was apparent during the interviews in this study. Specifically, Beth employed a range of euphemisms in place of the terms abuse ("*what I experienced*", "*what happened to me*") and abuser ("***the*** *coach*", "*the* ***last*** *coach*"). I suggest that if the mere utterance of terms related to the experience is threatening, then considering the place of the experience in relation to her overall life story, in other words producing narrative coherence, represents a distinct challenge. These efforts at resisting narrative constructions of abuse appear to protect Beth from what are, as she describes, disturbing consequences of revisiting painful memories: "*I just feel sick thinking about it. Now I still have nightmares about it and it makes me feel sick to talk*".

Given the highlighted barriers to Beth's narrative practice, her existing constructions are primitive and feature great uncertainty. Discussing her self-starvation, Beth highlights the absence of narrative plot: "*obviously it's confused in my head, why it's happened and where it all came from*". Beth is similarly void of plot when articulating her experiences of sexual abuse: "*there's still a lot of issues that I've not really got over I think. I've still not really worked it out in my head*". Beth is yet to construct a workable plot for either issue and this equates to narrative incoherence, the psychological consequences of which can include identity loss (Charmaz, 1991) and hopelessness (Frank, 1995). Further, a disrupted and incoherent narrative can be as problematic in and of itself as the illness or trauma that caused the disruption (Hyden, 1997).

It is suggested that in cases of narrative disruption the formulation of stories, the act of narrative (re)construction, becomes important in terms of rebuilding a sense coherence, finding meaning and adapting to trauma and illness (Crossley, 2000). As I have established, such a story escapes Beth, although as she talks about her life it is

apparent that she is taking tentative steps towards creating one. For example, she hints that at times her resistance to narrating her experiences may be alleviating: "*I think I've learnt to speak a bit more*". Perhaps the clearest indication that Beth has ceased to fight what Reissman (2008) calls our "narrative impulse" (p. 21), was Beth's volunteering to participate in this study. Research interviews, particularly those loose in structure, are narrative opportunities in their own right (Reissman, 2008) and Beth's willingness to partake in these implies an eagerness to work on her narrative construction.

Viewing the research process as a context whereby Beth makes a concerted effort towards narrative construction placed an enormous responsibility on myself as the researcher. To explicate, if, as I have emphasised, forming a narrative can help Beth understand and adjust to her experiences, and if it is also accepted that narrative construction is an interactional accomplishment (Gubrium & Holstein, 2009), then our interviews can be seen as a collaborative effort towards the critically important work of storying Beth's life. From the first interview Beth was both aware of and happy for such joint narrative practice to take place: "*you might be able to determine the build up of it, maybe better than I can myself*". The statement could also be interpreted as a direct request for help with her narrative endeavours, a pleading for the answers to the uncertainly that shrouds her life. Although qualitative research, particularly narrative research, often presents therapeutic consequences (Stuhlmiller, 2001) it is not therapy and, most importantly, I am not a therapist. This issue remained as a surface tension throughout all our conversations, with Beth, at times, seemingly seeking counsel and myself tempted to provide it. Staying acutely conscious of the porous boundaries between empathy and therapy was a challenging but necessary task requiring great discipline. Instead, my role in the Beth's narrative was to serve as an actively listening

audience, to evoke stories of experience through my questions and establishing a comfortable environment conducive to sharing intimate details, and also to allow Beth's story to be created as opposed to my own. This provided the platform for Beth to try and organise her life into a meaningful plot, an effective narrative opportunity. The ensuing sections dissect these efforts at emplotment and discuss the implications of each for Beth's psychological health and the quality of her present and future experiences.

Constructing Sexual Abuse

The use of the present progressive tense '*constructing*' within the title of this section, and the section to follow, is a deliberate choice to reflect the on-going nature of Beth's narrative work and it's continuation within interviews. The extended account presented next illustrates that Beth possesses two conflicting interpretations of the relationship she had with her coach:

> I mean it took it me a long time to realise it was actually an issue for me because it had been drilled in to me that it was like, that I was in love and it was a love thing you know…I still kind of blame myself. Actually, I don't know if you watch East Enders (UK television soap opera) but what's happening now at the moment has really helped me because they've profiled this paedophile and the situation is more or less exactly the same as what happened to me. The same ages, the same words that he uses that I used to hear and it's kind of helped me to realise that actually maybe I was, you know, abused and, you know, because the way they make it sound it just manipulates your mind and dupes you so much that you believe that it's this love story and to this day I've still not managed to get out of that manipulated way of thinking and so this has really helped me
>
> AP: How did it help you exactly?
>
> Beth: …because obviously they're profiling him as a paedophile and I've still not managed to see what happened to me as child abuse

Beth's original understanding of her abuse experience is that it was in fact not an abuse experience but rather an experience of romance, "*a love thing*". The romance tale is considered one of a limited stock of archetypal story forms, the basic themes of

which concern adventure and conquest (McAdams, 1993). A pervasive variation of the romance narrative is characterised by boy meets girl, they fall in love, and they live happily ever after (Kirkman, Rosenthal & Smith, 1998). Beth acknowledges that her coach manipulatively projected such a "*love story*" on to their abusive relationship, which, as a young and impressionable early adolescent, she understandably internalised. Beth consequently constructed the relationship in terms of the general plot of the romance narrative, normalising and legitimising the experience in the process. Her narrative duly became a story of forbidden love as opposed to sexual abuse. This is in accordance with Bruner (2004) who claims culturally prescribed canonical narratives of this sort can guide the way individuals understand and live out their lives. Reinforcing this romanticised construction of events, Beth's abuser manufactured what Davies and Harre (1999) describe as the two major roles for living out the romantic love narrative: that of the male hero with a heroic goal and that of the female heroine who is usually the victim of some circumstance, from which the hero must save her. Specifically, preying on her family instability, Beth's coach played the romantic hero who understands her troubles and can rescue her from the turmoil at home. It was an appealing story for a vulnerable adolescent girl to tap into.

Beth lived out the romance narrative for the entire period she was sexually abused. As a result, the story became such an established and coherent explanatory plot for the experience that it persists, to a degree, even now. Despite the emergence of a new interpretation of events, that she was actually sexually abused, she struggles to "*get out of that manipulated way of thinking*" and she claims she still cannot "*see what happened to me as child abuse*". At the time of the interviews Beth was grappling with the two competing narrative constructions of love story and abuse

story and their differing interpretations of the past. This is important narrative work for Beth given the diverse implications each narrative option provides for her present and future self. To illustrate, storying the experience in terms of a typical romance to which she consented implicates Beth as an equally responsible and willing participant in what now seems vastly inappropriate. From this standpoint Beth's moral integrity is jeopardised leading to a variety of persistent negative feelings, including, as she often repeated, guilt: "*I still kind of blame myself*". On the other hand, Beth is eager to story her experience as one of sexual abuse as it rightly absolves her of responsibility as a susceptible minor and places it on her coach as an adult in a position of authority. She will consequently cease to be a conspirator in an illicit relationship therefore alleviating feelings of guilt and self-hatred.

Beth asserts that her struggle to reconstruct her experiences in terms of abuse was greatly facilitated by a storyline depicted on *East Enders*, a popular BBC television soap opera in the UK. Beth had been watching the programme very recently and states that it "*really helped me because they've profiled this paedophile and the situation is more or less exactly the same as what happened to me*". In effect, seeing a fictional parallel of her personal story presented as a paedophilic crime serves to validate and strengthen the preferred abuse narrative and weaken the romance narrative. This demonstrates how a culturally available narrative can inform a personal narrative to produce new meaning (Somers, 1994). Guided by the fictional account, Beth is provided with a workable plot to understand her own life differently to the troubling romance story that has previously dominated. She is now capable of seeing that her vulnerabilities were exploited, she was manipulated and, crucially, she was not to blame. In this respect, the new story can be seen to take care of her (Frank, 2007) affirming her experience and, in particular, her innocent role in it.

In later conversations, Beth alluded to other similarly helpful means of narrative reconstruction:

> this last year has helped me…I've had a lot of friends and I've been more open with some people about it and I've managed to tell a couple of people, and you as well, and in doing that I've kind of realised people's reactions and the fact ok well it was weird of him and it was wrong and I wasn't to blame. That's helped me so much

Here, Beth outlines the relational element to narrative construction. In narrating her experience to a small number of people, including myself, she has tailored her story in line with the responses of these various audiences. It is a process whereby "*people's reactions*" help confirm that "*it was wrong*" and, again, that she "*wasn't to blame*". Just as the fictional drama verified Beth's abuse narrative, so too do these social interactions.

Despite the progress outlined thus far, the fact remains that Beth is still yet to fully subscribe to the abuse story over the alternative love story and, as identified from the outset of this section, both narratives co-exist as plausible options. In the following interview extract Beth reflects on the details of the duality of her understanding:

> Even now there's still like a little bit of doubt. Say then (time of the abuse) there was like ok there's 5% of me knows it was wrong but 95%…but now it's the opposite way round so 5% of me is blaming me still but the 95% knows it's wrong so I've turned that around now

This quote exemplifies what Holstein and Gubrium (2000) term 'narrative reflexivity' whereby Beth, as a narrator, is aware of her active involvement in deciding which story to convey in order to shape experience and the self. Beth has metaphorically stepped out of her story to provide her own narrative analysis of how the relative prominence of the two available narrative options has evolved over time. Beth ascribes a 95% figure to indicate the dominance of her current preference for

interpreting her experience as an act of abuse as opposed to the formerly dominant romance option. She acknowledges her personal agency in instigating this reversal of meaning when she states: "*I've turned that round now*". This turn around is offset by the "*little bit of doubt*", the insidious "*5 percent*", which refuses to dismiss the romance narrative and the negative emotions that accompany it.

Ultimately, it is evident that Beth is presently unable to produce a stable and coherent narrative of the sexual abuse she endured as a child. The consequence of this is that she lives in a torturously confused state, perpetually flitting between two opposing narratives neither of which can provide an understanding she is satisfied with. As long as this narrative resolution remains out of reach, Beth is condemned to repeatedly reliving the traumas of the past as part of a continued search for meaning. It essence, Beth cannot address nor move on from the experience until she is secure in her knowledge of what the experience actually was. This is a daunting prospect for Beth, and perhaps provides some insight as to why she has so often resisted opportunities to construct her narrative.

Constructing Anorexia Nervosa

Beth's uncertainty regarding the nature and origin of her eating disorder experiences also demands narrative work. Once again our interview sessions represented a rare opportunity for this work, a chance for Beth to engage in sustained narrative construction. Unlike our discussions of abuse, Beth seemed motivated to find *some* understanding rather than a specific understanding. Exploring different narrative possibilities, Beth continually monitored, modified and revised her story as she embarked on a process of narrative editing (Holstein & Gubrium, 2000). In this section I present some of the narrative constructions proposed by Beth and speculate as to the possible impact of each on her current self.

Given the wealth of literature implicating incidents of sexual abuse as a possible risk factor to eating disorder onset (e.g., Connors & Morse, 1993; Everill & Waller, 1995), Beth's sexual abuse experiences provided an obvious and culturally persuasive means to understand her eating disorder. It was a perspective supported within Beth's social milieu, including one pertinent example involving her general practitioner:

> she (doctor) new that I'd had an eating disorder and she just out right said, you know, "you're in sport, were you abused by a coach?", she just said it like that, and I said "how did you know?" and she said "well I'm really sorry but it's quite common, for people who have had eating disorders for this to have happened"

This incident outlines the relational forces pushing the abuse-anorexia link. The doctor's unhesitant and forthright identification of Beth's history of sexual abuse based on her eating disorder diagnosis practically portrays Beth's experience as the norm, implying an element of causal certainty. The doctor emphasises this when she stipulates that such a relationship is "quite common". Reflecting on this potential narrative line, Beth also acknowledges her father's adherence to it:

> it's correlating what happened (abuse) with what I put myself through (anorexia nervosa) which to my dad is very obvious but to me is not so much

Despite such relational influence from important sources, Beth exercises her narrative agency and resists what for her is an unsatisfactory explanation. She later reasons that given the eating disorder emerged when she was yet to interpret her experience as abuse but had "*written it off as a normal relationship*", it is illogical for abuse to be considered as a causal factor. It is implicit from the deep consideration Beth affords this narrative option, and her reluctance to simply follow an accepted narrative path, that it is important for her to construct a story that is faithful to her experiences.

Dismissing the sexual abuse hypothesis in this instance, Beth turns to other events in her childhood for more personally acceptable clues on the origin of her eating problems. Within the following extended extract Beth exemplifies narrative construction in action as she engages in a careful process of selecting events that might have had some bearing on the emergence of her eating disorder:

> I used to hate the jodhpurs, you know those tight jodhpur pants that you have to wear when you're riding. I can remember hating wearing those and my mum saying that I looked like I was pregnant or something…that must have been when I was 8 or 9. 9 probably. I always thought that I had fat thighs or something and if I'd ever express it to my mum she used to tell me it was puppy fat or I would grow out of it or you've just got fat cheeks but you'll get rid of it or something…or she'd say 'oh well unlucky, you're like me and you're always going to have to worry about what you eat all the time'. My mum would always express opinions about other people as well. Even children my age…at that age I don't know that it really sat in me that much and certainly didn't restrict what I was eating…but that was probably also because I was so sporty. I was outside all the time and I think my mum pointed out to me as well 'you'll be alright now, for now, because you do a lot of sport, you're always doing sport'…yeah that's one of the reasons why when I stopped playing tennis I was so aware that I had to stop eating or control what I was eating more.

Beth recounts an example of her early body consciousness when she describes her disdain for wearing jodhpurs while horse riding. She intimates that her mother's comment that she looked "*pregnant*" had some role in her concerns, perhaps as a cause or, at least, exacerbating her fears. Beth follows this by listing examples of her mother's unhelpful responses to her concerns about having "*fat thighs*". We are then informed that her mother would regularly "*express opinions*" on other people's weight, "*even children*". By citing these multiple selected memories in succession, Beth quickly portrays her mother as a primary and integral influence on her early body insecurities, setting up a possible link to her subsequent self-starvation. Such narrative devices ensure the developing story is a persuasive one, narratives are performed persuasively for strategic aims (Reissman, 2008). In the context of Beth's

current narrative uncertainty, we can speculate that her efforts at persuasion might reflect her eagerness to adopt this potential narrative plot, that her mother played some part in her eating disorder, as her preferred story. In narrating persuasively, Beth acknowledges my role in her constructions by encouraging me to concur with her forming narrative and uphold rather than challenge or alter it. If I accept the forthcoming linkages, the narrative thread is strengthened and some narrative uncertainty is resolved.

As Beth continues, there is further evidence that she is discussing a plot she is beginning to appreciate and understand. For example, discussing her mother's comments, she proclaims that "*at that age I don't know that it really sat in me that much*" and that they "*certainly didn't restrict what I was eating*". Both these statements can be considered to work against the narrative line in question. Perhaps sensing her preferred story under threat, Beth moves quickly and qualifies these statements by adding, after a moments pause, that the lack of *immediate* impact of her mother's weight comments was "*probably*" due to her being "*so sporty*" that she did not yet need to stop eating. The use of the word "*probably*" however implies an element of doubt to this justification. Countering this doubt, Beth adopts an ancient literary device of persuasion by providing a direct quotation to support the assertion: "*my mum pointed out to me as well 'you'll be alright now, for now, because you do a lot of sport'*". Satisfied that the absence of childhood eating issues was due to her high physical activity levels and not the inconsequentiality of her mother's comments, Beth can begin to link these comments to her adult eating issues. Beth achieves this when she identifies a specific eating related outcome of her mother's quote: "*yeah that's one of the reasons why when I stopped playing tennis I was so aware that I had to stop eating*". The constructed story is now complete, an experience from the past is

causally linked to later eating problems providing a sense of narrative coherence that gives meaning to the experience.

In this case, Beth's constructions of her experience can be seen to occur under the auspices of a culturally dominant story. Specifically, explaining an eating disorder from a familial perspective, such as a daughter's relationship with her mother, is consistent with the dominant medical narrative emphasis on individualised psychopathology (Botha, 2009; Rich, 2006). The fundamental premise is that either hereditarily (Klump, Miller, Keel, McGue, & Iacono, 2001) or via some dysfunction within the family unit (Benninghoven, Tetsch, Kunzendorf, & Jantschek, 2007) the vulnerable individual will be at increased eating disorder risk. The troubling subtext, as with all individualised etiological models of this kind, is that the person with the eating disorder, or the family, has some inherent flaw that has induced the illness (Rich, 2006). For Beth, this individual weakness might be considered her eagerness to please her mother, the ease at which she was influenced by comments, or, perhaps more straightforwardly, that she is genetically predisposed via her mother. Some theorists have expressed concern that this unfair character assassination, implicit in dominant etiological theories, damages individuals by stigmatising and silencing them (Rich, 2006; Lock et al. 2004; Lock, Epston, Maisel, & de Faria, 2005). Effectively, living by the dominant narrative leads to experiences of personal deficiency, worthlessness and helplessness (Lock et al. 2004, Lock et al. 2005). It might be argued that Beth's faith in this story, her eagerness to construct her experiences in line with it, might be somewhat misplaced given these negative implications. On the contrary, given the story's dominance and the distinct lack of viable alternatives (Lock et al. 2005), Beth's efforts might best be understood as finding meaning through the only narrative available. Although there may be troublesome

consequences associated with medicalised understandings, as Frank (2007) tells us, when it comes to making sense of illness any story is better than no story at all.

Many of Beth's further attempts at constructing an understanding of her eating disorder experiences were informed by the core assertions of the dominant medical narrative. This is logical given that the encompassing nature of such master narratives gives them a contagious quality that ensures they are more likely to be adopted by individuals (Holstein and Gubrium, 2000). Beth provides a good example of the contagiousness of certain narratives when she speculates on the role of the sporting environment during a tennis scholarship she attended in America: "*my coach was really strict about diet and lifestyle and very critical with anyone who wasn't aligning with his thinking. There was a girl on the team who was a bit bigger and he used to criticise her endlessly*". Beth goes on to make a link between this time and the onset of her restrictive eating:

> Well I'm a bit eager to please I suppose, maybe that's one of my faults and I suppose I just wanted to please my mum, please my coach and you know also the guilt of him bringing me over there. For me to then to turn round and just eat loads of shit and not be very fit I probably would have felt even more guilty so I wanted to kind of align with his thinking…

The above quotes are indicative of the dominant understanding within psychology and sport psychology that suggests performance related weight pressures in sporting environments encourage disordered eating in vulnerable individuals (Striegel-Moore, Silberstein, & Rodin, 1986; Smolak et al. 2000; Beals, 2004, Petrie & Greenleaf, 2007, Dosil, 2008, Thomspon & Sherman, 2010). Beth's consideration of this narrative as a means of explanation seemed out of sync with the experiences of much of her life history. Sporting pressures were not mentioned until the final interview, prior to which Beth had largely addressed the contrast between her own experiences as an athlete with an eating disorder and that typically portrayed: "*there's too much*

emphasis on the cliché people that have eating disorders like gymnasts". It is feasible that Beth, again desperate for meaning and short on resources with which to construct it, draws on this culturally dominant understanding irrespective of the extent of its applicability to her own circumstance.

In a previous discussion on her present day involvement in competitive distance running, Beth actually contradicts her above speculations regarding weight pressures in tennis. Speaking specifically about her recent formal involvement with her University running club Beth states:

> with running, immediately I can feel a different pressure with weight, than tennis, because some of the girls in the club are so small…it's hard to believe that they don't have a problem basically because they're tiny and just look not well…so you can see quite clearly with running there's very, very different pressures to being thin than there was with tennis. Tennis there's never a direct pressure to be skinny…
>
> AP: So what was the pressure itself? To fit in with the group?
>
> …yeah I guess to fit in and also, maybe, it's interpreted that that's how you need to be to be any good, to be the best and I guess logically if you're carrying less weight you have less to carry don't you.

Beth now downplays the weight pressures within tennis and suggests that her current distance running experiences more closely resemble the type of sporting environment that is typically viewed to potentially induce disordered eating. In contrast to tennis where there is "*never a direct pressure to be skinny*", running is associated with body comparisons with other athletes and an overly simplistic ethos that low weight equates to better performance. Although Beth later acknowledges that her original interest in running was "*tied in*" with her illness, the account above illustrates running currently provides its own added impetus for the maintenance of her anorexic tendencies. In effect, Beth's construction of running has evolved from a symptom, "*part of the illness*", to a cause of its persistence.

It is important to note that in recounting the tennis environment differently on different occasions the accuracy or truthfulness of Beth's narrative should not be called into question. Rather, as Jarvinen (2004) drawing on the work of Mead argues, individuals are always creative in constructing the past and that that this creativity is born out of the individual's ongoing projects. We view past memories from the perspective of an ever-changing present and our personal biases of the time shape how we see the past. Invariably, consciously or unconsciously, the past we choose is the one most significant to our present endeavours (p. 47). Applying these ideas to Beth's story, her contrasting recollections of the tennis environment can be seen as a function of her differing narrative goals at the time of each construction. In the first instance, Beth was seeking to explain the emergence of her eating disorder and implicating weight pressures in tennis, irrespective of how negligible they might actually have been, provided an acceptable means to achieve this given the overlap between her elite tennis participation and the onset of her dieting habits. Alternatively, when Beth sought to understand her current eating behaviours and how her disordered beliefs are currently maintained, emphasising her current sporting pressures provided a better explanatory fit.

Towards the end of our last interview, as it appeared that Beth had exhausted available narrative options, she offered the following powerful narrative that brings together the family and abuse issues that simmered throughout our discussions into a coherent explanation as to why she stopped eating:

> It was because I hadn't told my parents about what had happened you know with the abuse issue and I thought they'd disown me so I thought that if I made myself really ill and then they found out then maybe they wouldn't hate me so much or they'd see how much I was suffering. And that was matched with…I'd say 50% with my parents' issues because they were so, so obsessed with themselves and arguing over themselves and involving me in every argument…So you can see like when I had this eating problem, that was partly what was driving me to make myself so ill because I thought if I'm this ill then

> they'll stop all this arguing and stop putting pressure on me all the time…and all this stuff was coming at me and I just think that was my only way of coping…was to control it through controlling my food, and also I'd lost my identity because my whole identity was tennis and with that gone out of the window I had nothing. I guess my identity became being thin…there's like a load of things…

The narrative is immediately notable because it does not begin with verbs of uncertainty such as 'I think' or 'I suppose', which litter many of Beth's previous constructions. Listening to the narrative at the time, there was more an element of declaration than speculation and a sense that the pieces to the puzzle had fallen into place. Unlike previous constructions Beth did not overtly seek my confirmation of the narrative, as is evident by her lack of questions and rhetoric.

Contrary to her previous assertions, Beth links her abuse experience, or romantic relationship experience, as it was then perceived, to her self-starvation. The issue of how the abuse experience was constructed is a pertinent one. For much of Beth's life, she has constructed the abuse as a love story, which, as I discussed in detail at the outset of my analysis, led to feelings of immense guilt and shame. It is this guilt, the sense that she was doing something wrong, that Beth now believes led her to starve herself as a way of protecting herself from the wrath of her parents should they find out: "*if I made myself really ill and then they found out then maybe they wouldn't hate me so much*". This is an important illustration of how constructed narratives of past events are consequential for experience, sometimes traumatically. It might also provide insight into why Beth is currently unable to escape her restrictive eating. As previously outlined, despite a conscious struggle to interpret her experience as one of a blameless victim of child abuse, to the present day Beth cannot fully relent the love story. Resultantly, the associated guilt and threat of castigation from others persists, as does Beth's correspondent defence, her restrained eating. It may be that

resolving the narrative of her sexual abuse experience, already highlighted as critical for Beth to move on from the trauma, may also be necessary for Beth to move on from her disordered eating.

Beth's story is of a girl plagued with guilt over an incident of sexual abuse she did not fully understand, who turned to self-starvation as a means to gain sympathy and support in place of anticipated anger and accusation. This is Beth's central narrative to understanding the meaning of her eating disorder and, given it's incorporation of her abuse, the central narrative of her life. Other narratives exist, as Beth reminds us when she cites the loss of her tennis identity as an additional reason for her illness: "*I guess my identity became being thin*". Narrative lines like this however, as meaning constituting as they may be, are necessary though not necessarily central. McAdams (2001) articulates this well when he states "although no single story may encompass all of the many narratives that any given person can use to make sense of his or her life, some stories are larger and more integrative than others" (p. 117).

As Beth continues, she suggests that self-starvation also helped soften potential conflict with her parents' in a more general sense. Not eating was viewed as a way to stop their arguments, which she was frequently drawn into and often perceived herself to be blamed for: "*I thought if I'm this ill then they'll stop all this arguing and stop putting pressure on me all the time*". Constructing self-starvation as a useful tool to remedy threatening situations is an established phenomenon (Lee, 1995). The underlying connotation of such a construction is that an eating disorder has a positive side, a usefulness that can help Beth. This ambivalent perspective continues into the present as indicated in the ensuing paragraph.

When Beth talks about her current issues with food, she presents two opposing conceptions of the meaning of starving herself:

> I know now I'm not as strong in myself as I was then, as in strong to prevent myself from eating and regulate everything I eat. I just can't do that anymore because I just don't want to be that ill again. When I wake up in the morning I usually have plans, 'today's going to be better I'm not going to eat so much today'...generally speaking it's just in terms of quantity rather than what I'm eating and I just wake up thinking I'll just eat less today or eat nothing today then when it comes to the point where I'm hungry then something in my head sparks 'you can't stop yourself. Don't stop yourself'.

Firstly, self-starvation is considered a feat that requires great discipline, an obviously desirable characteristic. Beth's current inability to starve as stringently as when she was clinically ill is considered a consequence of not being "*as strong in myself as I was then*". The implicit message is that Beth construes eating with personal weakness and not eating with personal strength. This narrative link induces a motivation to self-starve: "*I usually have plans, today's going to be better I'm not going to eat so much today*". In contrast, Beth also understands starvation as causally linked to the extreme suffering that comes with anorexia. As well as being associated with strength it is also associated with mental exhaustion and physical weakness. Beth is adamant when she states: "*I just don't want to be that ill again*". She is equally motivated to avoid overly restricting food and issues the instruction "*don't stop yourself*". Shohet (2007) suggests envisioning self-starvation as both good and bad is associated with individuals who struggle to recover from anorexia as such ambivalence is not conducive to permanent recovery. Intrigued as to how Beth upheld these two conflicting positions, despite speaking so passionately about the ills of an eating disorder, I decided to try and bring this contradiction to her attention:

> AP: It's interesting that when you talk about restraining you mentioned it as a strength you said 'I don't have the strength now to do that'. It's interesting what that word strength connotes I mean it is a positive connotation isn't it?

> Beth: Yeah…maybe it shouldn't be.
>
> AP: Well, you know, no right or wrong answers…I'm just interested in that perspective…
>
> Beth: …but it is a strength though…maybe you're right but at the moment I'm still perceiving it as maybe being weak because I can't control it but maybe it's being strong. To anybody else it would probably be strong.

By describing Beth's use of the word "*strong*" as "*interesting*" I imply that it is unusual given its positive overtones. Beth comprehends my insinuation as a direct challenge to her thinking and acknowledges, albeit without much certainty, that perhaps her thinking is misguided. Eager not to enter into the therapeutic realms of restructuring Beth's thoughts, I feel compelled to reaffirm the research context whereby the goal is understanding narrative construction not moral judgement. Beth seems to accept this and gains the confidence to reassert her position: "*but it is a strength though*". She concludes by emphasising such thinking persists while recognising that it probably contravenes the thinking of "*anybody else*". To reiterate the contentions of Shohet (2007), so long as such ambivalence persists, so to will Beth's disordered eating.

Final Reflections

Earlier we described that the decision to study Beth's life, an atypical case of an athlete with an eating disorder, was taken after deliberation. In the end, the initial cause for doubt, that is the idiosyncrasy of the life-story, came to be it's greatest strength. We now provide some reflections on this decision in terms of the potential impact of Beth's story for eating disorder theory and practice, both within sport and more broadly. It is hoped that this will provide further justification as to the important benefits of exploring non-traditional experiences through non-traditional methods.

Understandably given the traumatic nature of many of her experiences, Beth had largely resisted opportunities to tell her story until her involvement in this study.

The result of this resistance was that her narrative constructions could be considered embryonic, lacking in coherence and stability. Often understandings of events were speculative, fragmented and multiple and the absence of meaning was psychologically troubling for Beth. The consequences of not disclosing eating disorder problems are usually discussed in terms of the burden of secrecy (Petterson, Rosenvinge, & Ytterhus, 2008), not seeking appropriate professional help (Hepworth and Paxton 2007) and a reduction is social support (Papathomas & Lavallee, in press) but rarely in terms of the negative impact on narrative construction. In not articulating her experience, Beth is deprived of the crucial mechanism for making sense of her life and her identity; she deprives herself of narrative understanding. Health practitioners such as eating disorder specialists and sport psychologists might therefore encourage those who experience eating disorders to not only disclose their issue but to also share their story. This is no easy task given the great stigma associated with eating disorders (Petterson et al. 2008). To openly speculate, practitioners could look to promote a comfortable, safe environment, where eating disorders are actively de-stigmatised and the patient need not fear judgement or reproach. Narrative therapy specialists may be able to move beyond eliciting a story and actively guide the constructed narrative into one that is conducive to psychological well being (e.g. Lock et al. 2004).

Despite initial assertions to the contrary, Beth eventually linked her eating disorder experiences to her experiences of sexual abuse. Reaching this conclusion, and therefore unifying the two most significant experiences in her life, is the product of complex narrative work. To summarise simply, Beth linked her self-starvation to the overwhelming guilt and self-blame associated with her abuse experience. Her belief was that if others, namely her parents, witnessed the extent of her illness and suffering, they would be less inclined to condemn Beth for her role in the relationship

she had with her tennis coach. This integrative narrative line, accompanied as it is by various descriptions of experience and musings on meaning, is important for both theory and practice. First and foremost, the story bears little resemblance to the literature linking eating disorders to sport (e.g. Thomspon & Sherman, 2010). Beth's life therefore serves as an important reminder to researchers to look beyond established understandings of eating disorders or risk the perpetual development of a body of work that is overly contained and fails to see beyond confirmation of it's own initial assertions. Likewise, sports practitioners such as coaches, sport psychologists or governing body officials of those sports typically perceived to be 'non-lean' or 'low risk' should remain open to possible incidence of eating disorders in their athletes. Beth's life is testament that athletes can have eating disorders in sports that are not considered high risk and through mechanisms largely unrelated to weight-performance pressures. Such a different manifestation should be incorporated into the eating disorders in sport literature for a more complete understanding.

Beth's life story narratives also serve an important function in terms of how an eating disorder, or indeed sexual abuse, is understood by those who experience it. The unique stories told might help form the basis from which to establish effective counter-narratives (Lock et al. 2004). For example, Beth's growing awareness that her feelings of guilt are a result of her coach's manipulations may encourage her and other victims of abuse to absolve themselves of guilt and blame. Additionally, athletes from non-lean sports who experience eating disorders may perceive their experiences as less marginalized in light of Beth's story. In a more general sense, the emotional experience of illness and trauma and the challenging search for meaning it invariably prompts, provides an alternative and inherently more accessible account which sufferers might find easier to resonate with than detached symptom focused

portrayals. These ideas correspond with Smith and Sparkes (2008) who suggest that the varied tales associated with narrative research can expand cultural narrative resources, providing stories to help people. The implication is that given there is a limited stock of cultural stories, and that stories are necessary to understand experience, it follows that increasing the number of different stories available may well increase the chances an individual can find a story that *fits* their personal experience appropriately and *works* for them. Returning to Beth, the narrative she has shared potentially represents an additional story from which athletes with eating disorders can draw from. It is necessary for professionals within sport and eating disorders to appropriately acknowledge Beth's story, as well as for researchers to continue to seek other stories that go against the grain, if Beth's distinct narrative is to be usable to others.

To conclude, we point the reader to the features of Beth's narrative of the present and the implications it holds for her future. As previously highlighted, Beth's current understanding of self-starvation is that it is both good and bad, an ambiguity unlikely to motivate a concerted push for recovery. On this issue, Shohet (2007) suggests that when experience is narrated through a given master narrative, for example feminist or psychoanalytic theory, the certainty of illness understanding and the clarity of recovery routes it provides resolves ambiguities and encourages lasting recovery. From this, the logical implication for practice is that eating disorder patients should be encouraged to adopt established medical narratives that script a means to remission. This assumption is however complicated by the fact that, as Shohet points out, some individuals will have different narrative preferences and choose to be faithful to their experience rather than squeeze it into an available master plot. As McLeod (1997) also warns, a poor fit between life experience and the cultural story

an individual is part of will likely lead to psychological crisis. The implication is that although established master narratives may be useful for some individuals to frame eating disorder experiences, for others, the potential infidelity to the past can be distressing, compounding their existing psychological issues. Practitioners should be mindful of simply providing plentiful narrative opportunities to encourage those with eating disorders to find their own acceptable narrative path in their own time rather than thrusting a master narrative upon an individual for whom it might not be appropriate.

References

Altheide, D., & Johnson, J. (1998). Criteria for assessing interpretive validity in qualitative research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Collecting and interpreting qualitative materials* (pp. 283-312). Thousand Oaks, CA: Sage.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: Author.

Atkinson, R. (1998). *The life story interview*. Sage university papers series on qualitative research methods, Vol. 44. Thousand Oaks, CA: Sage.

Axelsen, M. (2009). The power of leisure: "I was an anorexic; I'm now a healthy triathlete". *Leisure Sciences, 31*, 330-346.

Beals, K. A. (2004). *Disordered eating among athletes: A comprehensive guide for health professionals*. Champaign Ill: Human Kinetics.

Benninghoven, D., Tetsch, N., Kunzendorf, S., & Jantschek, G. (2007). Body image in patients with eating disorders and their mothers, and the role of family functioning. *Comprehensive Psychiatry*, *48*, 118-123.

Bordo (1993). *Unbearable weight: Feminism, western culture, and the body*. Berkeley, CA: University of California Press.

Botha, D. (2009). Psychotherapeutic treatment for anorexia nervosa: Modernist, structural treatment approaches, and a post-structuralist perspective. *Counselling, Psychotherapy, and Health*, *5*(1), 1-46.

Bruner, J. (1986). *Actual minds, possible worlds*. Cambridge: Harvard University Press.

Bruner, J. (1990). *Acts of meaning*. Cambridge: Harvard University Press.

Bruner, J. (2004). Life as narrative. *Social Research, 71*, 691-710.

Byrne, S., & McLean, N. (2001). Eating disorders in athletes: A review of the literature. *Journal of Science and Medicine in Sport, 4*, 145-159.

Carless, D. (2008). Narrative, identity, and recovery from serious mental illness: A life history of a runner. *Qualitative Research in Psychology, 5*, 233-248.

Charmaz, K. (1991). *Good days, bad days: The self in chronic illness and time*. New Brunswick, NJ: Rutgers University Press.

Coffey, A., & Atkinson, P. (1996). *Making sense of qualitative data*. London: Sage.

Cole, A. L., & Knowles, J. G. (2001). Principles guiding life history researching. In A. L. Cole, & J. G. Knowles (Eds.), *Lives in context: The art of life history research* (pp. 25-44). New York: AltaMira Press.

Connors, M. E., & Morse, W. (1993). Sexual abuse and eating disorders: A review. *International Journal of Eating Disorders, 13*(1), 1-11.

Crossley, M. L. (2000). Narrative psychology, trauma and the study of self/identity. *Theory and Psychology, 10*, 527-546.

Currie, A. (2007). A psychiatric perspective on athletes with eating disorders. *Journal of Clinical Sport Psychology, 1*, 329-339.

Davies, B., & Harre, R. (1999). Positioning and personhood. In R. Harre, & L. van Langenhove (Eds.), *Positioning theory: Moral contexts of intentional action* (pp. 32-52). Oxford: Blackwell.

Dosil, J. (2008). *Eating disorders in athletes*. Chichester: Wiley.

Ellis & Bochner, (2000). Autoethonography, personal narrative, reflexivity: Researcher as subject. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 733-768). London: Sage.

Everill, J., & Waller, G. (1995). Reported sexual abuse and eating psychopathology: A review of the evidence for a causal link. *International Journal of Eating Disorders, 18*(1), 1-11.

Frank, A. W. (1995). *The wounded storyteller: Body, illness and ethics*. Chicago: University of Chicago Press.

Frank, A. W. (2007). Five dramas of illness. *Perspectives in Biology and Medicine, 50,* 379-394.

Gergen, K. J. (2001). Psychological science in a postmodern context. *American Psychologist, 56,* 803-813.

Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40,* 266-275.

Gubrium, J. F., & Holstein, J. A. (2009). *Analyzing narrative reality*. London: Sage.

Hepworth, N., & Paxton, S. J. (2007). Pathways to help-seeking in bulimia nervosa and binge eating problems: A concept mapping approach. *International journal of eating disorders, 40,* 493-504.

Hiles, D., & Cermak, I. (2008). Narrative Psychology. In C. Willig & W. Stainton-Rogers (Eds.), The Sage handbook of qualitative research in psychology (pp. 147-164). London: Sage.

Holstein, J., & Gubrium, J. F. (2000). *The self we live by: Narrative identity in a postmodern world*. New York: Oxford University Press.

Hulley, A., & Hill, A. J. (2001). Eating disorders and health in elite women distance runners. *International Journal of Eating Disorders, 30,* 312-317.

Hyden, L. (1997). Illness and narrative. *Sociology of Health and Illness, 19,* 48-69.

Jarvinen, M. (2004). Life histories and the perspective of the present. *Narrative Inquiry, 14,* 45-68.

Johnson, M. D. (1994). Disordered eating in active and athletic women. C*linical sports medicine, 13*, 255-269.

Kerr, G., Berman, E., & De Souza, M. (2006). Disordered eating in women's gymnastics: Perspectives of athletes, coaches, parents and judges. *Journal of Applied Sport Psychology*, *18*, 28-43.

Kirkman, M., Rosenthal, D., & Smith, A. M. A. (1998). Adolescent sex and the romance narrative: Why some young heterosexuals use condoms to prevent pregnancy but not disease. *Psychology, Health, and Medicine*, *3*, 355-370.

Klump, K. L., Miller, K. B., Keel, P. K., McGue, M., & Iacono, W. G. (2001). Genetic and environmental influences on anorexia nervosa syndromes in a population-based twin sample. *Psychological Medicine, 31*, 737-740.

Lee, S. (1995). Self-starvation in context: Towards a culturally sensitive understanding of anorexia nervosa. *Social Science and Medicine, 41*, 25-36.

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis, and interpretation*. London: Sage.

Lock, A., Epston, D., & Maisel, R. (2004). Countering that which is called anorexia. *Narrative Inquiry, 14*, 275-301.

Lock, A., Epston, D., Maisel, R., & de Faria, N. (2005). Resisting anorexia/bulimia: Foucauldian perspectives in narrative therapy. *British Journal of Guidance and Counselling*, *33*, 315-332.

Manderson, L., Bennett, E., & Andajani-Sutjahjo, S. (2006). The social dynamics of the interview: Age, class, and gender. *Qualitative Health Research*, *16*, 1317-1334.

Marcus, G. E. (1994). What comes (just) after “post”? The case of ethnography. In N. K. Denzin & Y. S. Lincoln (Eds.), *The handbook of qualitative research* (pp. 563-574). Thousand Oaks, CA. Sage.

McAdams, D. (1993). *The stories we live by: Personal myths and the making of the self*. New York: William Morrow.

McAdams, D. (2001). The psychology of life stories. *Review of General Psychology, 5*, 100-122.

McLeod, J. (1997). *Narrative and psychotherapy*. London: Sage.

McMahon, J., & DinanThompson, M. (2008). A malleable body – revelations from an Australian elite swimmer. *Healthy Lifestyles Journal*, *54*, 1-6.

Monsma, E. V., & Malina, R. M. (2004). Correlates of eating disorder risk among female figure skaters: A profile of adolescent competitors. *Psychology of Sport and Exercise*, *5*, 447-460.

Muscat, A. C., & Long, B. C. (2008). Critical comments about body shape and weight: Disordered eating of female athletes and sport participants. *Journal of Applied Sport Psychology*, *20*, 1-24.

Neimeyer, R. A., Herrero, O., & Botella, L. (2006). Chaos to coherence: Psychotherapeutic integration of traumatic loss. *Journal of Constructivist Psychology, 19*, 127-145.

Neumann, D. A., Houskamp, B. M., Pollock, V. E., & Briere, J. (1996). The long-term sequelae of childhood sexual abuse in women. A meta-analytic review. *Child Maltreatment*, *1*, 6-16.

Ochs, E., & Capps, L. (2001). *Living narrative: Creating lives in everyday storytelling*. Cambridge, MA: Harvard University Press.

Pachankis, J. E. (2007). The psychological implications of concealing a stigma: A cognitive behavioural model. *Psychological Bulletin, 133,* 328-345.

Papathomas, A., & Lavallee, D. (2006). A life history analysis of a male athlete with an eating disorder. *Journal of Loss and Trauma, 11*, 143-179.

Papathomas, A., & Lavallee, D. (in press). Athlete experiences of disordered eating in sport. *Qualitative Research in Sport and Exercise*.

Petrie, T. A., & Greenleaf, C. A. (2007). Eating disorders in sport: From theory to research to intervention. In G. Tenebaum & R. C. Eklund (Eds.), *Handbook of sport psychology* (3rd ed., pp. 352-378). Hoboken, NJ: John Wiley.

Petterson, G., Rosenvinge, J. H., & Ytterhus, B. (2008). The "double life" of bulima: Patients' experiences in daily life interactions. *Eating Disorders: Journal of Treatment and Prevention, 16,* 204-211.

Pillow, W. S. (2003). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *Qualitative Studies in Education, 16,* 175-196.

Plummer, K. 2001: *Documents of life 2: an invitation to a critical humanism*. London: Sage.

Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences*. Albany, NY: SUNY Press.

Rapley, T. (2004). Interviews. In C. Seale, G. Gobo, J. F. Gubrium, & D. Silverman, (Eds.), *Qualitative research practice* (pp. 15-33). London: Sage.

Reel, J. J., SooHoo, S., Petrie, T. A., Greenleaf, C., & Carter, J. E. (2010). Slimming down for sport: Developing a weight pressures in sport measure for female athletes. *Journal of Clinical Sport Psychology, 4,* 99-111.

Rich, E. (2006). Anorexic dis(connection): Managing anorexia as an illness and an identity. *Sociology of Health and Illness*, *28*, 284-305.

Ricoeur P. (1984). *Time and narrative, Vol. 1*. Chicago: University of Chicago Press.

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Thousand Oaks: Sage.

Roberts, G., & Holmes, J. (1999). *Healing stories: Narrative in psychiatry and psychotherapy*. Oxford: Oxford University Press.

Sarbin, T. (Ed.). (1986). *Narrative psychology: The storied nature of human conduct*. New York: Praeger.

Saukko, P. (2008). *The anorexic self: A personal, political analysis of a diagnostic discourse*. Albany, NY: SUNY Press.

Sherman, R. T., & Thompson, R. A. (2001). Athletes and disordered eating: Four major issues for the professional psychologist. *Professional Psychology: Research and Practice*, *32*, 27-33.

Shohet, M. (2007). Narrating anorexia: "Full" and "Struggling" genres of recovery. *Ethos*, *35*, 344-382.

Smith, B., & Sparkes, A. C. (2008). Changing bodies, changing narratives and the consequences of tellability: A case study of becoming disabled through sport. *Sociology of Health & Illness*, *30*, 217-236.

Smith, B., & Sparkes, A. C. (2009a). Narrative analysis and sport and exercise psychology: Understanding lives in diverse ways. *Psychology of Sport and Exercise*, *10*, 279-288.

Smith, B. & Sparkes, A. C. (2009b). Narrative inquiry in sport and exercise psychology: What can it mean and why might we do it? *Psychology of Sport and Exercise*, *10*, 1-11.

Smith, J. K., & Deemer, D. (2000). The problem of criteria in the age of relativism. In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (2nd ed., pp. 877-896). London: Sage.

Smolak, L., Murnen, S., & Ruble, A. E. (2000). Female athletes and eating problems: A meta-analysis. *International Journal of Eating Disorders, 27*, 371-380.

Somers, M. R. (1994). The narrative constitution of identity: A relational and network approach. *Theory and Society, 23*, 605-649.

Sparkes, A. C. (2002). *Telling tales in sport and physical activity: A qualitative journey*. Champaign Ill: Human Kinetics.

Striegel-Moore, R. H., Silberstein, L. R., & Rodin, J. (1986). Toward an understanding of risk factors for bulimia. *American Psychologist, 41*, 246-263.

Stuhlmiller, C. M. (2001). Narrative methods in qualitative research: Potential for therapeutic transformation. In K. Gilbert (Ed.), *The emotional nature of qualitative research* (pp. 63-81). NY: CRC Publishers.

Tang, S. S. S., Freyd, J. J., & Wang, M. (2008). What do we know about gender in the disclosure of child sexual abuse? *Journal of Psychological Trauma, 6*(4), 1-26.

Thompson, R. A., & Sherman, R. (2009). The last word on the 29th Olympiad: Redundant, revealing, remarkable, and redundant. *Eating Disorders: Journal of Treatment and Prevention, 17*, 97-102.

Hudon, J. I., Hiripi, E., Pope, H. G., & Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological Psychiatry, 61*, 348-358.

Thompson, R. A., & Sherman, R. (2010). *Eating disorders in sport*. NY: Routledge.

Tillmann-Healy, L. M. (1996). A secret life in a culture of thinness: Reflections on body, food, and bulimia. In C. Ellis & A. P. Bochner (Eds.), *Composing ethnography: Alternative forms of qualitative writing* (pp. 76-108). Walnut Creek, CA: AltaMira Press.

Torstveit, M. K., Rosenvinge, J. H., & Sundgot-Borgen, J. (2008). Prevalence of eating disorders and the predictive power of risk models in female elite athletes: A controlled study. *Scandinavian Journal of Medicine and Science in Sports*, *18*, 108-118.

Van Maanen, J. (1988). *Tales of the field*. Chicago: University of Chicago Press.

Wilson, G. T., & Fairburn, C. G. (2002). Treatments for eating disorders. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (2nd ed., pp. 559-592). New York: Oxford University Press.