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Illness Experiences and Medical Discourses: A Case Study about Recovery from Eating Disorders in Japan

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Abstract

This study aims to explore how illness experiences were influenced by medical discourses. In recent times, eating disorders have recognized social problem in Japan, and now it has become easy for individuals to obtain medical information about eating disorders. This study identified a strong influence between the information through the Internet, books, and the advice of psychiatrists and their recovery experience. In this paper, the recovery experience of one participant in particular is examined in detail. It was clear that certain explanations of eating disorders can exacerbate the situation, while some can lead to recovery.

KEY WORDS: medical discourses, eating disorders, recovery, qualitative survey, Japan

Introduction

Outside Europe and the United States, Japan is the only country in which eating disorders have received much attention in the latter half of the twentieth century. Recent Japanese epidemiological studies show that one out of every 500 female high school students is estimated to have anorexia nervosa and one out of 50 has bulimia (Nakai, 2004). Further, terms such as kyoshokushou (anorexia) and kashokushou (bulimia) have become increasingly well known, and sesshokushougai (eating disorders) are now widely recognized in the Japanese society.

The proliferation of the Internet has allowed medical information to be shared not only among specialists but also among people who suffer from eating disorders. In fact, medical information from books and on the Internet may have a greater influence on people who starve themselves and binge-purge.

From interviews conducted with people who had recovered from eating disorders, I found that many individuals had some knowledge about eating disorders. For example, Ms. A, a 24-year-old woman with a

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four-year history of binge eating and purging, knew about eating disorders before she started starving herself. She explained that she deliberately chose to engage in anorexic behavior because she wanted to be sick and not because she wanted to be thin.

> I've never wanted to be thin or anything like that. I started dieting when I was 18 years old, well, because of a broken heart…. I wanted him to worry about me…. Yeah, I thought he would worry about me if I got sick. Of course, I didn't know how to make myself sick, so I thought that losing weight was the fastest thing I could do. I knew about eating disorders before from reading a book or something, and I remembered that people could eventually get sick from vomiting and not eating. I think I could just have an eating disorder. It's strange, but I decided to be anorexic. At first, I had a really strange method. I would get hungry if I didn't eat; but I wanted to get sick and so I would force myself not to eat.

In this case, the self-starving was not directly related to thoughts about losing weight or being thinner. It is clear from her narrative that her eating problem was triggered by her knowledge of eating disorders. Thus, it is clear that those who deal with eating disorders should not ignore the influence of medical information.

This paper looks at case studies of Japanese who have recovered from eating disorders and analyzes how a participant's illness experience is affected by medical discourse. It will try to identify the meanings that individuals associate with binge eating or purging and investigate how these meanings change over time. Although the issue of recovery from eating disorders in Japan has been discussed previously (Nakamura, 2004, 2006, 2007), in this paper, I would like to consider the process of recovery in more detail, particularly in view of the discourse environment. I will first summarize previous research conducted on this topic and clarify the analytical perspective of this paper. Then I will detail the narratives of individual participants who have recovered and finally draw conclusions.

Literature Review

The social construction of medical knowledge

Some sociologists have considered a knowledge of psychiatry and psychology were socially constructed (Foucault, 1963; Conrad & Schneider, 1992); this understanding extends to eating disorders as well. Sociologists and historians have considered the changing understanding of self-starving or binge eating through time (Brumberg, [1988] 2000; Gremillion, 1992; Hepworth, 1999; Mizrachi, 2002; Swartz, 1987; Vandereycken & van Deth, 1994).

For example, Brumberg ([1988] 2000) had surveyed the medicalization of self-starvation over time; she showed that women fasted to demonstrate religious devotion in the Middle Ages. Hepworth (1999) also showed that anorexia nervosa was a product of medical science. She observed that anorexia nervosa only came to be defined medically in the latter half of the nineteenth century, and began being studied scientifically in the early twentieth century.

A closer look at these historical developments shows that the ideology and politics of psychiatry and psychology are interwoven into our present understanding of eating disorders.

The social construction of illness

Previous studies have made it clear that anorexia nervosa was constructed as an object of medical science and also demonstrated that the perspective and knowledge about eating problems tends to change over time. At the same time, several studies have examined how this psychiatric and psychological knowledge and the medical diagnoses affect the individual's illness experiences. The Japanese sociologist Asano has argued that the medical concept of "eating disorders" emphasizes the deviance or abnormality of the sufferer's behavior or personal nature, and the concept acts as a "strong social force against recovery" (Asano, 1996, p.119).

Similarly, Kato (1997) explored why family factor models-wherein childhood family relationships, especially mother-daughter relationships, are deemed the cause of eating disorders-are widely accepted in the Japanese society. The participant in Kato's study linked her eating problems to her childhood family relationships only after reading books that cited the family as the cause of eating disorders. Kato found that the mechanism whereby an individual accepts that the family is the cause of his/her eating problems, leads the individual to recall only problematic memories from childhood. The individual then pieces together these fragmented memories and creates a story that fits into the notion that his/her eating disorders can be traced back to family problems. This story gains more credibility as it is retold firsthand to others by people who have eating problems; this is how the family factor model is established into society's collective mind. As Asano (1996) and Kato (1997) have indicated, familiarity with specialist medical knowledge and interpretation can influence the person suffering from eating disorders in many ways.

This study builds on the work of Asano and Kato. However, this study focuses on how people who did recover managed to overcome the "social forces" that Asano identified as a barrier to recovery. While Kato discussed the process through which an individual comes to adopt a family factor

model in her personal story of illness, in this paper, I ask whether the individual ever subsequently revises this story. Finally, while Asano and Kato focused on the power of a medical discourse to influence the sufferer, I suggest that people with eating disorders should not only be regarded as passive, powerless patients; instead, in this paper, I focus on the patients' power to give new meaning to their eating problems and their power to pave the way to recovery.

Data and Methods

Analysis

The cases of this study will be explored within the "natural history of trouble" framework proposed by Emerson and Messinger (1977). Emerson and Messinger found that "many troubles, particularly when first noted, appear vague to those concerned. But as steps are taken to remedy or manage that trouble, the trouble itself become progressively clarified and specified" (Emerson & Messinger, 1977, p. 123). They found that, as the individual undergoes a series of treatments to try to address his/ her uncomfortable and painful feelings, the specialists involved in the case will gradually identify and define the trouble and determine the action to be taken. In other words, Emerson and Messinger argue that "troubles," far from being objective or static, are continuously organized in an interactive process that is prompted by the intervention of doctors or family and friends, efforts toward treatment, and the everyday surroundings of the individual.

According to Emerson and Messinger, the "troubleshooter" has the greatest influence in this configuration of trouble. In this framework, troubleshooters are people with special knowledge or training, who define trouble and outline processes to address it. The definition of trouble vary depending on whether the troubleshooter is a physician, a psychologist, or a police officer. In case a new definition for a trouble is formed, all previous definitions and solutions will be rejected as void.

With this process in mind, the "natural history of trouble" approach to understanding a problem involves observing and analyzing the timeline of how a particular trouble has been defined and redefined, through the process of social interaction. This framework is appropriate to achieve the objectives of this paper as I examine how medical discourses relate to the illness experience of eating disorders from onset to recovery.

Participants

The participants in this study were 18 Japanese individuals who had recovered from an eating disorder[1)]. While all of these narratives are worthy of inclusion in this paper, it would be impossible to give due attention to each of them. Therefore, in this paper, I believe that the most appropriate

way to carefully examine the experience of an eating disorder from onset to recovery is through a single case study[2]. Therefore, I selected the case of Ms. U, a 26-year-old woman who had engaged in binge eating and purging for about eight years, as the key case study; I also included some brief testimonies from other participants to supplement this case study.

Ms. U was chosen as a case study for several reasons. First, of all the participants, she was the one who explained the most clearly how her life changed as she attached various meanings to binge eating and purging. Second, she maintained a webpage where she described her feelings regarding her experience with eating disorders. Since she permitted me to quote from her writing on the webpage, she offered a larger data sample as compared to other participants. In an effort to achieve a more complete picture of her experience, I have drawn on data garnered in interviews and data from her own website. To make the distinction between the data clear, in the rest of this paper, single quotation marks ('…') indicate interview data (date of interview 2005. 2. 26/2006.11.18) and double quotation marks ("…") indicate Ms. U's website (http://homepage3. nifty. com/girlsschool/mentaltrainingtop.htm, 2003.4.1).

The micro-politics of trouble about eating disorders: Ms. U's case

The adverse effects of diagnosis: From trouble to "eating disorders"

Although Ms. U describes herself as a "chubby child" growing up, she says she "never felt bad about being fat" and she had "practically no really bad memories." The first time she ever thought that being fat might be a problem was when she was enrolled in a class for overweight children in elementary school. She describes the effect of this incident: "after that, I thought I had to lose weight-and being fat became a big complex for me."

In the summer of her junior year in high school, she decided to go on a diet after reading about it in a women's magazine. Her weight plummeted from 56 kg at the start of the summer vacation to 40 kg by winter. Having lost a significant amount of weight, Ms. U decided to stop dieting. However, when she tried to go back to eating normally, she found that she was unable to stop; she was too afraid of gaining weight. Although she realized that "something was wrong" and decided to force herself to eat more, Ms. U writes, "I had already reached the point where I couldn't forgive myself for gaining even 1 kg." She did not want to gain weight and was going on a diet. However, it became increasingly difficult to maintain her weight and regained weight gradually. When she reached 46 kg, she began to "panic." One day,

she forced herself to vomit after dinner because she was afraid of gaining weight. After vomiting, she lost her fear of eating and began to binge and purge habitually.

It was around this time that Ms. U went to the library and learned from a book that she had an "eating disorder." She describes this experience in the following extract from her website:

> I didn't know what eating disorders were, but when I pulled the book out and read it, it was like, wow, this is exactly it.

Ms. U then proceeded to read many books about eating disorders in an effort to find out what was causing her behavior.

> I thought, if I can just find out why I'm doing this, and if I can fix it, then I would get better. Life would be easier. I totally immersed myself in anything related to eating disorders, and the whole time I was getting more and more sick.

Emerson and Messinger argue that "the effort to find and implement a remedy is critical to the processes of organizing, identifying, and consolidating the trouble" (ibid, 1977, p.122). This is illustrated in Ms. U's statement where she makes clear that, even while she was constantly reading about anything that might help her stop binge eating and vomiting, her condition continued to worsen. This was a trend that I saw in many of the participants. Like Ms. U, many of them first learned of the concept of "eating disorders," especially "bulimia" and "anorexia," from books or the Internet. This awareness of their condition affected the participants in different ways. For example, Ms. B, a 36-year-old woman who engaged in binge eating for twelve years, said,

> Even if someone has an eating disorder, I don't think you should tell them you are "eating disorders." Because they'll turn themselves into some kind of tragic heroine-a lot of people think, oh, I'm sick, poor me, and they don't try to get better.

Ms. B clearly believed that diagnosing someone with eating disorders actually inhibits recovery because these people will be more likely to cast themselves as tragic heroines, which impedes recovery. Her example reminds us that a diagnosis is not a static label; rather, an individual's experience is created, maintained, and changed when their illness is given a name. As we will see below, there are a number of typical interpretations that individual's tend to make after they have been diagnosed with an eating disorder; these interpretations often lead to new problems.

Meanings create reality: professional intervention and discovering familial factors

A closer look at Ms. U's diagnosis process can help us understand how the definition of a condition influence its progress:

> When I found out that my behavior was an eating disorder, I also read in the same book that the major cause of it is the relationship with parents. I was really struck by this and I thought my eating problems weren't my fault.

Thus, Ms. U first came across the familial model. When she was eighteen, Ms. U was admitted to a prestigious university; however, she continued her cycle of binge eating and purging. Soon after she enrolled in the university, she got a boyfriend. Ms. U wanted to spend more time with her boyfriend. However, her house was located far from the campus; therefore, she began to consider getting an apartment and living on her own. She believed that the only way she could convince her parents that she should live alone would be to reveal that she was bulimic, since they were not yet aware of her behavior. She decided to write a letter to her parents telling them about her bylimic behavior, in the hope that this might prompt them to let her live alone.

> I took quotes from books I had read and then wrote my parents a letter saying that there were doctors who thought I should live separately from my parents to recovery, and that I wanted to live on my own.

Her parents then took her letter to an acquaintance of theirs who was a psychiatrist and asked for his advice.

> When my parents took this letter to the psychiatrist, the doctor happened to staunchly believe that it was the family's fault, and he said it was my parents, not me, who were wrong…. The doctor read my letter and said that he was really impressed that I had analyzed the situation so well, and that my parents should let me do what I wanted. But, until then, we were arguing every day. We fought everyday and I didn't go home. Of course the relationship between my parents went bad. Most of books said that sufferers' mothers were responsible for their daughters' eating problems. So, then my dad blamed my mom, and there was no one to support her. She was really, really hurt and pretty much a wreck. Oh, we were all confused; I just got out of the house as soon as I could. Until I graduated from university, I probably called home maybe once a month, if that. We were estranged.

The psychiatrist placed the blame on Ms.

U's parents but did not offer help or introduce them to a family therapist to support her family. In other words, Ms. U's family was thrown into confusion because of the intervention of a professional; the family was left with only problems and no solution. As Ms. U describes, her mother was deeply hurt, the family fell apart, and Ms. U left home. "When I think about it now," she says, "it was like taking myself hostage and threatening my parents. It was pretty awful."

All 18 of the participants in this study were aware of the familial model, and many other participants also spoke of being influenced in some way by the familial model. For example, Ms. C, a 23-year-old woman who had engaged in binge eating and purging for nine years, explains,

> I was brainwashed by books. For typical eating disorders, these books say that it's related to family problems or how you were raised as a child. So, after reading those books, I began looking for the cause of my disorder on my own.
>
> —You were obsessed with finding out the cause?
>
> Yes. I thought, my family is the cause, and then I hated my father and my mother, I could not even tolerate the most trivial aspects that I did not like about my parents. But, when I think about it now, there was nothing really abnormal about my family.

It was only after Ms. C found out about the family factor model from books that she began believing that her eating problem was caused by her parents. This is similar to an incident discussed by Kato (1997), where an individual linked her eating problem to her family relationships during childhood only after she had read books on the subject.

Returning to Ms. U's case, we can see how an intervention by a doctor, that is, a "troubleshooter," can give rise to new problems in family relationships. Not only did Ms. U's binge eating and purging continue, but her family situation also worsened. The sociologist Miller (1987) has argued that family therapy created family problems. In other words, by explaining so many dysfunctional behaviors on the basis of the family situation of the sufferer, more dysfunctional families have been created.

Indeed, Ms. U identified this when she says, "although my family did play a role in my behavior, and I can't say that my family situation is completely unrelated, nevertheless, I don't think that the family explanation impacted my condition in a helpful way."

Ms. U became aware of the potential dangers of this tradition "family" explanation for behavioral problems:

> There is no way a family can change right away. They might change little by little, but they're not going to have some dramatic change and become a totally

different family. The irritating thing is that we start by trying to fix the family problems and then the binge eating and vomiting itself just gets ignored during treatment.

As Ms. U narrated, and as my research has highlighted, when blame is placed only on the family, it becomes difficult to change the individual' s situation or that of the individual's family immediately. In the next section, we will examine what happened to Ms. U after she moved out of her family home.

Behavior creates reality: the psychiatric exam and the sick role

After Ms. U graduated from university, she was offered a job at one of the companies of her top choice. In her first year, she often came home from work very late; nonetheless, she would still binge eat and purge when she got home, and she often managed to get a few hours of sleep before going to work again the next morning. She had no time to relax, either physically or mentally. Eventually, this stressful cycle of behavior exhausted her and she felt that she was unable to go to work. She decided it was time to see a psychiatrist.

—Did doctor tell you that you had an eating disorder?

"It was the one called bulimia I think."

—He told you this in the first consultation?

"Yes. He diagnosed me with bulimia and depression. So, I then took a break for a month."

—Did you decide to take a leave on your own?

"The doctor said I should take a break."

At the hospital, Ms. U was diagnosed with "bulimia nervosa" and "depression"; she was prescribed medication and told to take leave from work. When she returned to work after one month, her co-workers treated her with great care and her workload was considerably lighter than before. However, she felt guilty about increasing the workload of her colleagues; she began to feel depressed about being "useless at work and in life in general." Two weeks after returning to work, she overdosed on antidepressants and sleeping pills and was taken by ambulance to the emergency room. On her webpage, she writes about the incident: "It's not that I wanted to die. I just wanted to escape from reality."

At this time, Ms. U decided to resign from her job. Despite the fact that Ms. U had been binging and purging every day for several years, she still managed to graduate from a top university and she successfully secured a job with a top company; when her condition forced her to resign from her job, it was, as Ms. U reflected, "probably the first major setback of my life."

As Emerson and Messinger (1977) have

observed, the moment a troubleshooter such as a doctor, lawyer, or police officer actively intervenes in a problem, the nature of the trouble changes drastically; it is transformed from a private matter to a public one, and this transformation has dramatic ramifications for the patient. After her behavior was given an official name, the binge eating and purging that Ms. U had started in high school were, in a sense, moved into the public arena when she took leave from work and eventually resigned from her job.

After she quit a job, Ms. U continued to attend the hospital for consultations with her psychiatrists for four months. She explains that, during these sessions, the doctor simply listened to her: "I remember that the doctor kept telling me that I should rest and try to live a more balanced life." However, today, Ms. U still does not understand what the point of her treatment was. She had sought a "concrete way to actually stop binge eating," but she found that all that her counseling provided was "a place to spill my worries and even then it was completely ineffective. They didn't give me any real answers. All I got was medication."

> If the doctor asked me what was so hard about my life, I desperately tried to come up with topics about the latest thing that was supposed to be bothering me. I mean, the doctor wouldn't say anything unless I said something first. There were even times when the counseling ended and pretty much nothing had been said.

Counseling did not improve her situation at all; rather, she felt that she "developed a certain sense of resignation." She began to think, "I'm sick and there's no way to save me. I' m different from other people." Furthermore, Ms. U says that, as the sessions progressed, she increasingly identified herself as a "tragic heroine." Gradually, she lost faith in the doctor and stopped going to the hospital because she thought it would never make her better.

Many other participants reported a similar experience. For example, Ms. D, a 26-year-old woman who had engaged in binge eating and purging for eight years, related the following:

> I only started to recover when it wasn't my major life goal anymore to stop binge eating. When I actually tried to stop binge eating, it didn't get better…. I tried really hard. I went to all kinds of therapy. I became absorbed in psychology and psychiatry and I went around to different workshops and healing sessions. I wanted to find something that would make me better. But when I stopped doing that, and it wasn't like my life's purpose anymore, I thought, okay, so I might still be binge eating but that doesn't mean I shouldn't

> enjoy life. When I started doing the things that I liked, the binge eating started to go away. If I focused on it too much, I started to feel like I was only making it worse. Even though you' refocusing on the condition, in the hope that this focus might make it better, the fact is, you' re not thinking about anything other than your binge eating, so there's no way that it can get better.

In her efforts to get better, Ms. D describes how she was unable to think about anything other than her binge eating and mental treatments. In traditional approaches to psychological therapy, the client is treated as a "patient" and they are encouraged to talk about their current problems. However, this method has been criticized for fostering and maintaining the individual's problem by placing them in a therapist-dependent patient role.

In recent years, new types of therapy based on "social constructionism" have been gaining attention. The most popular types include narrative therapy, brief therapy, and the solution-focused approach. These new types of therapy depart radically from traditional therapies, which are based on the etiological model. For instance, de Shazer, who advocates brief therapy, divides conversation during a therapy session into "problem talk" and "solution talk." For example, during a typical session, an individual is encouraged to talk for 30 minutes about his/her problems in life; then he/she is encouraged to focus on his/her pessimistic feelings. After this, the individual is encouraged to talk for 30 minutes about his/her successes in life and focus on feelings of achievement. At the end of each section, both the therapist and the individual report lower spirits after the pessimistic session and higher levels of happiness after the optimistic session (de Shazer, 1994).

Following de shazer's findings, by talking about her problems with the doctor, Ms. U began to define herself as a person with problems. By resigning from her job, she lost confidence in herself as a responsible adult. By behaving as if she were a patient, she became more like one. By going to the hospital and taking medicine, she behaved more like a person who was ill. These actions were responsible for creating the reality of her as a bulimic patient.

From the time Ms. U began her first diet to the time she resigned from her job, we can see the same recurring pattern: in trying to fix the problem, it only became worse or led to new problems. When Ms. U's behavior was actually explained, the explanation itself created the reality of her illness, while her binge eating and purging was allowed to continue. The condition and treatment became self-fulfilling. In the next section, we will examine how her problems were solved and how Ms. U managed to recover.

New meanings lead to recovery:

discovering the stories of recoverers

After she resigned from her job, Ms. U spent her days "going from the convenience store, to my room, to the toilet, and back"; she spent a significant amount of her savings during this time. After two months, a friend of her father introduced her to a new employer and she was offered a job; she began working again. Although she continued to binge and purge, being around people prompted her to want to stop her behavior. At this time, despite vomiting, she began to gain weight rapidly. She thought that if she was gaining weight even when she was vomiting, then it would be preferable to gain weight by eating regularly.

> I was binging and vomiting left and right, and I dreamed of getting my old thin body back. But that was impossible. It would never happen unless I began refusing food. But more than that, I thought for the first time that I didn't want my life to be controlled by food and my body anymore.

For the first time since her dietary behavior began, Ms. U reached a turning point; she decided to give up trying to lose weight. In many cases, even after a person suffering from an eating disorder loses the strong desire to be thin, binging and purging will continue because he/ she does not know how to stop. In Ms. U's case, she came across the website of someone who had overcome their eating disorder. The website described how the girl had stopped refusing to eat and had halted her vomiting behavior by ensuring that she ate fixed amounts of food.

> I was surprised because I'd never tried this approach and I only knew about psychological approaches. I thought: Of course! All I had to do was change my eating habits. Until then, it was either binge or don't eat much at all. Eat three meals a day of what I want, how I want it. If I eat right, I might gain weight. But I thought I wouldn' t regret gaining weight if I was living a healthy life instead of binging and vomiting and gaining weight anyway. I didn't want to get fat. But then I thought, this is my only choice.

Ms. U began cooking on her own. If she ate too little she would feel like binging; so at first, she made meal plans and tried to eat set amounts of food. After approximately three months of following this routine, her overeating had mostly stopped and she began to be less concerned about losing weight.

> It's not that once I stopped binging, it was gone forever. If it didn't happen for a week, I knew it still might happen again. That's the way it was for me. I would be okay for about a week, and

> then I would do it again. But, the time between binging sessions got longer and longer–next it would be two weeks, then three weeks; then I was okay for a whole month. When I made it through the whole month, I was so excited. After that one month, I stopped doing it at all–so I guess that one–month landmark is pretty big. If you were to ask me when I recovered, it would have to be when I reached that first one–month mark. That's when I really thought, it's going to be okay.

The social psychologist Gergen has written that "a transformation in discourse may frequently provide a release from the tyranny of the implied authority of governing beliefs" (Gergen, 1994, p. 250). This can be seen clearly in Ms. U's case; she had the opportunity to find new meanings in her condition and consider a new solution, that is, to stop binge eating by not dieting and eating properly instead.

The turning point for Ms. U came when she transformed the meanings of her binge eating. Just as associating certain meanings with a problem can make the situation worse, changing these meanings can make it better. Some interpretations of a problem only complicate it while others can make recovery a reality.

Obtaining new meanings: post-recovery

Now fully recovered, Ms. U recalls her experience:

> When I left home, I half–believed the explanation that my eating problem was my family's fault. Or maybe I believed it a little more than that. But when I think about how I was away from my parents for about five years with college and working, I really wonder about that–because not only did I not get better at all, I got worse. I've got better because I eat properly, not because anything has changed about my relationship with my parents. I was ill because I didn't eat right! That's what I think now–that I was ill because I wasn't eating right.

On her webpage, Ms. U examines her past experiences again, in further detail:

> I didn't begin the recovery process when I blamed my parents and left home. I didn't recover when I didn't have to worry about college entrance exams anymore, and I didn't recover when I didn't have to worry about what I was going to do with the rest of my life. I finally moved forward only when I put an end to my years of thinking that it was "wrong to be fat." I repaired the distorted body image that I had and I worked hard at good eating habits. I used to think, "No way! I don't have an eating disorder just because I want to

> be thin!" (Before, I would have required more exaggerated explanations for my eating disorder).

Ms. U also suggested that eating disorders were a social issue. She stated that "everywhere you look there is this pressure to "Lose weight! Lose weight!" It should be obvious where women get the desire to be thim." Finally, Ms. U expressed her doubts about the efficacy of the "psychotherapy" she had received in the past.

> For any other kind of addiction, the first step of treatment is to stop it. If someone's addicted to drugs, you don't give them drugs. Or you don' t let someone drink alcohol, if they are an alcoholic. So why is only for bulimia that most specialists suggest starting mental care with therapy–It's really strange to me.

Ms. U's comments clearly indicate that her experience of recovery has changed her interpretation of her own past experience with bulimia. The concept of "reclaiming," as defined by the medical sociologist Frank (1995), defines this process of integration between old and new associations of meaning. "Reclaiming" the details on how an ill individual, having been defined as such by specialists and doctors, tries to find a voice of his/ her own to describe his/her own experience. We can see from Ms. U's analysis of her past experiences that there was a period when she understood her problems only on the basis of the opinions of specialists and the information that was circulating in society. After her recovery, however, she reevaluated her understanding of eating disorders. She retold her personal experience of binge eating and purging in her own words. Instead of relying on the statements of doctors and other people, Ms. U told her own story in her own words with the authority of a person who had recovered.

In this way, we see that the conditions of recoverers like Ms. U cannot be easily explained by medical discourses. As subjects of therapy, many individuals are defined by psychiatric and psychological knowledge, but, as Ms. U's experience and the experiences of my participants make clear, they may later disagree with these definitions and present their own new interpretations.

Discussion and Conclusion: Meanings, Stories, and Language

Much of the research on eating disorders in the field of sociology has problematized social environments that drive people to adopt abnormal eating behaviors. These social environments are usually defined as societies that are obsessed with being thin and the diet industry, and as the social norms about women (Bordo, 1993; Fallon, Katzman, & Wooley, 1994; Hesse-Biber,

1997). In contrast to this previous research, this study proposes that medical and psychological knowledge and discourse may contribute significantly to the prolonging of eating disorders.

While studies by Brumberg ([1988] 2000) and Hepworth (1999) adopt a historical approach toward building medical knowledge about eating disorders, this study directly examined the concrete experiences of recoverers to understand how they were affected by present-day discourses on eating disorders.

The findings of this study indicate that various meanings or stories and the language surrounding anorexia nervosa and bulimia nervosa are very influential on an individual's eating disorder throughout the process-from onset to recovery.

Social psychologist Gergen says,

> From the pragmatic perspective, it is of paramount importance, then, to inquire into the effects of the prevailing vocabularies of the mind on human relationships. Given our goals for human betterment, do these vocabularies facilitate or obstruct? And, most important for our purposes, what kinds of social patterns does the existing vocabulary of psychological deficit facilitate (or prevent)? How do the terms of the mental health professions—terms such as "neurosis," "cognitive dysfunction," "depression," "post-traumatic stress disorder," "character disorder," "repression," "narcissism," and so on—function within the culture more generally? (Gergen, 1994, p.147)

Therefore, debates on eating disorders should consider not only those individuals who have eating problems, but also specialists, that is, the doctors and therapists who continue to select the vocabulary that is used in this arena.

I propose that psychiatrists, therapists, doctors, researchers, and, of course, sociologists are themselves part of the problem; they are not merely passive observers. This new perspective, which emerges from the viewpoint of the discourse environment, demands a significant paradigm shift in how we in the field of eating disorders should shape future research, clinical practice, social policy, and discourse environment. How should we talk about eating disorders to support recovery in the future?

1) Semi-structured interviews were conducted with 18 Japanese participants between June 2003 and November 2006. The 18 participants consisted of 16 women and 2 men. At the time of the interview, 11 participants were in their 20s, 6 participants in their 30s, and 1 participant in her 40s. One participant had suffered from an eating disorder for less than two years (measured from the point of the first diet that lead to the disorder and ending with full recovery), five participants had suffered

for more than two years and less than five years, seven participants had suffered for more than five years and less than ten years, and five participants had suffered for more than 10 years and less than 16 years. Of the 18 participants, 17 had experienced binging. Of the 17, 12 had experienced vomiting.

2) In Natural History of Stalking, Emerson, Ferris, and Gardner (1998) generalize interview data from a number of subjects to extract various categorizations regarding how people interpret stalking behavior. Since this type of generalization was not conducted in this study, in this sense, I should note that I have only indirectly referenced Emerson's analytical framework.

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