Storying "Recovery": Exploring the Narratives of Young Women in Eating Disorder Recovery

by
Andrea LaMarre

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ABSTRACT

Storying “Recovery”: Exploring the Narratives of Young Women in Eating Disorder Recovery

Andrea LaMarre
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Advisor: Dr. Carla Rice

This thesis is a qualitative, arts-based exploration of the narratives of young women in eating disorder recovery. Using a new materialist/body becoming theoretical lens, I aimed to determine how young women navigating the ambiguous construct of “recovery” story their experiences, whether these experiences reinforced or challenged dominant discourses around eating disorders, and how social location informed the telling of their stories. I conducted narrative interviews with 10 young women (20-31) from Southern Ontario; three participants also participated in a digital storytelling workshop. Participants articulated a relational “biopedagogy of recovery,” a new set of instructions for body management to which individuals “recovered from” eating disorders are held. The digital storytelling workshop provided a “community of inquiry,” crystallizing themes. Biomedical discourses around eating disorders and recovery may be helpful to a certain point at which they may begin to constrain the possibilities of knowing oneself as recovered.
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Chapter 1: Introduction

Young women deploy various discourses in recounting their experiences of having and overcoming eating disorders and disordered eating. Over the course of this research, the notion of recovery in particular came to the fore as a concept imbued with meaning and laden with morality. A key tension throughout this study was the challenge of putting criteria and labels to states of recovery. Various definitions and experiences of “recovery” weaved in and out of participants’ accounts, with the construct perceived as an ambiguous and sometimes problematic entity. In asking: how do young women story their experiences of having and overcoming an eating disorder? How do these stories challenge or reinforce the dominant discourse about eating disorders? How does an individual’s social location (e.g. sexuality, race, class, socioeconomic status, body size, etc.) inform the content and form of these stories? I discovered that participants’ lived experiences with disordered eating and “recovery” are diverse and complex.

The young women involved in this research made use of various discourses, often interchangeably, in describing their experiences. At times, they troubled the very prescriptions and possibilities for eating disorder recovery offered in the mainstream. However, the young women’s stories are not simply critical of dominant discourses around eating disorders and recovery; on the contrary, these stories reflect a nuanced and complex navigation of discourses that have been felt as alternatively helpful and constraining. Bringing together critical feminist approaches to “reading” eating disorders and dominant biomedical understandings of these disorders with attendance to newer modes of understanding including narrative, body becoming and new materialist lenses, this thesis explores the intersections between these discourses and centralizes the lived, embodied experiences of participants. The narrative interviews and digital stories that form the corpus of data analyzed herein reveal various tensions inherent to
participants’ experiences and opens up space for complexity within experiences that might otherwise have been coded as uniform.

**Objectives**

Many stories are told *about* people who have suffered from mental illness in general, and eating disorders in particular. Fewer stories from the perspectives of diverse individuals who have struggled with and overcome eating disorders become a part of societal discourse. Despite the extensive contribution of critical feminist and narrative approaches to the study of eating disorders, literature exploring the stories of individuals who have overcome eating disorder in their own words and voices remains relatively sparse. Hearing the stories of those whose experiences of disordered eating fall in some way outside of the norm of what we “know to be true” about eating disorders is even more rare.

Filling the gap left by stories that are told about individuals with eating disorders and their experiences of recovery in particular, my research employed qualitative methods to give voice to young women who self-identify as having recovered from eating disorders. I explored these experiences using digital stories (short, first-person films) and narrative interviews to illuminate the unique perspectives of those most affected, the women themselves. Through this exploratory, qualitative and arts-based project, I hoped to answer the following research questions:

- How do young women who identify as having overcome an eating disorder story/narrate their experiences of having and overcoming an eating disorder?
- How do these stories challenge or reinforce the dominant discourse about eating disorders?
- How does an individual’s social location (e.g. sexuality, race, class, socioeconomic status, body size, etc.) inform the telling of their story?
Literature Review

**Dominant Discourses on Eating Disorders.**

The literature on eating disorder etiology, course, and treatment is strongly coloured with a biomedical brush. A large body of literature comments on the need to establish an often illusive “cause and cure” for anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), and eating disorder not otherwise specified (EDNOS), now other specified feeding and eating disorder (OSFED). Anorexia nervosa was first noted in psychological and psychiatric literature as early as 1689 (Silverman, 1987), and has been codified in the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM) since 1980 (Duran et al., 2000). Bulimia nervosa, described by Gerald Russell (1979) as “an ominous variant of anorexia nervosa” that included “the dread of overeating, various compensatory measures, and the morbid fear of gaining weight and getting fat” (Steinhausen & Weber, 2009, p. 1331), entered the psychological arena around 30 years ago. Since this time, clinicians and researchers have sought to better understand these disorders, which are noted to be mental illnesses with high rates of death and low rates of recovery.

Despite an intense focus on determining the cause of and, subsequently, establishing a cure for, eating disorders, the rates of mortality and recovery have remained relatively static over the years (Smink, van Hoeken & Hoek, 2012). The frequently cited recovery statistics around eating disorders still suggest that approximately 50% of individuals diagnosed with eating disorders will completely remit from their disorders, achieving “full recovery,” while 20-30% will exhibit sub-clinical symptoms and 20-25% will not recover; of these, a mortality rate of up to 5% is expected (Steinhausen, 2002; Steinhausen & Weber, 2009). Disagreement on the proper course of treatment and the best system for classifying eating disorders persists. With the recent
release of the fifth iteration of the DSM, significant changes to the classification system for
eating disorders were intended to satisfy, in part, those concerned about the up to 60% of
individuals seeking treatment for eating disorders that defied prior categorizations (Fairburn &
Bohn, 2005; Wade, Crosby & Martin, 2006 in Wonderlich et al., 2007). Though studies indicate
slightly greater diagnostic validity with the new iteration of the DSM (Machado, Goncalves &
Hoek, 2013), the volume has been widely criticized by organizations as well-respected as the
National Institute of Mental Health (NIMH) in the United States (Insel, 2013). The linguistic
shifts between volumes four and five may also take time to shift into public discourse; if EDNOS
was little-known and poorly understood, often deemed a “problem diagnosis,” (Machado,
Goncalves & Hoek, 2013) it is unlikely that OSFED will see a different result.

While a number of criticisms can be lodged at any iteration of the DSM (these criticisms
will be addressed as this literature review progresses), it is helpful to understand the diagnostic
criteria laid out in this tome. In a field in which language has currency and labels dictate the
possibility and potentially the course of treatment (i.e. by providing access to insurance coverage
and certain treatment programs)(e.g. Frank, 2005), diagnoses can hold actual and psychological
weight. In the DSM-IV, anorexia nervosa (AN) was characterized as the “refusal” to maintain
body weight at/above 85% of the “minimally normal” weight for one’s age and height,
accompanied by an intense fear of weight gain/becoming fat (despite being underweight), denial
of the seriousness of low body weight, perceptual disturbances in evaluating body weight or
shape, said to “unduly influence” self-evaluation, and, in females, amenorrhea (American
Psychiatric Association, 2000). Under DSM-IV guidelines, anorexia nervosa was also sub-
divided into two subtypes: restricting and binge-purge. The DSM-IV specified that bulimia
nervosa (BN) included the consumption of an “amount of food that is definitely larger than most
people would eat during a similar period of time and under similar circumstances” accompanied by a perception that one has lost control and compensatory behavior (including but not limited to vomiting), occurring on average at least twice per week over three months; further specifications included that self-evaluation was “unduly influenced by body shape and weight,” and that bingeing and purging did not occur solely “during episodes of Anorexia Nervosa” (APA, 2000). Eating disorder not otherwise specified tended to “catch all” remaining behaviours that crossed the line from normal to pathological but did not fit squarely into the other two categories. In an appendix to the DSM-IV, binge eating disorder was specifically defined in an attempt to limit the large number of individuals receiving a diagnosis of EDNOS; BED was therein defined as “uncontrolled binge eating without emesis or laxative abuse” (APA, 2000).

In the DSM-V (2013), criteria for both AN and BN were made less stringent in order to address the “problem” of the large number of individuals diagnosed with EDNOS and to attempt to more closely capture the actual behaviours and cognitions of individuals engaged in disordered eating. Some clinicians have praised this iteration, suggesting that the new criteria improve upon the “poorly defined and highly heterogeneous entity generated by exclusion” (Helverskov et al., 2011, p. 303) that was EDNOS. Though the edition was just recently released in 2013, studies have begun to suggest a reduction in diagnoses in this “other” category (Machado, Goncalves & Hoek, 2013). This could certainly be seen as an improvement in terms of increasing access to timely care, which some have suggested may be important in improving outcomes for eating disorders treatment (e.g. Le Grange et al., 2007). As up to 70% of those diagnosed with EDNOS under the DSM-IV criteria later presented with clinically significant AN or BN at 30 month follow up (Milos, Spindler, Schnyer & Fairburn, 2005 in Wonderlich et al., 2007), refining and opening up diagnostic criteria was perhaps long overdue. However, whether
increasing the number of individuals fitting into categories of severe mental illness could be seen as a promising direction is debatable: can these categories, no matter how broad, articulate and attend to the need of diverse individuals, who may reject the labels they are given (Boughtwood & Halse, 2010)? What to make of evidence that labels may potentially lead to the rejection of treatment (Becker, Hadley-Arrindell, Perloe, Fay & Striegel-Moore, 2009)? Can expanding diagnostic criteria correspond with the desires of those who feel that the medical care there are offered is imposed or unhelpful (Shohet, 2007), or whose struggles do not fit the modes of change imposed in treatment (Gremillion, 2003; Malson, 2009b)?

Evidently, “the biomedical discourse” does not begin and end with the DSM. However, there is notable crossover between the eating disorders as articulated in the DSM and what we “know to be true” about what constitutes an eating disorder. The way that eating disorders are described in the DSM may colour the ways in which clinicians and others interpret behaviours from individuals so diagnosed. For example, resistance to treatment and non-compliance may be understood as elements of the individual’s pathology, rather than as an indication of incongruity between patient needs and treatment modalities (Malson et al., 2004; Rich, 2006; Ryan, Malson, Clarke, Anderson & Kohn, 2009). The DSM is acknowledged to be at least in part socially constructed (e.g. Cooksey & Brown, 1998; Crowe, 2000); thus, clinical encounters may also inform the categorization of eating disorders in the DSM, as is evidence by the recent revisioning of categories to correspond more closely to the incidence of behaviours in clinical populations. However, the standards on which diagnoses are based tend to stem from largely white populations (Wonderlich et al., 2007), which may lead to missing or mis-diagnosing eating disorders that do not fit the standards established based on a limited subset of the population and/or stereotypes circulating around the “skinny white girl” with an eating disorder held by
clinicians and the general public alike (e.g. O’Hara & Clegg Smith, 2007; Shepherd & Seale, 2010). The problematics of diagnosing individuals who do not fit a prototypical mold emerge, for example, when considering that the majority of individuals of “non-white” background and men are diagnosed with ED-NOS, if they are diagnosed at all (Wonderlich et al., 2007).

Perhaps where biomedical approaches have had the most influence is in developing an understanding of the complex etiology of eating disorders. Earlier studies targeting etiology revealed potential genetic predisposing factors for eating disorders (e.g. Bulik et al., 2006; Wade, Bulik, Neale & Kendler, 2000; Wade et al., 1999); a model that recognizes the biological predisposing factors that can increase vulnerability to developing eating disorders has significantly contributed to expanding understanding of how to identify and treat eating disorders (Bulik, 2013; Wade et al., 2013). Many researchers operating from a biomedical standpoint recognize that “the tension between the stigmatization of fatness, idealization of thinness, and easy access to highly palatable foods, perhaps eaten in secret, could lead to weight control behaviours that can have a destabilising effect on the biology of appetite control” (Treasure, Claudino & Zuker, 2010). These researchers and clinicians understand that humans are not genes in a petri dish: as biological entities, we are continually in the process of changing in response to our environments, which, equally, are mutable in the face of our interactions (Fausto-Sterling, 2000).

Perhaps the largest contribution of quantitative studies has been the extent to which statistics and “big data” have led to widespread recognition of the need to develop better mechanisms for understanding and treating eating disorders. These studies have also increased attendance to the devastating, often long-term, effects on the body wrought by engaging in disordered eating, including severe distress impairing function, recurrent hospitalization,
increased risk for suicidality, obesity, depression, anxiety disorders, and substance abuse (Stice & Shaw 2004). Medical inroads may lead to improvements in the treatment models used to treat eating disorders, for those willing or able to seek treatment. Recognition of the high level of comorbidity in eating disorders may lead to a greater degree of individualization in treatment methods and the concurrent examination of the various “disorders” that may trouble an individual (Bulik, 2013). Further, the medical community is beginning to recognize the worldwide prevalence of eating disorders beyond the Western context, as well as the narrowing of the gap between men and women with eating disorders, particularly those involving binging and/or purging (i.e. bulimia, binge eating disorder)(Treasure, Claudino & Zuker, 2010).

Advanced understanding of the brain chemistry and genetic components of eating disorders may yet improve the ways in which eating disorders are approached and managed, helping to improve treatment outcomes.

However, while the increased acknowledgment of the seriousness of eating disorders has helped in some ways to leverage resources (both human and financial) toward the research and treatment of eating disorders, there have been some unintended consequences of this intensive focus. Media uptake of eating disorder research has led to a proliferation of a discourse of contagion around eating disorders (e.g. Bray, 1996; Burke, 2006), which may reduce individuals with eating disorders to passive victims of a social plague of body dissatisfaction. In such representations, lived, embodied experience may be glossed over or wholly subsumed into the eating disorder (Malson et al., 2011; Warin, 2010). Pathologizing and individualizing approaches may neglect to acknowledge the various elements of individuals’ subjectivities that go beyond (but may intersect with) their behaviours around food, weight and shape.
Labels that circulate around eating disorders in both medical and social discourse can profoundly impact the individual’s experience. An inherent hierarchy may be imposed on eating disorder diagnoses, placing bulimia and/or eating disorder not otherwise specified at the lower end of the spectrum in terms of severity and recognition (Ison & Kent, 2010; Roehrig & McLean, 2010). Herein we can observe some of the problematic discourses circulating around bodies and control that feminist scholars begin to tease apart. Positioning bulimia in diametric opposition to anorexia posits a disdain for the “loss of control over bodily appetites” that bulimia has come to represent (Eckermann, 2009). Further, EDNOS, now OSFED, tends to be read as a “problem diagnosis,” (e.g. Machado, Goncalves & Hoek, 2013) potentially leaving those so diagnosed in somewhat of a state of legitimacy limbo. DSM criteria continue to be criticized for failing to accurately represent the complexity and variety present in individuals’ experiences of disordered eating (Becker, Eddy & Perloe, 2009; Wonderlich et al., 2007). As I will elaborate on in a section on biopedagogies of obesity, weight criteria stipulated in the DSM may also limit the ability of certain individuals to receive diagnoses that they feel resonate with their experiences.

Cross-cultural research has also revealed the boundaries of the DSM categories. For example, Katzman & Lee (1997) problematized the “excessive fear of weight gain” criterion for anorexia, finding that young women in Hong Kong did not present with this symptom. Other notable studies in Fiji (Becker, 2004b) and Japan (Pike & Borovy, 2004) have similarly nuanced the cultural presentations of eating disorders. Such scholars have asked us to move beyond the White thinness ideals so long hypothesized to underlie eating disorder symptomatology (e.g. Burns, 2009; Nasser & Malson, 2009). Significant barriers to treatment seeking may exist among those who do not see their experiences articulated in these criteria and labels, potentially exacerbating noted barriers such as stigma and shame and feeding into stereotypes around who
may have an eating disorder (Becker, Hadley-Arrindell, Perloe, Fay & Striegel-Moore, 2010). Cultural myths including the idea that Black or Latina women are “immune” to eating disorders fail to recognize the nuances of ethno-cultural identity present in diverse young women’s experiences of living in the world (for considerations of these experiences, see for example Anderson-Fye, 2004; Hesse-Biber, Livingstone, Ramirez, Barko & Johnson, 2010; McDonald, 2011; Thompson, 1996). Rice (2014) noted significant distress among Canadian women of diverse races (e.g. Asian and South Asian Canadian women) whose eating problems went undiagnosed as they felt the double bind of their “traditional” and “new” cultures and societies. For example, South Asian young women felt the conflicting gender ideals circulating at home (e.g. “the good Indian girl/woman”) and outside of the home (e.g. “the sexually-attractive Western woman”) (p.89); this impacted their ability to “successfully” embody either ideal in light of the multiple imperatives for and readings of their bodies. The ability to seek help for bodily distress expressed through “eating disordered symptoms” may be complicated by cultural beliefs that preclude the option of engaging in “Western” therapies and/or bringing “family troubles” outside of the home (Rice, 2014; Thompson, 1996).

Evidently, there are a number of limitations of labels and criteria circulating around eating disorders and around the acknowledged social, cultural and institutional barriers associated with treatment-seeking (e.g. Becker, Hadley-Arrindell, Perloe, Fay & Striegel-Moore, 2010). Accordingly, both prevalence and outcome studies may underestimate the number of individuals who struggle with eating distress (Yu, Agras & Bryson, 2013; Steinhausen & Weber, 2009). The experiences of individuals who are not diagnosed with eating disorders, either due to not seeking treatment or presenting with symptoms not flagged as “eating disordered” by treatment professionals, remain untold. Conversely, those diagnosed with eating disorders may
reject imposed labels and/or medical care (e.g. Boughtwood & Halse, 2010; Shohet, 2007), thus potentially exacerbating stereotypes of individuals with eating disorders as difficult, unmotivated to change, or treatment resistant.

**Feminist Poststructuralist Approaches to Eating Dis/Orders.**

Feminist scholars since the second wave have also taken a strong interest in understanding how and why eating disorders come to pass. Early feminist writers including Orbach (1979, 1986), Bordo (1993), and Chernin (1981, 1985) wrote about how a Western cultural milieu focused on a thin ideal can come to be internalized. This earlier work was critical of the stranglehold that dominant discourses on femininity could exert on the female body, suggesting that eating disorders could be understood as the internalization of or resistance against these norms. Accordingly, early feminist scholars lodged critiques against the scrutiny to which the female body has been subject and the objectification of the female body more broadly (e.g. Bordo, 1993). Eating disorders were situated on a continuum of dieting behaviours, thus suggesting that a reorientation of norms around weight control via dietary restraint could help to reduce the incidence of disordered eating (e.g. Orbach, 1979, 1986).

While these critiques helped to orient researchers to the sociocultural factors that can influence or exacerbate eating distress, this intense focus on eating disorders as an “obvious” by-product of Western society has been taken up in popular media representations of the eating disorder experience. A perpetuation of the image of a young, White, Western woman fallen prey to “dieting gone too far” has come to represent the “eating disordered individual” de facto in the social imagery and consciousness surrounding eating disorders (O’Hara & Clegg Smith, 2007; Shepherd & Seale, 2010). Eating disorders have equally been presented as the purview of the young woman, suggesting that eating disorders are a passing phase that would be unlikely to
affect the woman in mid-life; despite evidence for an increasing incidence of eating disorders among older women (Hay, Mond, Buttnner & Darby, 2008), relatively few studies focus on eating disorders in this group (Gagne et al., 2012). To a certain extent, despite an acknowledgement of the cultural situatedness of individuals with eating disorders, these earlier feminist critiques reproduced the individualizing nature of the very biomedical discourses they sought to dislodge (Burke, 2006; Saukko, 2008; Warin, 2010). Some earlier works (perhaps inadvertently) largely ignored the body in theorizing about eating disorders, by-passing a critical piece of the agency of individuals with eating disorders (Burns, 2009).

Accordingly, more strongly socio-historically and socio-culturally situated works have sought to extend the optic beyond “reading” individuals with eating disorders as those who have fallen prey to cultural imagery (e.g. Malson, 2009b; Saukko, 2008; Warin, 2010). Leading efforts toward more soundly situating readings of eating disorders in social, historical and cultural contexts were Julie Hepworth (1999) and Helen Malson (1998), who used critical discourse analysis to deconstruct the production of eating disordered subjectivity. These early works helped to tease out the raced, sexed and classed nature of eating disorders and eating disorder diagnoses. Focusing on “evidence based practice” and symptom reduction in treating eating disorders, it could be argued, replicates a deficit model in which individuals are wholly defined by their diagnoses (Malson, 1998; Malson & Swann, 1999; Malson et al., 2011). Reducing eating disorders to a set of symptoms able to be resolved by enacting behavioural strategies, including weight gain and “normalized eating,” can serve to understate the complexity of the experience of eating disorders, removing them from sociocultural contexts essential to their expression (Halse, Honey & Boughtwood, 2007).
Saukko (2008) in particular is critical of many of the discourses surrounding eating disorders from “biomedical,” “feminist,” and “narrative” readings alike. For her, these discourses constrain our understandings of the “anorexic self” within a notion of overcoming in the name of achieving a “true self” that reflects the many political and social boundaries placed on individuals in general. Instead, she argues for a spacially oriented (as opposed to temporally organized) approach to understanding eating disorders, wherein individuals relate to society in complex ways and cannot simply replace one self with another (e.g., through recovering from an eating disorder); by “spacially oriented,” Saukko refers to the existence of multiple “selves” along a plane wherein one is not inherently more true or authentic. Several “selves” or subjectivities then exist alongside each other, with various aspects of subjectivity coming to bear in different situations and during diverse interactions with other social actors.

Many important efforts in the post-structuralist feminist tradition have employed critical discourse analytic methods. For example, Malson et al. (2004) and Ryan et al. (2006) explored the discursive construction of individuals diagnosed with anorexia in hospital settings. Nurses and patients alike constructed the eating disorder as wholly representative of the sufferer; this presented recovery as a problematic resolution from the patient’s point of view, for to recover would be to erase the self. Equally, Malson et al. (2011) explored patients’ perspectives on the possibility or impossibility of recovery from a patient-centered perspective, urging clinicians to move beyond totalizing constructions and attributing patients’ symptoms as constitutive of their identity. Patients’ perspectives may not (and perhaps seldom do) replicate those of clinicians; listening to the stories of young women with eating disorders reveals complex tensions between internalizing “expert” knowledge on their conditions and expressing unique understandings of their disorders and “readiness to change” (Mathieson & Hoskins, 2005).
Those seeking to blur the lines between “normal” and “pathological” also explore spaces that are coded as problematic when eating disorders are read as individual pathologies subject to technologies of cure. For example, Day & Keys (2009) conducted study of pro-ana and pro-mia websites, revealing these websites as spaces of simultaneous resistance and conformity to cultural ideals. The authors demonstrate how users navigate complex norms around bodies and bodily management at play in dominant health discourses and eating disorder “communities,” in some ways subscribing to cultural norms of thinness while also resisting dominant discourses and surveillance by becoming “active agents or experts of their own condition or lifestyle.”

Eckermann (2009) also nuances the idea that there is “a” (singular) dominant discourse. She theorizes “multiple cults of thinness,” suggesting that different media and cultural ideas may inform individuals’ perspectives on/relationships to their bodies. Eating disorders, she argues, may be “the ultimate contradiction between compliance and defiance”; they may represent the simultaneous subscription to and transgression of stereotypical ideals of thinness.

While individuals with eating disorders may deftly navigate and embody dominant regulatory scripts for the body up to a certain point (i.e. by occupying a visibly slim frame), self-starving occupies an ambiguous place between control and loss of control. The “anorexic female” can be “read” as either femme fatale (Moulding, 2009) or saint/ascetic in pursuit of “holy grace” (Day & Keys, 2009; Eckermann, 2009). Equally, “bulimic” bodies are read in multifarious ways, also often reduced to the sum of their symptoms; individuals diagnosed with bulimia are often coded as more likely to accept treatment and take action to change (Treasure & Ramsay, 1998). However, “the bulimic” body is less often theorized in biomedical and feminist discourse alike, as it is rendered “invisible” through its seeming “normalcy” (Burns, 2009; Squire, 2003). As Burns (2004; 2009) suggests, the bulimic body provides a challenging “text”
through which eating disorders can be read; as the eating disorder is (seemingly) produced through behaviours more so than appearance, theorists must engage with bodily processes in order to make sense of bulimia. While it is the consequences of anorexia nervosa (evidenced through the body on the way to emaciation and erasure) that are perceived as deviant, pathological, or problematic, the practices of bulimia nervosa and binge eating are “out of control,” while the body remains “visibly normative” (Burns, 2004). The perplexing dilemma of categorizing the eating disordered individual (and perhaps more challenging still the eating disordered body) persists.

Nuanced critical feminist analysis of the experiences of individuals with eating disorders moves beyond seeing eating disorders as either solely individual pathology or solely culturally-driven phenomena. As Katzman & Lee (1997) argued, “by arguing for a contextual understanding of symptoms, one not only legitimizes the eating problem, but reduces treatment hierarchies as the patient is made expert on her problems rather than having to colonize them into biomedically established norms.” Listening to patients’ voices about their unique embodied experiences in more recent work, Warin (2010) revealed the “everyday worlds of anorexia” in her multi-site ethnography. By attending to the meanings diagnosed individuals make of their experiences, Warin revealed how individuals enacting behaviours coded as eating disordered may draw comfort and empowerment from “their disorders.” These analyses and other similar approaches go beyond reading the “eating disordered body” as a spectacle offered up to the gaze (or to multiple gazes), or “a carnivalesque image that is represented by femaleness, thinness, illness, horror, fascination, and death” (Warin, 2010, p. 9).

While alternative readings or interpretations of eating disorders may suggest separating the individual from pathology via externalization (see narrative therapeutic approaches, below),
attempts to disentangle “eating disordered subjectivity” (i.e. what it means to enact behaviours coded as eating disordered) are not so simply achieved. Saukko (2009) addresses one aspect of this problematic: seeing certain elements of eating disorder “pathology” as villainous, she argues, neglects to recognize the roles that these elements may play in other aspects of an individual’s life. A recognition of the multidimensional and intersecting elements of “the disorder” and of “the self” acknowledges the need to transcend the “normative absolutes” of sick vs. recovered or healthy vs. unhealthy with which we usually perceive eating disorders. A poly-vocal approach, understanding individuals’ multiple subjectivities that operate in different contexts and through time and space, allows for a recognition that individuals with eating disorders do not essentially “become someone else” or disappear completely into their eating disorder; equally, one cannot necessarily simply or completely “divorce themselves” from all things eating disordered through recovery (Saukko, 2008; 2009). Brown, Weber & Ali (2008), too, note that it is important to avoid fully dichotomizing “the eating disorder” and “the individual,” as to do so may limit or neglect an acknowledgement of the ways in which individuals may express or enact elements of self via “eating disordered behaviours.”

**Bringing Feminist Theory to Bear on Embodied Eating Disorder Experiences**

Critical feminist theorists have offered much to the field of eating disorder research, as discussed above. Theorists such as Helen Malson (1998; 2009; 2011), Maree Burns (2009), Susan Bordo (1993; 2009), and Helen Gremillion (2002; 2003) have significantly expanded upon the notion of what it means to be an individual with an eating disorder and theorized eating disorders beyond the pathological, helping us to gain a deeper understanding of the driving forces, maintaining factors and expression of distress through disordered eating. These theorists urge a reconsideration of the very nature of “disorder,” suggesting that eating disorders are more
complex than simply being a “normal” or “abnormal” eater. Bordo (1993; 2009), for example, offers insights into the ways in which eating disorders come to transcend lines of class, race and status. Examining the “multiply deployed” aspects of culture that can come to perpetuate disordered eating offers insight into the complexity of these disorders, as well as their individuality. Burns (2009) discusses the need to expand our understanding of eating disorders beyond the ways in which society comes to impose ideals on to (particularly female) bodies in order to fully grasp the experience of disordered eating. She focuses on the meanings held by “eating disordered behaviours,” which have at times been ignored in favour of a focus on the etiology of eating disorders and on body image.

Being mindful of this individuality in expression of disordered eating practices has been key in framing my research. Too often, as described above in terms of the dominant discourses surrounding eating disorders, a focus on the creation of an eating disordered phenotype for study limits or ignores individuals’ embodied experiences. Assumptions may be made about who can or cannot possess an eating disorder and what their recovery will (and must) look like. A focus on “fixing the problem” or subverting body image ideals may obfuscate diverse women’s embodied experiences. Narrowly focusing on the way in which culture is inscribed upon the body (i.e. through the internalization of thinness ideals/norms) misses a significant part of the picture (Burns, 2009). Hinging analyses on the “body image” discourse fails to capture the productive nature of the body. Burns, in particular, argues that an undue focus on the visible elements of the body have led, in part, to the under-theorization about bulimia, as “bulimic bodies” often appear “normal” (2004; 2009). The concept of body image is itself ripe with problematics; in assuming that body image “exists” as a static and fixed entity, the unique experience of being in one’s body, an experience necessarily mediated by discourse and social
context, may be missed (Gleeson & Frith, 2006). Bringing in an embodiment perspective (Rice, 2014) helps to theorize eating disorders beyond the normal/pathological divide and attend to the experience of being in the body, a necessary next step in theorizing eating disorders from a critical feminist standpoint.

Lester (1997) argues that women with disordered eating are acutely aware of their bodies and the ways in which they exist in Western culture. The medical model of eating disorders constructs women with eating disorders as “manipulative, secretive and deceitful.” The individual is bounded and fixed within the body, in a Cartesian mind/body dualism split wherein the body becomes the “jailer” of the self (Battersby, 1998; Shildrick, 1997). The feminist critique of this model, Lester suggests, “threw open doors for us, liberated us from the feelings of isolation and shame we were taught we should feel about our “sick” thoughts and behaviours. The causes of our destruction are not personal madness but cultural lunacy. We are not crazy- we are merely women trying to survive in a crazy world” (p. 481). However, inroads remain to be made, she posits, in examining the self in the eating disorder as a way of thinking, feeling, and relating to society. While “anorexic women” may envision thinness as a means of liberation, “women cannot simply make thinness mean whatever they want it to mean.” In this, Lester and other theorists grapple with the tension inherent in dealing with the self in context. Neither can be abstracted from the other.

To be fully critical of the biomedical approach to understanding eating disorders neglects an acknowledgement of the significant inroads such approaches have made in illuminating the etiology and prevalence of eating disorders. Despite the progressive nature and benefits to the field of eating disorder prevention and treatment in some biomedical studies, however, an over-reliance on the biomedical aspects of eating disorders may again lead to a failure to examine the
ways in which food, bodies, and diets intersect in society (Austin, 1999). Biomedicine and nutritional science may collude to perpetuate the very factors that contribute, in some cases, to the development of eating disorders, particularly in equating fatness with deviance (Austin, 1990; Kwan, 2009). Though acknowledgment of the biological reality of the body is essential to examining eating disorders in their current, largely biomedical, conceptualization, simply relying on biomedicine to guide analysis neglects to respond to the cultural, individual, and social elements that come to bear on the body and body management practices.

My research is guided by the ways in which critical feminist scholars have conceived of the “eating disordered” body. I recognize the body’s materiality, rejecting a postmodern focus on the entirely linguistic construction of reality. Culture, society, language and discourse all have an impact on material (in this case, the body), but do not wholly constitute that matter; matter and these domains interplay to create reality, rather than consisting of wholly separate domains (Hird, 2009). New materialism articulates a holistic understanding of the inseparable nature of biology and society; the body, rather than being seen as fixed and passive, has agency (the ability to act) and interacts, rather than being acted on (Asberg & Birke, 2010; Hird 2009; Rice, 2014). Rice (2014) emphasizes the body’s “becoming,” taking a view that transcends traditional psychological theorizing by seeing human development not as a universal, uni-directional, past-oriented trajectory but rather as a process that can undergo multiple shifts and revisions. Through a body becoming optic, biology and culture are not polarized but “lived in social contexts” (Rice, 2014, p. 36). The meaning and expression of bodies and body practices act and interact in a continuous process; rather than being separate, the mind and the body (as well as culture) are not clearly demarcated (Rice, 2014). Taking a new materialism and body becoming approach to critical feminist analysis helps to draw out the intersections between individuals’ social
locations, their bodies, and their eating disordered practices and recovery. It brings the body into
the frame of analysis without discounting the effects of living and interacting in society to
construct reality of condition.

**Discourses on Recovery.**

Biomedical discourses, including those explored above, also strongly inform approaches
to treatment and recovery for eating disorders. Increasingly, this biomedical framing has focused
on how “brain chemistry,” genetics, and biology play a role in the development and course of
eating disorders. Large-scale initiatives such as the anorexia nervosa genetics initiative (ANGI)
out of the University of North Carolina and Charlotte’s Helix in the United Kingdom have been
seeking to establish a better understanding of the genetic markers for anorexia nervosa in
particular through analyzing genetic samples from over 25000 individuals diagnosed and not
diagnosed with anorexia (No Author, 2013). These initiatives build on research indicating
genetic heritability ranging from 28 to 74% for anorexia (Trace et al., 2013) and between 28 and
83% for bulimia (Wade et al., 2013). Other studies have examined brain size, composition, and
function in relation to eating disorder incidence (e.g. Swayze et al., 2013) and gestational
influences on fetal development (e.g. Allen, Byrne, Kusel, Hart & Whitehouse, 2013). In terms
of biomedical interventions, deep brain stimulation (DBS) has emerged (to a great deal of
controversy—see, for example, Hutton, 2013; Lipsman, Woodside & Lozano, 2014) as a potential
treatment mechanism for individuals with “chronic” or “refractory” anorexia (e.g. Lipsman &
Lozano, 2014; Wu et al., 2013).

These highly mechanistic and scientific explanations for and possible “solutions” to
eating disorders have been taken up and endorsed by many individuals seeking to recover from
eating disorders, as well as their families. For example, the Families Empowered And Supporting
Treatment of Eating Disorders (F.E.A.S.T.-ED) organization strongly supports a neurobiological orientation toward understanding eating disorders (e.g. F.E.A.S.T., 2012). Perhaps this orientation is particularly salient to caregivers given the long history of family (and particularly mother) blame in earlier accounts of eating disorder etiology (e.g. Bruch, 1978; Minuchin et al. 1975; Palazzoli, 1974). Minuchin and colleagues’ (1975) “psychosomatic family” model posited that eating disorders were rooted in family dynamics including enmeshment, rigidity, over-involvement and poor or non-management of conflict. Though the model has long been criticized (e.g. Eisler et al., 2005), echoes of family blame have circulated in more modern approaches to unraveling the “mystery” of eating disorders, potentially complicating dynamics of recovery (LeGrange & Eisler, 2009). It is thus perhaps unsurprising that parents have sought alternative explanations that present the opportunity for family empowerment over family blame.

Equally, understanding eating disorders as biologically based illnesses may help clinicians to establish parameters through which to judge illness status and recovery. Since Ancel Keys’ (1950) Minnesota Starvation Experiment, clinicians have understood the necessity of restoring nutrition in individuals suffering from eating disorders. This landmark study demonstrated that thoughts and behaviours commonly associated with eating disorders (e.g. preoccupation with food, depression, self-harm, etc.) followed extreme weight loss, sparking an interest among researchers and clinicians around the ways in which nutritional deprivation might “cause” or at least exacerbate eating disorders. Accordingly, most, if not all, treatment programs tend to have nutrition and/or weight restoration as a primary goal (Rance, Clarke & Moller, 2014). There is a great deal of variation in terms of adjunct psychological therapies, however, and widespread disagreement on the “best” or most “evidence-based” method of treatment for eating disorders (Strober & Johnson, 2012; Wade, Byrne & Touyz, 2013). Despite decades of
research, “we lack clear direction about duration of treatment and sequencing” (Bulik, 2013, p. 490). Despite a biomedical formulation for eating disorders, biomedical “solutions” for eating disorders still lag, particularly when not used in concert with psychological therapy.

Biomedical parameters for recovery generally rely on the attainment of a weight considered minimally normal for one’s age and height, and the resumption of eating patterns coded as normal (Bardone-Cone et al., 2010; Gremillion, 2003). Long-term follow up studies highlighting outcomes and “recovery” may not problematize the construct of recovery, often reporting on those who do not fit DSM criteria as “recovered” regardless of their subjective perspectives (e.g. Fichter & Quadflieg, 2004; Fichter, Quadflieg & Hedlund, 2006). Though there is an acknowledgement that defining recovery should attend to physical, behavioural and psychological elements, a clear and consistent definition of recovery continues to elude eating disorder researchers (Bardone-Cone et al., 2010; Noordenbos & Seubring, 2006). A lack of definitional clarity surrounding recovery from anorexia nervosa, bulimia nervosa, and other eating disorders continues to pervade the clinical literature (Bachner-Melman, Zohar & Ebstein, 2006; Wasson, 2003), limiting the comparability of studies investigating this construct.

Where studies distinguish between “cognitive” and “behavioural” recovery, scholars suggest refining criteria for recovery to incorporate more elements of “cognitive recovery” (e.g. Bachner-Melman, Zohar & Ebstein, 2006). However, such studies remain unclear about what such a “cognitive recovery” might entail, and we are limited in our ability to comment on “cognitive recovery” by the use of self-report questionnaires which vary between studies and which may not demonstrate strong cross-cultural applicability. Instruments used to measure “recovery,” such as the “gold standard” Eating Disorder Examination Questionnaire (EDE-
Q(Wade, Byrne & Touyz, 2013), have been established using community norms, which may be more or less salient to those being measured.

Current models for intensive treatment seem to subscribe to a primarily biomedical conceptualization of recovery through such means as meal surveillance, hospitalization, and weight gain (e.g. Gremillion, 2003; Guarda, 2008; Long, Wallis, Leung & Meyer, 2011; Mehler & Crews, 2001), though there is an increasing understanding of the need to supplement refeeding with psychosocial therapies (Bulik, 2013). Nonetheless, intensive treatment structures in particular tend to encourage passive following of set structures for treatment rather than encouraging patients’ active participation (Vandereycken, 2003). Individuals’ social identities and social locations may play a role in shaping not only their conceptualization of recovery, but their desire to achieve it (Ison & Kent, 2010). Little research has examined how the biomedical definition of eating disorders, compounded with the classification of what it means to be recovered, may impact the ways in which individuals with eating disorders feel that this construct is available to them. While recovery can be seen as “finding who you really are” (Mathieson & Hoskins, 2005), there may be differences in the ability to find who one is given the social and individual resources that one perceives to be at their disposal.

Another tension implicated in defining recovery is the idea of attaining recovery when one’s body already conforms to social norms or exceeds the standards society sets for “healthy bodies.” As previously mentioned, weight stabilization is a common goal for eating disorder treatment programs (Bardone-Cone et al., 2010; Gremillion, 2003). Despite a medical abjection of the ultra-thin body, “healthy thin” or “normal” bodies are simultaneously viewed as morally, medically and aesthetically desirable (Saguay & Ward, 2011, p. 54). In contemporary Western societies, fatness is equated with laziness, ill-health and ugliness (Saguay & Ward, 2011). A
construction of the fat body as unattractive, unhealthy, and indicative of a lack of personal restraint and control pervades cultural discourse (Rice 2007; Saguy & Riley 2005). Particularly in the wake of the moral panic and fear associated with what has been labeled as the obesity “epidemic,” fatness is itself highly stigmatized (Granberg 2011; Saguay & Ward 2011; Saguy & Riley 2005; Stearns 1999). How then, can the fat individual attain recovery from an eating disorder, if their body size already exceeds the norm? Adding body size to the recovery equation draws out the difficulties of a too-narrow discussion of recovery that remains largely tied up in medical parameters of health and ill health that does not account for a variety of experiences of eating disorders and of recovery.

**Discourses on the Body and Biopedagogies.**

Eating disorders and disordered eating must also be situated within a broader socio-cultural and historical milieu that capitalizes on surveillance of the body. The surveillance and regulation of “deviant” bodies has captured the attention of post-modern and post-structuralist theorists (e.g. Foucault). Foucault (1978; 1979; Foucault & Gordon, 1980) theorized the operation of power in modern societies, suggesting that citizens’ bodies are subject to a more diffuse kind of governmental power, that of “biopower.” Rather than exerting direct force on the populace to make docile and cooperative citizens, biopower operates more subtly, and is internalized by individuals who enact, for example, “health promoting” behaviour (Foucault, 1979; Harwood, 2009; Rose & Novas, 2005). Social constructions of the human body are grounded in notions of bodily stability and the Cartesian mind/body split that have circulated for centuries and that to this day colour our collective understandings of the possibilities and limitations of the body (Shildrick, 1997). Shildrick proposes that the feminine body in particular has provoked anxiety, as it threatens to exceed its boundaries through a number of processes,
including its “leaks and flows,” such as menstruation, breast feeding, and tears. Women are constructed as at once invisible and (re)productive beings; manipulable and passive within the confines of a medical model of bodily possibility. As loss of control is expected for women under this model; paternalistic intervention is to be expected.

As Baynton (2013) illuminates, this loss of control and boundary transcendence is seen as something to be feared; it is unknown and exceeds the “great categorizer” of normality. Women attempting to escape the confines of a “leaky” discourse have felt the need to distance themselves from “disability,” claiming that they were “erroneously and slanderously classed with disabled people, with those who were legitimately denied suffrage” (Baynton, 2013, p. 24). This rejection of difference holds strong implications for our understanding of difference as something to be avoided at all costs (Davis, 2013). Battersby (1998), too, takes up and challenges assumptions about the female body by exploring the body-as-container, troubling the “body boundaries” that have been inscribed upon us. She argues that boundaries are not “innate” to the body but rather imposed by the social context in which individuals live, taking up Kristeva’s articulation of abjection. According to Kristeva (1982), the grotesque, abject body is at once compelling and repulsive, terrifying and fascinating. The abject may be a “terror-invoking” presence that lurks within and threatens to emerge at any moment (Stacey, 1997). As Stacey (1997) suggests, the “clean and proper” body is disrupted by the excess of the abject; the abject exceeds the boundaries imposed on productive and moral bodies and can provoke a rupture between the desire for (self) control and the reality of the uncontrollable.

The fat body, especially the feminine fat body, has been made abject through social discourse. Lupton (2013) explores how a fear of engulfment proliferates in contemporary anti-obesity discourse. Biomedical discourses, she suggests, position the mind in control of the body
and replicate discourses of “righting” the “wrongs” wrought by disability. These discourses have been used by both proponents of anti-obesity discourses and those who contest this framing, generally from within a public health, medical, or nutrition standpoint (e.g. Gaesser, Campos, and Oliver in Lupton, 2013). Statistical and epidemiological information, too, has been used both for and against “anti-obesity” policy making. In much the same way that Davis (2013) suggests that statistics have fixed boundaries between normal, abnormal, and ideal and perpetuated the anxieties associated with disability and difference, “norming” trends have been brought to bear on the large body, invoked to make a case for the body “ideal” or the body “normal” and to ground arguments about what the body can and should be.

Foucault (1978) wrote extensively about bodily surveillance and the internalization of governmentality, articulating a concept of “biopower,” wherein control is exercised through self-monitoring in the interest of the “protection of life.” The state’s interest in disciplining the body is centered around a discourse of optimization and making docile and self-surveilled citizens; bio-power is more diffuse than sovereign power. Indeed, Foucault argues that with the advent of capitalism has come a shift in the operation of power wherein power is now “bent on generating forces, making them grow, and ordering them,” instead of “impeding them, making them submit, or destroying them” (Foucault, 1978, p. 136). Biopower, he suggests, permeates the institutions with which we come into contact each day, from families to schools to medical authorities. Wright & Harwood (2009) take up Foucault’s biopower; they and others theorize a set of “biopedagogies” as they operate around obesed bodies in modern (Western) society. Biopedagogies are taught and internalized by way of both formal and informal educational sites that promote “healthy” bio-citizenry, informing individuals’ understandings of what they “must” do in order to be healthy (Halse, 2009; Wright & Halse, 2013).
Many authors theorizing biopedagogies have focused on the operation of moralizing instructions about bodies and bodily management in such contexts as schools (Evans & Rich, 2011; Evans, Rich, Allwood & Davies, 2008; Rich, 2010; 2011), doctors offices (e.g. Rail, 2012) and, more broadly, in public health campaigns (e.g. Mansfield & Rich, 2013). These writings reveal the tenacity of biopedagogical messages in a society enamored of “obesity prevention” efforts and bent on promoting productive bodies. They illuminate the at-times subtle workings of bio-power, which can have detrimental effects on those who are unable to replicate the expected results of body-work. Though some of these writings allude to eating disorders and the implication of internalizable messages about body management in the production of eating disorders (e.g. Wright & Harwood, 2009), to my knowledge there has yet to be significant theorizing around the idea of a biopedagogy specifically related to recovery from eating disorders. Understanding bodies, including those coded as eating disordered, as “political spaces” (Wright & Harwood, 2009, p. 12), we can begin to interrogate the ways in which individuals come to learn about how to act with and on their bodily subjectivities.

Body becoming pedagogies open up new possibilities for extending conceptualizations of bodily possibility and rather than fearing “engulfment by disability,” embrace differences as possibilities (Rice, 2014). However, the idea of the body in continual process of becoming may be resisted or feared in light of traditional understandings of the mind body split and the mind’s control over bodily process. Bio- and body-becoming pedagogies alike have implications for understanding eating disorders. Individuals with eating disorders (in “the West” in particular) are situated within a cultural milieu that offers a set of instructions for how to manage and discipline the body in order to be a “responsible citizen” (e.g. Foucault, 1979; Foucault & Gordon, 1980; Harwood, 2009; Rose & Novas, 2005). Future, unknown, bodies in the process of becoming are
coded as bodies to fear and to be wary of; they defy the categorization of healthy productive citizen vs. undisciplined body in their unknown-ness. They disrupt dominant schemas around what a body is and what it is not, for example the notion that fat or thin bodies are fixed expressions of corporeality or that gender identity is fixed over the life course. Enacting the kind of self-surveillance described by Foucault (1978; 1979; Foucault & Gordon, 1980) and taken up by Shildrick (1997) seems, thus, a logical solution to the dilemma of how to manage one’s body in a culture that prizes thinness and toned bodies while simultaneously peddling consumer products encouraging excess to the masses. Indeed, as Aphramor & Gingras (2009) posit, bulimic behaviours in particular can be understood as lying on a continuum from “healthy” to “unhealthy” strategies for navigating complex body discourses that encourage adherence to a distinct set of body management instructions.

The monitoring of bodies reinforces boundaries of normal and abnormal and dynamics of individual bodily monitoring through “offering [the self] up for scrutiny” for the medical gaze (Shildrick, 1997). The medical model and the gaze have been especially and perhaps equally implicated in the construction of “extreme embodiments” on the side of corpulence and thinness: eating disorders and fatness (Lupton, 2013). The circulation of power in the portrayal and treatment of “fat” and “anorexic” bodies is evident. As Lupton articulates, both bodies are simultaneously feminized and asexualized, portrayed as freakish, abnormal, emotionally damaged, and irrational. Taking up a medical explanation for these “conditions” allows people to categorize and “fix” different bodies and practices, calming the anxiety that these bodies provoke (Battersby, 1998; Shildrick, 1997).

Some of the problematics of the medical model are evident in readings urging us to bring biology back in to the equation. Fausto-Sterling (2000) explores the intersection between biology
and environment, deconstructing the essentialization of a genes/environment split. As she explains, “partitioning genes from environment, nature from nurture, is a scientific dead end, a bad way of thinking about human development” (p. 235). Fausto-Sterling’s understanding of the interaction of biology and culture necessarily disrupts the silos into which we place “bodies” and “minds.” Though she makes her argument with a particular emphasis on the possibility for continued gender development over the life course based on the plasticity of the brain and the context-dependent action of genes and DNA, her argument holds for disordered eating as well. In capturing the complexity of body/environment interaction through the use of the metaphor of Russian nesting dolls, Fausto-Sterling highlighted the necessity of deploying interdisciplinarity when studying complex ideas like gender and eating disorders. Rather than hunting down a singular gene that expresses “homosexuality” or “eating disorders,” perhaps one of our quests, as researchers, should be searching for ways to better understand the limits of individual disciplines for addressing both “causes” and possibilities of eating disorders. This is not to claim that the singular quest of researchers has been to discover a discrete genetic cause for eating disorders and/or other variants in behaviour; indeed, the recognition of gene-environment interaction in producing behaviour is not the sole purview of feminist or new materialist theorists. Engaging with both these more “mainstream” or “biomedical” approaches to understanding the body more broadly and eating disorders in particular (including but not limited to the genetics at play) and critical feminist critiques of such approaches would enhance our ability to draw conclusions about the complex and individual experiences of individuals with eating disorders.

**Narrative Approaches.**

This thesis is informed by narrative approaches to therapy and to identity that intersect in a number of ways, will be briefly outlined below. These approaches have helped to inform this
study through an attendance to the importance of stories to individuals’ lives, as well as in the
acknowledgement of alternative and potentially “sprit nourishing” (Maisel, Epston & Borden,
2004) approaches to treating eating disorders.

**Narrative Identity**

A large body of literature explores the notion of narrative identity, or the idea that
individuals live their lives along “internalized and evolving narratives of the self” (McAdams,
2001, p. 100). An individual’s narrative identity consists of an autobiography of one’s past and
an imagining of one’s future, and human beings tend to tell stories as a natural part of their being
in the world (McAdams & McLean, 2013). These stories are unique to individuals and reflect
cultural situatedness (McAdams, 2001); the stories people tell reflect their identities and the
ways in which they make sense of themselves in the world; they are not static but instead
integrate new experiences as they arise.

While the focus of this thesis is not on the concept of narrative identity in particular,
aluding to the ways in which such an approach has coloured interpretation of participants’
accounts will help to illuminate analytic processes; for example, theorizing narrative identity has
led to the development of life-story constructs which can be used in narrative analysis.

Narratives can be analyzed for the degree to which they reflect an individual’s agency, or ability
to exert change, exercise mastery over the self, and influence others and environments
(McAdams & McLean, 2013, p. 234). Redemption sequences reflect the reclaiming of “bad” or
“negative” events into positive outcomes, and have been found to correlate with overall well-
being, suggesting that making meaning from experience is one key facilitator of healthy coping
(McAdams, 2006; McAdams et al., 2001). This “master narrative” of redemption is common in
(Western) societies; it circulates in mediatized stories as well as individuals’ accounts (McAdams & Adler, 2010).

However, McAdams (2006) acknowledges that “not all experiences can be redeemed.” Indeed, Breen & McLean (in press) suggest that we know less about how redemption is expressed in the stories of individuals in more vulnerable populations. Examining the redemption narrative in context, it too can be seen as a social construct; a master narrative that “might itself contribute to marginalization and oppression” (p. 20), potentially by placing the onus for non-redemption on the individual and/or obscuring larger structural issues that may constrain redemption in certain contexts (Breen & McLean, in press; Jiwani & Young, 2006). Nonetheless, the redemption narrative is compelling even for those in vulnerable societal positions; while not linked to desistance from antisocial behavior in their sample, Breen & McLean note that redemption was not fully lost and that the youth involved in their study at times narrated their “future stories” in ways that were perhaps unrealistic but reflected a desire for redemption.

How might redemption narratives feature in the stories of young women recovered from eating disorders? Though much work has been done in constructing eating disorder narratives in the context of narrative therapy (as explored below), there has not been as heavy an emphasis on bringing together the fields of narrative identity and narrative therapy. When writing “anti-anorexia” and “anti-bulimia” stories in narrative therapy, an emphasis is indeed placed on differentiating between a storied self “with” and “without” (or, as will be explored, in a relationship with) an eating disorder. The “re-storying” of a life beyond the eating disorder may indeed feature redemption; however, there is relatively limited research on the effectiveness of narrative therapy for eating disorders alongside limited analytic work of anti-anorexia and anti-bulimia stories (cf. Maisel, Epston & Borden, 2004; Scott, Hanstock & Patterson-Kane, 2013),
which limits our ability to determine the degree to which this redemptive focus features in the stories of individuals recover(ing/ed) from eating disorders. As analysis will reflect, participants did not always articulate happy endings, and despite employing redemption sequences to a certain extent, problematized this construct. Achievement and overcoming hold particular weight in the eating disorders literature; as such, over-reliance on telling the mainstream story of fall from grace, followed by redemption or work toward a cure may miss some of the complexity in the experiences of individuals in recovery from eating disorders. Nonetheless, the concept of narrative identity helps us to identify the cultural and sociohistorical context in which participants are embroiled (e.g. the persistent and compelling master narratives circulating in sociocultural milieu). Understanding their stories requires that we attend to contexts and understand how individuals select memories and events with which to construct their narratives of identity.

*Narrative Therapy.*

Among the best recognized “alternative” approaches to understanding and treating eating disorders, narrative therapy has proposed patient-centered and non-individualizing care for individuals seeking “recovery.” David Epston and Micheal White, two forerunners of narrative therapy for eating disorders, have engaged with patients to create “anti-anorexia” and “anti-bulimia” stories. These stories encourage clients to externalize the eating disorder from the individual and set up space for sufferers to re-envision their relationship to their disorder. White (1991) asserts that one’s story is never neutral; all stories require telling, deconstruction and reconstruction. Through externalizing “the problem,” in this case eating disorders, sufferers are able to see themselves as separate from their disorder, and to create a story that goes against that driven by the eating disorder. Importantly, narrative therapy recognizes that though
externalization can be a helpful mechanism for deconstructing and reconstructing stories, “totalizing can obscure the broader context of the problems that people bring to therapy and can invalidate what people give value to and what might be sustaining” (White, 2007). The eating disorder may represent a great deal of mastery on the part of the individual expressing eating distress: this individual has discovered a means through which to regulate the self that seems adaptive in the short term (Gremillion, 2003).

The main alternative- or counter-story created in narrative therapy for eating disorders is “anti-anorexia/bulimia” (Maisel, Epston & Borden, 2004). Coined by Epston, “anti-anorexia/anti-bulimia” scripts position the individual with the eating disorder as an active member of their treatment (Epston & White, 1989). By upholding an oppositional stance between “self” and disorder, this scripting enables the sufferer to recognize the ways in which the disorder has governed their behavior, while also acknowledging the functions that the disorder has served in their life; for example the delaying of uncomfortable emotion or the seizure of control in an uncontrolled world (Maisel, Epston & Borden, 2004). Metaphors are used to organize relevant life events into a story, and are seen to help eating disorder “patients” to make sense of the eating disorder as external to their core being (Madigan & Epston, 1995). Epston began to compile these anti-anorexia/anti-bulimia stories created by patients of he and his colleagues in 1980 (Duran et al., 2000). The now-online repository of these studies is intended to “inspire the creation of new meanings around anorexia and bulimia” (Madigan & Epston, 1995 in Duran et al., 2000).

A narrative approach to therapy is one postmodern therapeutic orientation that has infused, to some degree, eating disorder research. Cross-cultural studies, such as Becker’s analysis of the emergence of eating disorders in Fiji, have generated rich narrative data which
captures the experiences of individuals with eating disorders in a way that transcends what could become an essentialist discussion of Westernization resulting in eating disordered behavior (Becker, 2004b). Brown, Weber & Ali (2008) used feminist and narrative approaches to more fully understand the role the eating disorder plays in an individual’s life. Exploring women’s experiences of their bodies through the expression of eating disorders, the authors envision feminist and narrative approaches to eating disorder research as generating empowerment, social change, and self-direction. Brown, Weber & Ali in particular recognize how identity-expressing stories can shift according to context, or the idea of the “multi-storied version of life.” The potentially problematic dichotomization of individual and eating disorder is explored, recognizing that by envisioning the individual and the disorder as wholly separate can obscure the ways in which the eating disorder serves a purpose in the life of the individual with the eating disorder.

Narrative techniques have also illuminated the ways in which individuals’ experiences of their eating disorder can differ markedly from the biomedical conceptualization of eating disorders. Shohet (2007) explores the narratives of young women at different stages of recovery from eating disorders. While this author’s approach to examining the stories of young women with eating disorders and/or in recovery reveals the ways in which these women themselves structure their disorders, it is limited by a focus on only those women with thin bodies. She explicitly states her focus as “explor[ing] the role the label “anorexia” played in slim women’s lives” (p. 347). Further, though the role of narrative in extending the views of identity as dynamic is strong, the author takes a strong stance that privileges the “full recovery” narrative, seeing in this particular narrative more value than that of a “struggling to recover” narrative. She posits that developing a full recovery narrative “may well be critical for recovery to remain a
stable condition of life” (p. 375). What this approach fails to recognize are the different presentations of recovery among individuals with eating disorders, not only among “diagnoses” of eating disorders, but those that may differ based on other salient elements of identity for those individuals themselves.

The stories of young women with eating disorders have also been explored in the context of specific treatment centres. Mathieson & Hoskins (2005) examined the metaphors expressed by 10 girls, all participating in a treatment program based on the transtheoretical model of change. What is most interesting about the metaphors expressed by the young women in this study are the ways in which the girls’ narratives do not often match up with their institutionally prescribed “stage of change.” Soliciting the voices of the young girls in this example provides evidence for the value in listening to the stories of those engaged in eating disorders and/or treatment in order to further understanding about what it means to be an individual with an eating disorder within a particular context. This approach may, as proponents of narrative as empowerment suggest, help to avoid the potential obscuring of patient voice that can occur in medical settings (Gremillion, 2003; Katzman & Lee, 1997). Listening to the voices of individuals with eating disorders may be especially important given that “being understood” is referenced as an essential element in recovery from eating disorders (Hsu, Crisp & Callendar, 1992).

Bridging these critical feminist theoretical perspectives and the narrative approaches to identity and therapy introduced earlier, it is worth attending to the idea of body narratives, in brief. Featherstone & Turner (1995) commented on an increased interest in, but conspicuous absence of, attendance to embodied experience in social science research. Though some theorists never “lost” the focus on the body (e.g. Davis, 1997; Grosz, 1994; Shildrick, 1997), some would suggest that recent theorizing around the body tends to be “cerebral, esoteric, and ultimately a
disembodied activity that has operated to distance us from the everyday embodied experiences of ordinary people” (Sparkes, 1999, p. 18). In focusing on “body narratives,” these theorists suggest, we might begin to approach a knowledge of the body through the necessarily mediated stories individuals tell about their experiences. Being sensitized to the idea of the body narrative has helped to drive analysis of digital stories in particular, as these stories invite viewers in to “relive” experiences and events with their creator, opening up new spaces for understanding and knowing complexity.

Chapter 2: Methods

Participants

Recruitment. Inclusion criteria were kept deliberately broad in order to explore the stories of young women with diverse backgrounds and experiences. The main criterion for inclusion was that participants should identify as having overcome an eating disorder/disordered eating in young adulthood (e.g. 18-25). Though the choice of young women arguably risks reproducing some of the stereotypes that circulate around disordered eating articulated in the literature review, this choice was made on the basis of, on a practical level, time constraints, and, on a theoretical and analytical level, a commitment to complicating the notion that we can subsume the diverse experiences of even a group considered “homogenous” into a singular story. Initially, I tried to capture the experiences of participants who self-identified as having overcome (i.e. recovered or in recovery) from the eating problem within the past 5 years. However, as the research progressed it became clear that putting a “timeline” on recovery was not so easily done. Participants often articulated the difficulty of putting a particular date or time to “recovery.” As such, though recruitment posters specified “if you are a young woman who identifies as having
overcome an eating disorder/disordered eating when you were 18-25 (within the past 5 years),” some of the young women interviewed were unsure whether their exact moment of recovery occurred during this timeframe. In accordance with inclusion criteria, all participants were from or lived in Southern Ontario and identify as women. Examining the experiences of men would be a fascinating endeavor; however, for the purposes of this research project, funded by the Ontario Women’s Health Scholar Program, a more in-depth exploration of the unique experiences of young women was selected. Given the small sample size, exploring the individuality expressed even within a “homogenous” sample revealed a surprising diversity and richness of experience perhaps not yet captured in the literature. This sample is also more easily compared to the extant body of literature on the experiences of individuals with eating disorders, which helps to complicate the picture of what it means to “have” and “recover from” an eating disorder. Importantly, to my knowledge no research using digital stories as an arts-based research methods for exploring eating disorders has yet been conducted. As such, using a sample that (“objectively”) closely resembles the samples that have been explored in the existing literature allows for a deeper exploration of what arts-based practice can offer in terms of expanding the focus on lived, embodied experiences in eating disorder research.

Participants were not required to have a formal diagnosis of an eating disorder along Diagnostic and Statistical Manual (DSM) criteria (i.e. anorexia nervosa, bulimia nervosa, binge-eating disorder, or eating disorder not otherwise specified/other specified feeding and eating disorder). This decision was made for a number of reasons. In keeping with a critical feminist theoretical perspective, this allowed for an attendance to participants’ experiences of disordered eating, which may be significantly distressful and impactful regardless of an externally imposed label. This also allowed me to centralize the participant experience, rather than clinical expertise.
As analysis will demonstrate, labels fluctuated through participants’ experiences to greater and lesser extents; this variation is expected and encouraged, and helps to illuminate the complexity underlying eating distress. Likewise, individuals did not need to have received treatment in order to participate. Recruitment posters also asked participants if they had unique elements of their story that they would like to share. This last inclusion was commented on by several of the participants, who indicated that this was a part of their reasoning for participating.

Recruitment was primarily conducted at the University of Guelph, through posted signs that outlined the research and listed contact information. The Wellington Dufferin Guelph Eating Disorder Coalition also assisted in the recruitment process by sending out a call for participants. Information about the study was also shared via social media, including Tumblr, Facebook, and Twitter. Interestingly, social media sharing accounted for only one of the ten participants recruited in total. The majority of participants responded to posted flyers or hearing about the study via word of mouth; participants referred acquaintances to the study.

A mixed purposive/convenience and snowball sampling strategy was employed. Though participants were selected in accordance to specific criteria as detailed above and it was my intention to select a diverse group of young women, some decisions around sampling were made on the basis of convenience. For example, a more representative sample would have included a set of participants from a variety of socioeconomic statuses and education levels, whereas all participants in this study had obtained at least three years of university education at the time of the interview. This was likely due to the primary recruitment location: a university campus. Further demographic details are described below, but it is worth noting that despite intentions to utilize purposive sampling, the sample most closely resembles a convenience sample. Due to the participant referrals, the sampling strategy also incorporated an element of snowball sampling, as
participants recommended friends or acquaintances who might be interested and satisfy the criteria to the study.

**Participant Demographics.**

A total of ten young women participated in narrative interviews. Three of these individuals also participated in a three-day digital storytelling workshop, where they created short films about their experiences. Participants ranged in age from 20 to 31, with an average age of 24.8. All were university educated; two were in the process of completing undergraduate degrees, three had completed undergraduate degrees, three had completed Masters degrees, and two had completed doctorate degrees. Eight participants had been diagnosed with anorexia nervosa at some point during their experience and three participants had been diagnosed with bulimia nervosa (not mutually exclusive; some participants had experienced diagnostic crossover). Two participants had not received formal diagnoses, one of whom self-identified as having experienced bulimia nervosa and the other as having experienced an eating disorder not otherwise specified. When asked about racial/ethnic identity, five participants identified as Caucasian, two as Jewish, two as European, and one as Black/mixed race (Black Caribbean/middle eastern/white). Several participants also complicated the notion of sexuality. Seven participants identified as heterosexual. The remaining three participants specifically articulated viewing sexuality on a continuum, and responded accordingly: one participant identified as a lesbian in a relationship with a heterosexual man, one as fluid and married to a man, and one as mostly heterosexual.

One goal of this research was to address the relationship between social location and eating disorders; given this (“objectively”) heterogeneous sample, this goal became more complex. As will be explored in analysis and discussion sections, social location came to bear on
the expression of eating disorders less through discrete categories as expressed in categories of belonging such as ethnic/racial identity, gender, or sexuality; instead, a nuanced social location emerged from participants’ accounts and understandings of their own embodied social location. Nonetheless, when considering the broader relationship between this and other, similar, studies, the homogeneity of the sample should be taken into account as a potential limitation to the generalizability of the conclusions.

Ethics

All data collection and analysis was conducted in compliance with an ethics protocol reviewed and approved by the University of Guelph’s Research Ethics Board (REB)(protocol #13MY14; Appendix 1). The main ethical risks involved in this research surrounded confidentiality, as participants may desire to keep their eating disorders undisclosed from members of the community at large, or even members of their families, friends and colleagues (Ison & Kent, 2010). Particularly in the case of the digital storytelling workshop, participants were asked to explore in great depth topics that may be uncomfortable. It was made clear to participants in the digital storytelling workshop that the information shared by other members of the group, particularly during story circle, may be sensitive.

Following guidelines set out by the Center for Digital Storytelling and Project ReVision, norms of respect and confidentiality were established at the workshop: participants were also asked not to discuss the information or the identities of fellow participants outside of the workshop and to turn off their cellular phones to avoid accidental phone calls and interruptions. Visual methods for conducting social research inherently necessitate a great degree of ethical consideration and negotiation of comfort with research participants, whose image may be attached to the research data (Harrison, 2002). Participants were given several options for
sharing their stories in order to give participants as much control as possible. All participants elected to release their stories for educational use and to have their names associated with their stories. Participants were also given copies of their stories, which they may choose to use at their discretion to share beyond the context of the research.

Navigating ethics within the digital storytelling context revealed the importance of attending to the participant’s wishes in terms of control over their “data”: unlike in other methods, where the data might become the “property” of the researcher and/or advisor, the digital stories belong to the participants, who have allowed me, the researcher, to make use of their insights as data for my thesis. The ways in which this approach has enriched my research will be detailed below; this co-ownership of “research data” also reflects a more community-based approach to research strongly in line with commitments to centralizing the lived experience of participants, a move strongly encouraged in recent scholarship on eating disorders (e.g. Warin, 2010).

Procedures

Narrative Interviews.

Narrative interviews were conducted with ten participants, beginning in July 2013. Interviews ranged in length from 26 to 76 minutes, averaging 48 minutes in length. Five interviews took place on the University of Guelph Campus and five were conducted via Skype. Narrative interviews engage the researcher and the participant in a collaborative process of meaning making; participants were invited to share their stories detailing their experiences in a discursive process between researcher and participant that resembles a conversation (Riessman, 2004). In keeping with a narrative approach, interviews were conducted using a loosely semi-structured interview guide (see Appendix 3). Key questions probed participants to reflect on their
experiences of having (e.g. “What did having an eating disorder mean to you? How did it feel, to you?”) and recovering from an eating disorder/disordered eating (e.g. “What does the word recovery mean to you?”). Within the guidelines laid out by broad questions encouraging participants to explore their unique experiences, much of the discussion during the interview was participant-directed; I followed an interview guide but followed the participants’ particular areas of interest and responded accordingly. Interviewing, transcription, and analysis took place with the knowledge that participants construct their stories in specific way and for a particular audience; attending to participants’ social locations plays an essential role in effectively using narrative interviewing as a research method (Riessman & Quinney, 2005; Reissman, 1993). Participants select, organize and connect their experiences to form a story, which they may tailor, in part, to the intended audience (Hinchman & Hinchman, 1997; Riessman, 2004). In conducting analysis of these interviews, I thus acknowledged that participants may, in part, have been answering these questions in a way that corresponded with what they thought I would want to hear, as a researcher.

**Digital Stories.**

All participants were invited to take part in a digital storytelling workshop upon completion of their interviews. Four participants indicated interest; one participant later elected not to participate prior to the workshop due to a scheduling conflict. Three participants attended a three-day digital storytelling workshop at REDLAB at the University of Guelph from January 24th-26th, 2014. This workshop followed guidelines adapted from the Centre for Digital Storytelling (CDS) by Dr. Rice’s Project ReVision. In June 2013, I received facilitator training through Project ReVision, which enabled me to carry out the small workshop with the assistance of one volunteer to help with logistics and workshop details.
Prior to the workshop, I designed a curriculum loosely following guidelines from Project ReVision workshops dealing with disabilities and differences (see Appendix 5). In this curriculum, I explore sociohistorical representations of eating disorders and encourage participants to speak back (consider in relation to experiences) to dominant cultural narratives surrounding eating disorders. It is possible that this encouragement to deconstruct dominant cultural narratives around eating disorders shaped participants’ stories. In the initial presentation, I asked participants how they felt about common representations of eating disorders (e.g. the thin white woman) and how they felt their stories did and did not relate. Participants did not always agree with each other or with me, but all were able to articulate both positive (e.g. awareness-generating) and negative (e.g. exclusionary) elements of these discourses. The curriculum also deals with technical aspects of digital storytelling, including instruction on how to use Final Cut Pro, a video editing software. This curriculum was designed to help facilitate a generative and collaborative process in which participants are encouraged to find their own voice and deeply engage with their experiences from a place of personal expertise. Digital stories have not, to my knowledge, been used in research to explore the stories of individuals who have overcome eating disorders. Individuals with eating disorders have, however, been making use of technology to tell their stories, for example through producing video slideshows and posting them on Youtube. Digital storytelling in the context of this research differs from these individually produced videos, however, and offer something new in terms of representing experience.

Creating and sharing digital stories allowed for deeper engagement with participants; these young women were placed the role of experts about their own experiences (Benmayor, 2008), an orientation I frequently reiterated throughout the workshop in working with participants. It could certainly be argued that I was a part of the story production process, as well
as acting as audience member. I tried to mitigate my role in shaping stories by asking participants questions about moments that stood out for them rather than making explicit suggestions about what their experiences might be. By deepening understanding for participants and audiences alike (Rossiter & Garcia, 2010), digital stories produced in the workshop context have the potential to challenge dominant discourses concerning the presentation of and psychosocial and therapeutic resources necessary to overcome eating disorders. These videos also have the potential to reach broader audiences than traditional approaches to research, mobilizing knowledge about subjective experience beyond the walls of the academic institution or therapy office. As previously noted, participants have discretion over how they share their stories. At the time of writing, one participant had already spoken about her desire to share her story with a broad audience through her popular blog about eating disorders. Informal conversations with participants throughout the workshop revealed a desire to complicate the overly simplistic representations of eating disorders often present in public fora.

Participants were contacted two weeks prior to the workshop with an introductory letter (see Appendix 7) to start the process of thinking about the digital story. One week prior to the workshop, I contacted each participant again to explore ideas around the story they wish to tell. Each participant had a rough idea, at that point, of the story they wanted to work through at the workshop. In keeping with the Center for Digital Storytelling guidelines, an important part of the process is facilitating the participant’s experience of telling the story he or she wishes to tell in the moment. This corresponds closely to the acknowledgment in the narrative approach that the participant’s story may not be the same at different moments and for various audiences (McAdams, 1985; Reissman, 2008). Accordingly, conversations around scripting were designed to help the participant toward a story that they wanted to tell, rather than the story that best
corresponded with the research agenda; for example, in conversations with participants prior to and during the process, I asked questions rather than telling them what “would be best” and encouraged participants to tell a story that resonated with them as opposed to one that they felt most fit with the construct of recovery. Following initial email contact, participants attended a half-day introduction to the digital storytelling workshop and story circle on Friday, January 24th, at which point they met the other participants and began to focus their efforts toward creating the digital story.

During the first day of the workshop, participants signed consent forms and participated in a discussion around norms of confidentiality and respect for the workshop. After consent procedures, we engaged in a discussion about the socio-historical representations of eating disorders, in which participants actively participated. A script for this discussion is appended to the thesis; conversations evolved from this script. This discussion helped to shape the production of the digital stories, as participants were invited to speak back to dominant discourses surrounding eating disorders and recovery. Following this discussion, we moved into story circle. For story circle, we once again followed the tradition of the Center for Digital Storytelling. “Story circle” is a method designed to facilitate participants’ development, clarification and/or structuring of their story in a supportive group environment (CDS ref). This aspect of the workshop follows a storytelling tradition in bringing people together to build relationships through the mutual exploration of diverse issues and experiences. Participants are able to ask for feedback and/or respond to each others’ stories in a co-learning community.

After story circle, participants continued to structure their scripts, with an ultimate goal of writing a 250-350 word script to be read as a voiceover. This work continued into day two of the workshop, during which time I consulted with participants in script development. Each
participant worked through several drafts before coming up with a script with which they were satisfied. I then recorded each participant’s voiceover until they were satisfied with a take. I also provided a brief tutorial on Final Cut Pro (script in Appendix 8) to familiarize the participants with the video editing software. Participants began rough edits of their stories on day two of the workshop, importing images that they felt represented their stories and placing them in order in the program. I worked with participants over the course of days two and three on a one-on-one basis to troubleshoot technical issues and facilitate the process of storyboarding and video editing. Once the stories were complete, I exported each as a Quicktime file onto an external hard drive for the final screening. Each participant also received a copy of their story to use at their discretion.

The final element of the workshop is the “world premiere” of the stories. At the end of the final day, the participants and I gathered together to watch each story and see how each had progressed from story circle to final screening. While participants finessed edits on their stories, I had also created a brief story reflecting on the process of the workshop, which I screened. Creating my own story helped to deepen my connection with participants by sharing in the production and telling of stories about our experiences. After each story was screened, participants commented on their own stories and those of their peers.

**Data Organization and Analysis**

**Narrative Interviews.**

Interview analysis followed Riessman’s (1993; 2007) thematic narrative analysis method. Pseudonyms were assigned to each participant and used from the transcription stage to help protect participant confidentiality. In keeping with this methodological framework, transcription was an essential element of the process of analysis (Riessman, 1993). I transcribed each
interview in its entirety, attending to pauses and tones in a detailed orthographic style. A second-pass transcription allowed me to check the accuracy of the transcription. During this second pass, I also made general notes about my thoughts and observations, being sure to attend to my own emotional reactions to the data. These notes also helped to contextualize each individual story, enabling me to centralize each individual narrative as a story in its own right. Transcription helped to guide analytic focus by way of analytic induction (Katz, 1983), allowing me to become familiar with each individual story and aspects of the stories that converge and diverge.

Once I had transcribed and checked over each interview, I imported the documents (with identifying information removed, as specified above) into Dedoose, an online qualitative software program, to begin coding. I performed preliminary open coding on each interview, making notes via the memo function in Dedoose. Following initial open coding of all interviews, I observed trends in codes and collapsed similar codes to form a more structured coding system, and checked over each document for consistency in codes to excerpts. Recording the incidence of different codes helped to focus in on those that occurred most commonly across the stories; I created a basic count chart with the assistance of Dedoose, noting which codes occurred and co-occurred most frequently (overall) and which codes appeared most frequently in each individual interview. I noted, however, that the most salient codes are not necessarily those that are most frequently applied; for this reason, I then explored in more depth the themes that featured prominently in individual interviews and across the data set to ensure that the analysis was more qualitatively rich than a simple content analytic approach. While performing more in-depth analysis of each theme and the excerpts therein, I asked questions of the data following Goodbody & Burns’ (2011) critical narrative analysis based on Murray (2000), who looks at the personal (individual), interpersonal (dialogical), positional (social) and ideological (discursive)
levels that fluctuate throughout narratives. Though analysis was primarily grounded in thematic narrative analysis, engaging with critical narrative analysis helped to bridge epistemological and theoretical perspectives within the analysis; that is, as the grounding theoretical framework is critical feminism, bringing critical perspectives to bear on narrative themes helped to more explicitly identify and elaborate on the operation of power, social context, and dialogical elements within the broader narrative themes.

Once I had identified common codes, I analyzed each emerging theme in more depth by linking excerpts from each interview to the overall theme, which was often a combination of several codes (for example, “Doctors Orders: Standards for Recovery” incorporated such codes as “biomedical/medical aspects,” “full recovery,” “rethinking health” and others). With each excerpt added to my master document, I noted novel specifics of the relevance of the excerpt to the overall theme. This helped to focus the description of the theme overall, as well as to capture the specific contextual details of the associated excerpt, to ensure that the richness of the narrative was not lost in excerpting. To more deeply engage with individual participant narratives and the various expressions of (at times multiple) subjectivit(ies), I also performed a “poetics analysis” for each interview, following Chadwick (2012), who suggests that performing this kind of analysis helps to centralize the embodied experiences of participants. This analytic step involved abstracting the “I” statements from a chunk of text, and creating a poem from these statements. Chadwick situates this type of analysis within a tradition of “embodied analysis,” drawing on Kristeva’s (1984) theorizing around the constitution of subjectivity through the “speaking body,” as well as discursive (Parker, 1992) and rhetorical (Billig, 1987) traditions. Engaging in “deep listening” to and analysis of participants’ stories, Chadwick is inspired by Gilligan’s (2003) “listening guide.” Extracting I statements, for example, helps to draw out
participants’ multiple (and at times conflicting) expressions of subjectivity; “I poems” centralize the at-times shifting subjectivity participants articulate (Chadwick, 2012). This helped me to engage more closely with the positions participants occupied within their own stories and, as Chadwick suggests, “‘tun[e]-in’ to different voices and subversive currents within women’s stories” (p. 94).

**Digital Stories.**

Examples of the analysis of digital stories for the purposes of research are only just emerging, and as such there are few agreed upon conventions for analyzing digital story data, which is unique in its focus on the intersection between personal, first-person narrative and visual imagery chosen by participants. Analysis of the digital stories generated for this research is grounded in the traditions of visual sociology, participatory arts-based research, and narrative analysis. Given the democratic aims of digital storytelling to “allow unheard voices to be heard” (Gregori-Signes & Pennock-Speck, 2012, p. 3), participants have been included in the analysis process in a number of ways. In this way, analysis of digital stories replicates approaches used for photo-voice, a participatory arts-based approach originally conceived as an approach to health promotion (Wang, Yi, Tao & Carovano, 1998). In photo voice data analysis, the participants take part in the “coding” of photographs (e.g. associating photographs with themes speaking to their content and meaning) once they have been collected in order to ensure that they represent their realities (Drew et al., 2010). Though some aspects of photo voice are helpful in considering methods for analyzing digital stories, analysis of photo voice-generated data tends not to focus on what the participants say about their images (Ibid). Analysis of digital stories necessarily focused on both the visual imagery selected by participants to tell their stories and the verbal stories they tell.
An unexpected result of the digital storytelling process was that the workshop helped to provide a lens through which to analyze both the stories and the interviews. Spending three consecutive days with participants allowed us to bridge traditional divides between researcher and “researched,” which helped to confirm analytic direction. While I consider this close proximity with participants a strength of this research, this intensive engagement with some (but not all) of my participants may have led to their stories being the key lenses through which I came to understand the experience of eating disorder recovery for all participants. I have attended to this further in the analysis section. At the time of the workshop, I had developed a thematic framework for my analysis of the narrative interviews, which helped to mitigate the risk of a confirmation bias in selecting only those elements of the interviews and emerging themes that resonated with the smaller group, whose stories may have been impacted by my presence as workshop “leader” and discussion facilitator, as well as audience member and (at times) participant. Conversations over the course of the digital storytelling workshop then resembled, in some ways, member checking: participants inquired about my thematic directions, and together, we engaged in a conversation about their perspectives on my interpretations. Overall, participants’ contributions to my thought process helped me to be more confident about the degree to which my interpretations reflect their experiences as told to me through narrative interviews and digital stories. Throughout the process of analyzing data, I elaborated my emergent interpretations of participants’ narratives with the intention to accurately represent participants’ experiences. As such, I consider my participants co-analysts and co-narrators of the research conclusions despite my having initially (autonomously) analyzed interview data. Accordingly, I also brought a narrative thematic analysis approach to the digital story analysis to
increase continuity to the analysis process and draw links between participants’ stories as told via interviews and via digital stories.

Thematic analysis has been used to analyze digital/visual stories, with sets of visual data open-coded in small units and rearranged by researchers using axial coding with the aid of memos, establishing major and sub-themes based on commonalities between stories (Drew, Duncan & Sawyer, 2010). However, given the overall narrative focus of this project, it was important to stay close to the story’s arrangement as constructed by participants in order to avoid imposing particular story arcs or themes that may not exist on participants’ accounts. Other studies implicitly use a thematic analysis approach without exploring or describing their method of analysis in depth (e.g., Brushwood Rose, 2009; Vivienne, 2011). My approach to analysis most closely resembled Riessman’s (2007) narrative analytic approach to visual imagery. Riessman suggests that an effective visual analysis involves a close reading of situated images—that is, participants have chosen or made images with a particular understanding of the object of their gaze. Though visual analysis “pushes the boundaries of narrative and narrative analysis” (p. 145), Riessman argues that we can locate stories in participants’ accounts throughout the process of research, including through an analysis of images participants select. This orientation enabled me to “find the story” in participants’ words and images by looking for the “told” and “untold” story and themes present in the digital narratives. To fill in the gaps left by this narrative thematic analytic scaffolding for my digital story analysis, I made use of a/r/tographic practice (Irwin & de Cosson, 2004) as an analytical lens, allowing me to attend to meanings found “in-between” voiced stories (primary narrative written and then spoken by participants) and sequenced images (placed into order by participants alongside their narrative storyline) portrayed in participants’ digital stories.
A/r/tographic practice orients inquiry toward the space in between image and language, focusing on five “renderings”: contiguity (elements that come to co-exist in stories told), metaphor/metonymy (which help to make sense of that which is too big for words), openings (new meaning emerging from the spaces in between what we see and what we do not see), reverberations (a reflection of movement and energy present in a group when meaning and understanding are revealed) and excess (recognition of what is not acceptable or understandable) (Springgay, Irwin & Leggo, 2007). Rather than envisioning a/r/tography as another method herein, it acts as an analytical lens; a/r/tography’s merging of “knowing, doing, and making” (Leavy, 2009) allowed for the integration of the data analysis process into the making of the digital stories themselves; while engaging in the digital storytelling workshop and later the “coding” and interpretation of digital stories in consultation with the participants, I remained aware of what resonated and reverberated, opened up, and was contiguous within the group.

I also acknowledged the metaphors that surfaced in discussion (which I recorded in “field notes”/memos following the workshop each day) and products of the digital storytelling workshop, as well as the ways in which participants articulated that which was in excess of words or understandings (for example, see analysis section for a discussion on the limits of labels and how digital storytelling attends to that which cannot be expressed through words). Though traditionally used in education research (Leavy, 2009), similarly to digital storytelling itself, including aspects of the a/r/tography method in this research added depth to analysis and helped to recognize the multiple roles held by participants and myself throughout the workshop process: we were artists, researchers and co-teachers in continual interaction (Ibid). Keeping the principles of a/r/tography in mind when analyzing the stories helped to maintain an awareness of
the space “in between” image and voiced stories. Though I analyzed each story in its own right, keeping an awareness of a/r/tographic practice allowed me to take into account the co-influence of participants and myself that may have shaped the end products. Each digital story case study generated through analysis was also emailed to the participant for member checking to ensure that her voice was accurately captured.

Reflexivity

Process.

Essential to this research, informed as it is by a critical feminist lens, is reflecting on my own positionality and experiences. Accordingly, I took critical self-reflection seriously in the process of conducting this project. Dr. Rice’s (2009) critical self-reflexive approach articulated in Imagining the Other? helped to guide my approach to reflexive praxis. Prior to and following each interview, I probed my own experience of conducting this research. During transcription, particularly in the second pass, I noted observations about my experience of hearing the participants’ stories, especially at moments in which they converged or diverged with my own in marked ways. Evidently, some participants’ stories spoke to me and resonated with my own experiences more than others. This informed my practice of research in a number of ways: for example, when a participant’s story reminded me of my own (e.g. if a participant noted having struggled with perfectionism and channeled this into exercise in ways that became destructive), I made note of this in order to ensure that I would not read my own meaning-making into their story. By marking these moments of convergence I kept an awareness that no matter how similar my story might be, I can never fully access the embodied experience of the other. Conversely, when a participant’s story differed markedly from my experience, and/or I would problematize certain constructs they identified (e.g. if a participant referred to “clean eating” having helped
them to achieve a body weight medically defined as “healthy”) I tempered my potential “gut reaction” response in order to honour their experience or “truth” as they perceived it in the telling.

To facilitate my critical self reflection, I made over 60 memos bracketing my thoughts, both personal and theoretical, which I would either need to address in making sense of the data or put aside as anecdotal reflections on my own experiences. While conducting analysis, I also noted moments at which participants’ stories seemed to intersect either with each other or with my own. Finally, following each day of the digital storytelling workshop I wrote several pages of notes upon arriving at home, reflecting on the experiences of the day. On the last day of the workshop, as noted above, I also created my own digital story about the experience of running the workshop, which touched on the ways in which participants’ articulations of their experiences informed my own personal and theoretical orientations to the concept of recovery.

**Positioning Myself.**

In conceptualizing this research project, I teased out my motivations for embarking on this work through an examination of my own positionality (socio-contextual and historically-situated space of belonging which impacts my understanding of the world as well as my relationship to my topic of interest and my participants). In 2009, I was diagnosed with ED-NOS after having struggled with disordered, disruptive eating and exercise for five years, and obtained day-hospital treatment for 8 months at a hospital in the greater Toronto area. After my recovery and subsequent re-evaluation of my academic and personal future, I began to envision a project that would address some of the tensions I found to be present in my own struggle and those of my peers, some of whom drifted in and out of treatment several times before deciding to (or deciding not to) engage with treatment and recovery. Until recently, very few people knew about
my past and the ways in which it has driven my research interests and commitment to telling the first-person stories of individuals who have overcome eating disorders. In the critical feminist tradition, I feel that the acknowledgment of my position and values helps me to make transparent the potential assumptions that may play into my research process. I strove to engage in embodied engagement, recognizing my own positionality while being open to and privileging the stories and perspectives of my participants (Rice, 2009).

In the spring of 2011, I had the opportunity to create a digital story, in which I explored themes similar to those I asked my participants to consider. Since creating this story, I have had the opportunity to share it in several different contexts, using it to examine the interface between identity and body, lived experience and research. In telling my own story, I came to acknowledge the ways in which my story both fits within and falls outside of the common conceptualization of what it means to have an eating disorder. I am a white, upper-middle class female, thus fitting me within what might be understood as a “normal” eating disordered “subject.” However, my diagnosis of ED-NOS brought me up against some of the hierarchies of eating disorder diagnoses that can serve to delegitimize the experience of identifying as having an eating disorder (Ison & Kent, 2010; Roehrig & McLean, 2010). Falling in some ways outside of the “norm” of eating disordered behavior and presentation is undoubtedly a part of what drives me to understand whether others’ social positioning or experiences create for them different encounters with society and with themselves.

In the time since I created my digital story I have come, through encounters with Project Revision, to re-evaluate my own story as I have engaged with those created by others and as I have grown and changed as an individual and as a researcher. My digital story reflects my experience as I envisioned and understood it at the time of its creation, but does not necessarily
reflect my recovery as I now perceive it. Through viewing others’ stories and engaging in discussions, I have begun to problematize the idea of “wrapping up with a bow” the experience of recovery. In a recent (March 23rd, 2013) retreat for Project Revision, a debate about whether stories need/should have “happy endings” sparked in me a desire to further probe my own story, which concludes with a definitive statement of recovery. While at the time of the story’s creation, I was comfortable with this ending, I now wonder about my choice to gloss over some of the less than desirable elements of recovery in an effort to represent myself in some way as the “perfect recovered individual.” I began to wonder, as I read more about feminist and embodiment research, whether through my story I was concealing some parts of myself that I may come up against in conducting this research.

Perhaps, as Mulvey et al. (2000) suggest, concealing the fact that some struggles still remain may have served to reinforce my position of power relative to my participants. By representing myself as one who has lived experience but who has “come out the other side,” I may have benefited from being relatable but removed from participants; however, at times, I sensed “cracks in my own armour” vis a vis my participants and the concept of recovery. Nowhere did this become more evident than in spending three days with participants during the digital storytelling workshop. Conversations over coffee and lunch brought us into dialogue that may have been impossible had I not shared similar experiences to participants. A fellow graduate student who had volunteered to help at the workshop remarked that she felt that she would likely never have been exposed to conversations such as those with which I engaged in with participants (for example, discussions about treatment experiences) had she not been at the workshop. Though these informal conversations do not explicitly feature in my analysis, this level of connection with participants can obviously not be glossed over as these unstructured and
not explicitly research-focused encounters inform my approach to the “data” generated both before and during the workshop.

My revisioning of my storied experience, now immortalized through a digital story I conceive of as a coda to my prior story, also represents the multiple meanings that can be made of my experiences, as I come to observe through reflection the ways in which my interpretation of my story has shifted alongside my subjectivity (Rice, 2009). I sought, and continue to seek, to demonstrate to participants my knowledge about issues while remaining open to different interpretations and representations of the experiences they may be able to share. By creating my digital stories and reflecting on the ways in which my social position, including my struggles, come to drive and influence my research, I feel that I am able to approach this research more honestly and fully. Though the stories told by participants do not replicate my own, I welcome these divergent viewpoints on eating disorders, identity and recovery, which, held together, help to complicate the “commonly told story” surrounding eating disorders and recovery.

Chapter 3: Results

Narrative Interviews
In their interviews, participants shared stories that reflected deeply situated understandings of the experience of having eating disorders. I attended to each participant’s socially situated story by beginning analysis with an in-depth analysis of each story as it’s own narrative. No two participants shared identical experiences and each narrative was coloured by social location, including sexuality, race/ethnicity, socio-economic status and religion. However, a number of cross-cutting themes emerged from these stories to form an overall picture of the complex and multi-faceted experience of having and recovering from an eating disorder. The following
themes should be interpreted with an acknowledgment of the various ways in which and degrees to which participants both adopted and complicated “dominant” (e.g. more “biomedical” perspectives readily adopted in much eating disorder research, clinical practice, and popular culture) and “subjugated” (e.g. alternative accounts including narrative and feminist perspectives) explanations for and discourses around having and recovering from eating disorders. In this section, I will present three large thematic areas, each underscored by a number of subthemes. “Doctor’s Orders: Standards for Recovery,” is comprised of four subthemes: “The Materiality of Eating Distress and Recovery,” “Beyond Biometrics,” “Embodying Counter Culture,” and “Recovery is an (Embodied) Place?” A second thematic area, “Through the Eyes of the Other,” includes three subthemes: “The Girl I Was,” “Authenticity and In/Visibility” and Be/Longing.” The last thematic area, “Fitting/Not Fitting Stereotypes,” is underscored by two subthemes: “Pretty Textbook” and “Missing Stories.”

**Doctors’ Orders: Standards for Recovery.**

This theme emerged across participants’ narratives in various ways, through an exploration of the various instructions given, both implicitly and explicitly, by others in participants’ lives. For some participants, the state or label of “recovered” constituted yet another set of expectations and standards to which individuals are held. However, these instructions for “living recovered” should not be read as wholly problematic: some participants found having a set of criteria (e.g. a meal plan to follow, a weight standard to attain, etc.) to be helpful in terms of “keeping them in check” or keeping them “healthy.” Others found this to be an unfitting and unduly constraining imperative, particularly as “recovery” progressed.

“Doctors orders” for eating disorder recovery may individualize the “problem” of the eating disorder and place the onus for recovering squarely within the individual. This orientation,
participants acknowledged, can be helpful or hurtful. For example, biomedically-based explanations helped some participants to achieve symptom-reduction through setting goals and rules that could objectively be followed. However, there are limits to the biomedical model that are exemplified in participants’ stories: namely, that the idea of “recovery” can uphold new instructions for living that contradict health promotion messages for the general public (e.g. having to follow a highly-caloric meal plan in an environment that encourages caloric restriction) and that participants’ understandings of recovery may not fit within measurable metrics. This theme is underscored by several subthemes: materiality of eating disorders and recovery, beyond biometrics, embodying counter-culture, and recovery is an (embodied) place.

Materiality of Eating Disorders and Recovery

Despite the potential limits of a biomedical framing outlined in the introduction, participants were fluent in biomedical discourses and often found these to be helpful frameworks for understanding their eating disorders. For example, understanding eating disorders and the process of recovery through a biomedical lens helped some participants to accept slips or relapses along the way. As Andie articulated:

I had to work a lot with my individual therapist about […] taking those moments as learning experiences and taking pride in the little things that I could do to delay binge eating and viewing those moments as ways that I was breaking the habitual nature to just continually engaging in the eating disorder […] and then just reminding myself of like, ok, I study addiction. Of course I’m going to relapse, that’s what these behaviours do. The cues that are associated with binge food intake, they’re going to trigger the compulsion to engage in it again. It’s extreme. What makes my brain so different from the norm?
Andie used her knowledge around eating disorders from a neurobiological standpoint to make sense of compulsions around food and relapse. Positioning her brain as “normal,” and these behaviours as scientifically logical helped Andie to forgive herself for “resorting to” eating disordered symptoms. Margot, too, identified her symptoms as logical, suggesting that it would be more strange if she did not return to such behaviours in times of stress:

One thing that my psychiatrist once said that was really helpful was […] “there’s no reason for you to feel guilty if you binge and purge. You’ve been doing this for 6 plus years. It would be more surprising if you didn’t.” You know, given these events. So it’s like there’s no real reason to feel guilty, it’s just like a habit, really. And that’s kind of what it feels like.

Listening to her psychiatrist, Margot took comfort in the knowledge that coping with stress by engaging in behaviours coded as disordered can actually be seen as a logical response. This demonstrates a nuance in biomedical discourses surrounding eating disorders; though these attributions do locate the problem within the individual, they also in some ways allow for a less moralizing construction of behaviours around food and exercise. Locating the problem in the brain allows for a reading of disordered eating behaviours as ones that are not the fault of the individual. Instead, they are scientifically, biomedically explained responses to stressful stimuli.

Note, however, that both Margot and Andie come from science backgrounds; both young women told their stories in ways that profoundly reflected their tendency to rely on scientific, “rational” and “logical” explanations for phenomena. However, other participants also more subtly endorsed biomedical discourses around disordered eating. Specifically, they recounted stories through words and instructions that closely mirrored medical professionals’ instructions
for eating disorder recovery. Gabrielle, for example, saw the reason and logic around prescriptions for recovery including adhering to a meal plan:

I think I had been malnourished for quite a long amount of time and I now, like one of my friends who, she’s in med school and she’s a psychiatrist […] and also had an eating disorder at one point [she] sent me some research articles that she had read which were actually saying things along the lines that being malnourished can actually start or even perpetuate [eating disorders] so I’m like, well that kind of makes sense! And they always said to us, that like no matter what after treatment we just had to keep eating and I always questioned why, and they said it affects your brain.

Quotes such as these illustrate participants’ facility in taking up biomedical explanations, particularly as they reflect back on their experiences. One of the most compelling things about these discourses, it would seem, is their overt rationality. Through these discourses, participants are able to make sense of behaviours socially coded as irrational and extreme. These biomedical discourses often featured strongly in the beginning of participants’ stories about recovery. Asking participants what the word “recovery” meant to them yielded varied responses, many of which began quite simplistically and then became more nuanced as participants complicated these concepts. Nonetheless, these initial, biomedical thoughts about recovery served to frame deeper explorations and reflect the ability of these reasonable, logical attributions to act as currency in stories about recovery. As Isa noted:

I would think that a part of it is the biological parts, right? So like getting your body back to a point where it’s healthy. So the weight gain, for me, you know like biologically getting your period back, becoming more healthy, putting on the weight
These explanations featured early on in recovery stories, which reflects a focus in the medical community on weight gain first, in order to begin the “psychological work” involved in attaining a state of recovery.

*Beyond Biometrics*

Though participants articulated biomedical discourses that reflect a commitment to the logical and rational, their stories also reflect an understanding of the limits of biological metrics in measuring recovery. Participants accomplished this complicating of biomedical discourses in both the content and delivery their stories. Katie, for example, troubled the strict biomedical criteria established in treatment programs for eating disorders using a change of voice to denote skepticism with the discourse of weight gain.

When you’re in the hospital for anorexia, it’s like…[different voice] “Recovery means being a BMI of 20” [back to normal voice] I’m like, ok, sounds good. 20 plus or minus.

Whatever, sounds good.

By telling this discourse of weight gain in a different voice, and following up with a dismissive “whatever, sounds good,” Katie demonstrates a lack of buy in. She expands on this by exploring whether it is possible to be recovered when one’s BMI is less than 20, and suggests that BMI is just a tool that health care providers can use to determine health:

There are healthy people that are less than a BMI of 20. 100% positive about that. And there are healthy people who are well over a BMI of 20. I don’t think BMI is a really good thing, anyways […] it’s the only thing that the hospitals have to measure, especially in adult treatment, as to where someone’s supposed to be. So I think it’s a useful tool in terms of getting someone to where they need to be and if they maintain a healthy lifestyle after treatment and they end up losing weight after treatment and that’s where they’re
supposed to be like whatever, cool. Though I think the whole BMI thing it’s like, it’s a tool that the professionals use, but I really don’t think it’s the be all and end all.

Further, participants problematized the notion of attaining recovery strictly by adhering to a meal plan or “refeeding,” even suggesting that such an approach set them back in their recovery journey.

When I was seeking treatment here in Ontario, I would say a huge part of it was placed on the refeeding process, and the getting me to a healthy weight. Which is understandable, I understand that completely, but it almost felt like they were rushing into that part of that and didn’t have a game plan for what help I was going to be receiving after I got to a healthy weight. I did have a lot of weight to gain but I knew that it was going to take me a lot longer to mentally be healthy again. It’s one thing to gain weight and be sent on your way, and then come home and start planning that you’re going to start losing weight again, which is exactly what I did after treatment; so, I think you do have to worry about the physical aspects, obviously, but I think that you have to come at the emotional aspect just as hard, I think (Alice).

This quote demonstrates the problematics of using medical metrics to gauge recovery. While participants adopted some aspects of biomedical discourses as useful, therefore, other aspects of a biomedical approach were seen as unhelpful when employed alone. BMI or weight, participants suggested, might be used as a proxy for recovery, but say little about the psychological well-being (or even, in some cases, the “physical” well-being) of individuals in recovery from eating disorders.

In addition to criteria for weight gain, other aspects of mainstream treatment programs implemented to support the journey toward health may be perceived as problematic. Meal plans

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in particular proved problematic in participants’ accounts, as they struggled to articulate whether meal plans were helpful or constraining for their recovery. Some participants used their abilities to set goals and follow rules to adhere to a meal plans that facilitated (at least a “physical”) recovery. For example, Gabrielle noted, “We had a goal setting group that was really good; I’m kind of a compulsive goal-setter, I like to make lists, make plans, set goals.” Meal plans also provided some participants with the security to be able to take calculated risks, while gathering the evidence they desired that to do so would not constitute a loss of control. Andie, for example, noted:

I guess recovery to me is just trying to push myself a little bit more to eat more that what I’m used to but not too far beyond to the point where I’m going to get anxious and want to relapse. And eating a full meal, I never skip anything. It doesn’t matter if I’m hungry or not, I’m going to eat at a regular time.

However, meal plans often failed to take into account some participants’ cultural practices or desires, as these were interpreted to be a part of eating disorder psychopathology. Gabrielle noted feeling quite upset, for example, when she was not allowed to dress her holiday meal in accordance with Jewish traditions:

When they served baked potatoes and pork and beans and I put my applesauce on my baked potato they called it a weird food combination, and we weren’t allowed to eat weird food combinations. And I was like how is that weird, we put applesauce on latkes, and latkes are made of potatoes, and everyone said what’s a latke?

The notion of “normal eating” loomed large in participants’ accounts, as they attempted to disentangle the eating plans prescribed in treatment in a societal context that prescribes practices around eating that directly oppose prescriptions for recovery.
Embodying Counter-Culture.

Discourses around recovery, whether prescribed by clinicians or self-imposed, come to intersect with dominant biopedagogies for bodily management in ways that participants described as constraining and overwhelming. The limits of a purely biomedical discourse on recovery (i.e. attaining recovery via “normal eating,” following a meal plan, and gaining weight to a “healthy BMI”), perceived as helpful in “early recovery” are illuminated when they are juxtaposed with “normal eating” for the masses. Participants articulated feeling that they were caught between opposing discourses for body management: those spoken by family members, friends, media, and others in the general public, and those prescribed in healthcare settings designed to facilitate recovery from eating disorders. Especially in moments of “vulnerability,” some participants expressed a feeling of differentness in the way they “have to be” or are instructed to be around food. Describing this feeling of being caught in between, Andie said:

I’m still surrounded by thoughts that losing weight is always better, any weight loss is better. Like I was fairly thin before I became vegetarian and went into strict dieting, but still because I lost weight I was like oh I’m even healthier now, I’m even better now. And that really was not the case, I shouldn’t have lost any weight.

The messages participants were exposed to were especially challenging once their bodies had crossed over into a place where they were read as “normal”: no longer marked by the physicality of “having an eating disorder,” participants were assumed to be in thrall to the same biopedagogical instructions as those who had never “had eating disorders,” a bind that weighed heavily on some participants:

And that’s always seen as something that everybody does. People don’t just ask “are you on a diet,” but “what diet are you on?” I run into people who are surprised that I’m not on
a diet. I’m like … are they trying to say that I should be? Or is it just that everybody is?

(Gabrielle)

Some participants described following a “counter cultural” recovery as extremely difficult, even “mind-blowing”:

When I was in the first stage of recovery […] I couldn’t believe the things they asked my parents to do like put melted butter in hot chocolate to boost the calories, you know? Like dessert every day right after dinner and then a snack after that. Mind blowing. [...] it’s like very opposite [to] “make healthy choices, follow Canada’s food guide,” that kind of thing and I’d be like well, sorry, I’ve got to go home and eat my chocolate cake and Ensure! So it was very hard— it made it very hard to believe the doctors that were telling my parents that. I was convinced they were wrong because they were saying the opposite of what everything else was saying. And that made it really hard to follow through. (Ella)

Enacting this counter culture entailed acknowledging the prescriptions given to the general population (e.g. Canada’s Food Guide) and recognizing that “recovery as prescribed” often involves embodying the reverse of these prescriptions (e.g. by eating chocolate cake and drinking Ensure). Despite this difficulty, however, instructions and meal plans prescribed by dieticians to participants in recovery acted, at times, as evidence and ammunition that allowed them to combat dominant discourses surrounding weight, shape, and food, in ways that others may not be able, lending credence to the uphill battle of acting counter to culture.

She asked me how often I ate chocolate, and I say, you know, every other day. And she says “you should be at the other end” [of a “healthy” food vs. “junk” food consumer spectrum] and I said no, I’ve seen a dietician who has actually told me that this is what I should be eating and I follow a nutrition plan almost exactly. And the woman’s kind of
looking at me like, but you eat chocolate and chips and cake and I’m like yes I do

(Gabrielle)

The extent to which gazes of surveillance operate on and are internalized by individuals with a history of disordered eating is evidenced by their behaviours around food in and beyond treatment. In describing her experiences at a non-specialist treatment centre, Katie reflects:

I felt like I was treated like a not even a child- like a case study, it was very, very odd. I just remember this one woman, giving me my night snack or whatever […] she just sat there and looked at me. Sat there and looked at me with this sandwich, and I was terrified of eating this stupid sandwich, and she was so mesmerized by this anorexic girl eating this sandwich and I was mortified. It was awful.

This surveillance does not end in the treatment setting; individuals’ histories of eating disorders may continue to colour interpretations of their behaviours long after treatment. The idea that individuals who have recovered from eating disorders must be ok with eating things that others would be praised for not eating was often described as problematic. Behaviours and actions that would be read as health-conscious and imbued with positive meaning for “normal” people may be read, in individuals who have recovered from eating disorders, as elements of continued pathology. Margot in particular took issue with the standards to which individuals in recovery are held, versus those given to others.

It’s like you have to be ok with eating everything […] and for other people’s it like some level of “oh well that’s kind of oily I don’t want to eat that,” but for you it’s like “that’s your eating disorder talking”

Calorie-counting, too, takes on a very different meaning in the different “phases” of eating disorder recovery. Participants expressed difficulty with determining when following a meal plan
moves from something that is required in treatment to evidence of the remnants of a disorder. Particularly in “recovery-oriented” online communities, Margot reflects, calorie counting is frowned upon as evidence of one still being engaged in disordered eating. However, she and other participants challenged the idea that calorie counting or being relatively rigid around meal timing is evidence of continued disordered eating, seeing it instead as evidence of a continued commitment to health.

If I don’t count calories I’m going to lose weight […] for me counting calories helps because I just am not that hungry for things, or if I don’t know then I tend to under-eat. But if you mention counting calories in those [recovery-oriented] communities, it’s like you’re just trying to lose weight. Right? It has this huge negative connotation. Huge.

(Margot)

Meal plans and other metrics for health are evidently not simply “good” or “bad” for eating disorder recovery; different social actors, including participants, doctors, dieticians, friends and family members deploy these discourses in alternatingly problematic and helpful ways. Participants described significant tension associated with knowing that some aspects of the treatment or care may have saved their lives, but were in some ways problematic as recovery progressed. This reveals an important distinction to be made when critiquing approaches to treatment and care for eating disorders that repeatedly emerged in participants’ stories: it is impossible to reduce discourses to solely being helpful or hurtful; these discourses serve fluid and dynamic roles in participants’ lives and are more or less helpful depending on where a participant is in her recovery and life. Maya encapsulated this tension in reflecting on her experiences with cognitive behavioural therapy:
You know as a critical mental health researcher now I often write a lot of work that resists cognitive behavioural therapy, or at least its use as a cure all, but cognitive behavioural therapy saved my life when I was 21. You know, it really did. Exercises like [...] I drew my body or what I thought my body looked like, what other people saw when they looked at me, and then my therapist drew what she saw and these sorts of very quick dismantling of my frameworks of looking at myself and understanding myself. And it was really it was amazing. I’d just basically been living in a lot of fear for a really long time. And it sort of made me realize where I was coming from.

Rather than dismantling or completely abandoning these discourses, therefore, participants discovered ways of working both within and beyond dominant discourses and prescriptions for recovery.

*Recovery is an (Embodied) Place*

Participants differed markedly in terms of their orientations toward recovery as a state or a process; both orientations toward recovery featured in participants’ accounts, with some participants articulating both within their stories, and others choosing one orientation which pervaded their stories. A distinct tension also emerged as participants considered whether they actively sought out recovery or felt that they had “no choice” but to recover, which informed participants’ orientation toward their recovery (i.e. as journey or destination, or even as something they actively desired). For those participants who saw recovery as having been externally imposed, stories were told about imposed imperatives to recover in order to please others. Gabrielle, for example, felt that she literally had nowhere to go if she did not recover:

> By that point I kind of realized I had no choice. Because my mom didn’t want me to come home, I had attempted suicide and ended up in the hospital so she didn’t want me at
home, my roommates weren’t speaking to me, residence had kicked me out. The guy I was dating at the time said that I could have come with him, but he said that I could trust the fact that I wouldn’t be eating any less than I was in treatment. Like I once said can I drop out and come to live in Boston with you and he says sure but you’re still going to be eating 2000 calories a day. I’m like oh. And then. And so I think I just gradually started realizing that I’m basically really had no other choice.

Left without any other option, Gabrielle recovered in order to reclaim a sense of belonging in her life and to be accepted back into her relationships with family and friends. For others, “recovery” was more explicitly forced upon them:

The only reason I got recovered, was forced to be recovered, was because I got found out about it [by] my family. And then when that happened it became basically impossible. They were watching everything I did. And I was basically- went to eating disorder counseling just because they wanted me to. I never wanted to like recover (Amy)

Accounts such as Amy’s differ markedly from other participants, who describe their desire for recovery as deep-seated. However, a desire for recovery was not enough to “get there”: other participants were adamant that recovery was not simply a choice to be made, but a journey that involved a great deal of work.

I had wanted recovery for a very, very long time, even prior to going into treatment, but I had no idea how to get there. I had convinced myself that I would never recover, basically. It was something I was just going to have to deal with for the rest of my life. And it just seemed that it took so long to get where I was in terms of my eating disorder and be so low that I couldn’t imagine coming back from that. So to begin with it was very overwhelming to think about ever being fully recovered. Yeah. I did want to recover,
which I think really worked in my favour- I think so many people go into treatment and fight it tooth and nail, and I think to get out of these things- so at least I wanted recovery and was open to, you know, treatment, and that I wanted help, so I think that played a major part in my recovery but like I said it wasn’t like an easy task once I wanted it (Alice)

Ongoing efforts to recovery were also complicated by this “overwhelming” idea of “full recovery”:

Thinking so much about full recovery is kind of like only being able to run one kilometer and thinking about when you can run a whole marathon, right? It’s like that’s too big and it seems so, like it can seem motivational to some people like yes I want to get to that point where I can run a full marathon, but to other people it seems ridiculously intimidating (Margot)

Evidently, there is a major difference between the desire for and the achievement of recovery. Further, recovery did not always feature in participants’ stories as something that could be measured objectively. Recovery often resembled a process or something that participants lived every day.

The term recovery to me is tricky because I consistently think of recovery as a process, and not something that I necessarily fully achieve but that is something that I’m continuing to maintain. So it’s kind of like an action, like I’m living my recovery every day. Rather than like I’ve reached this one moment saying ok I’m better. Because I feel what that does and using the term in that way it sort of denies you the space to say that it’s hard. To say that it’s actually difficult sometimes. To say that sometimes I eat too much pizza and I feel that thing in my chest and I, and I could go and throw up but I
don’t. And to me that thinking of when I say that I’m recovered, perhaps would be in those moments I feel that I’m recovered when I don’t do it. That I choose not to, that I make the choice not to. Because it’s ok. And so that- but it’s not something that you know it still happens now. So in a psychiatric medical model I might not necessarily fully be recovered, because I still have thoughts about eating, you know, I still think about it, but you know I don’t I don’t do it anymore. (Maya)

Maya’s quote explicates the nuances around seeing recovery as a “place,” a state, or even a choice versus seeing recovery as an ongoing process. Rather than seeing a turning point in her recovery, Maya sees recovery as a *series of choices*; the decision to act opposite in the moments where she knows she would previously have engaged in symptoms. Seeing recovery as an ongoing process in some way resembles other types of recovery, and participants sometimes likened the process of recovery to alcoholism in saying that they would “always be in recovery” or refusing to place a label of “recovered” on themselves. However, other participants distinguished between recovery from eating disorders and other types of recovery.

Some treatments like for alcoholism and stuff like that that is your identifier, like you are an alcoholic, and that never flew for me. Because even when I was the sickest that was still just a part of me, which pissed me off, because then my dad couldn’t see those other parts so I think that’s something of what recovery means. (Isa)

Isa nuances the concept of recovery from an eating disorder and differentiates this recovery from recovery from alcoholism, for example, by refusing to see the eating disorder as being wholly representative of her and her life. In much the same way, participants’ stories were rich with acknowledgement that though their eating disorder and recovery had played a major role in making them who they are today, the eating disorder was not the only salient element of their
personalities or lives. Neither the label of “eating disordered” or “recovered” fully encapsulated their subjectivity, regardless of where on this “journey” they could be found.

**Through the Eyes of the Other.**

Another major theme evident throughout participants’ narratives was the sense of knowing oneself through the eyes of the other. Participants reflected back on their experiences in profoundly relational ways. Not only did these young women relate their stories through interactions with significant others, however, but they also explored the similarities and differences between their own “past,” “current” and “future” selves. As such, this theme is divided into the sub-themes: the girl I was, authenticity and in/visibility, and be/longing.

*The Girl I Was.*

In their stories, each participant reflects back on the “person she was” at various moments in her eating disorder and recovery. In the retelling, some participants constructed themselves as entirely different than the person they were during their illness. Some reflected that they didn’t recognize that person, or that their memories of the time were blurry, foggy, or fuzzy. Some participants explicitly addressed this sense of change, where other implicitly alluded to “stages” of their lives that they are now able to reflect upon. For some participants, reflecting back on the “girl she was” while engaging in eating disordered behaviours was quite distressing.

When I came into treatment I couldn’t think properly. I used to be a straight A student and that semester before going into the hospital I could barely write a sentence properly, I was having trouble reading, and it was kind of weird […] I was a very avid reader when I was a child and then suddenly I was 19 and I was finding it really hard to read. It never occurred to me that it was because of the eating disorder. I thought I’d suddenly become
stupid or something. I couldn’t grasp quite why it was so difficult to… like I could decode a sentence but I wouldn’t really know what it meant. (Gabrielle)

At the same time, participants recounted some of these experiences with humour, as though they were sharing stories of someone else, watching from the outside as things that seem laughable now played out: “I was the girl who had a panic attack and passed out from hyperventilating because of a baked potato” (Gabrielle).

Reflecting back on experiences such as these, participants explored the negative aspects of their eating disorders. Many described their memories of this time as blurry or foggy, and the “girl they were” during the eating disorder as somehow less than the person they “normally” were or wanted to be. For some participants, this was a strong motivator for recovery. Desiring other things from life, including either returning to a more ideal self or seeking a future self, acted as a turning point in some participants’ stories.

I think I was just mentally and physically exhausted. I wasn’t even the same person as who I am. This was slowly destroying me, not only physically- I couldn’t do any of the things I’d done before, but emotionally I was just a disaster, I didn’t have any of the same interests, I had no goals, you know waking up the next day and losing more weight was my only goal, I couldn’t see anything beyond that. I couldn’t plan for my future, anything like that. It just really hit me one day, it was just like- I don’t want this to be my life anymore. (Alice)

I wanted to be… I wanted to be free like the people around me. Like my friends didn’t diet […] that kind of stuff it just makes you isolated. I didn’t want to be isolated. And I think I always had sort of this future self in mind of what I wanted (Margot)
The kind of self-reflection evident in participants’ stories was acknowledged by many to be borne of time and space offered by recovery. When asked about what the difference was between her acknowledgement of the issue now versus when engaging in disordered eating, Julie noted:

I think just time. Time and situation. Like I can compare now to then and it’s like… ugh. So I think I just recognize a lot more situations […] 20/20 vision, looking back you can always see better […] I think that just time and letting myself come to terms with the fact that maybe I did have a problem was really helpful

“Coming to terms” with the idea that she had a problem was particularly difficult for Julie, who was never diagnosed with an eating disorder. She was not unique, however, in not feeling like her disordered eating was problematic while it was happening. Despite the salience of reflection in the young women’s stories, this theme should not be interpreted as reflective of a desire to return to a self ostensibly “before” the eating disorder, nor should it be taken to indicate that participants’ subjectivities were fully subsumed into the eating disorder. For example, Margot noted that the idea of going back to a self prior to the eating disorder is illogical and not even desirable:

[…] going back to the state you were before your eating disorder, and I don’t think that’s possible. Most of the time. Because you’re a different person. When you’ve gone through this experience. You can’t undo this experience. This experience changes you, like every other experience

For Margot, the changes wrought by the eating disorder were not unique to eating disorders, but rather a function of generally moving and evolving through life. The difference between changes attributable to the eating disorder and those that have come as participants have matured was a subtle distinction that some participants began to tease out. For example, Maya described coming
As I’ve gotten older I have become more accepting of what my body is and isn’t. So over time I’ve stopped trying to change it, in the sense that when I was like 18 I was running because I wanted thinner thighs. Whereas at 30, I’m running because my brain is going to explode because I can’t look at this thesis one more second, I’m going for a run. So it’s kind of like very different purposes around what I use running for. And I think, you know, being ok with the fact that I have bigger thighs or that I have, don’t have a 6 pack, or that, just sort of liking the way my body is. Which is not something I ever did. Before.

The “before” and “after” of eating disorders is inextricable, in some ways, from the before and after of maturing into adulthood. As Maya’s quote illustrates, the motivations behind behaviours can also change without the behaviours actually changing, an important distinction to be made that is also relevant to the theme of standards for recovery. Participants deftly navigated standards for health as they created their own definitions for which behaviours were personally salient in maintaining health, such as running for Maya, or continuing to follow a meal plan, for others. This illustrates the individual differences that pervaded participants’ accounts, as well; just as behaviours are not categorically “healthy” or “unhealthy” for individuals without eating disorders, so too are behaviours more indicative of individual orientations toward bodies, food, weight and shape than they are of adherence to specific standards of recovery among those with a history of disordered eating. Nonetheless, these behaviours are negotiated in interaction with past, present, and future selves, in addition to members of the general public.

_Authenticity and In/visibility._
A pertinent subtheme in analysis of the relationality in participants’ accounts of their eating disorders and recovery is how encounters with others, and seeing their disordered eating through the eyes of significant others in their lives, coloured their feelings of authenticity surrounding both eating disorders and recovery. Participants’ stories were rich with descriptions of encounters with doctors, friends and family members who interpreted their illness or lack thereof via observations of their physical bodies. When probed for the effect of such observations on their feelings, participants tended to respond that these encounters made them struggle with feelings of legitimacy or authenticity.

I think it started after I’d lost about 20lbs, so about halfway through the total weight I lost. Because at that point like I did not look healthy, I mean my skin looked grey, I started losing hair, like, my wrist bones and collar bones and stuff were sticking out, like my clothes were all sort of falling off, so my mom definitely was one of the first to kind of notice and say hey this isn’t good. My dad sort of stayed for quite some time even after my mom spoke with him he said no no she’s just being healthy, which I think he, like it’s understandable. It’s not an easy thing, and I didn’t live with him so he only saw me when I went to his house to visit every week, so it was a little different (Ella)

Often, however, participants’ physical appearance was at odds with their psychological well-being. Sometimes, participants were struggling but maintaining a “normal” body weight, leading to their symptoms being missed and an increased ability to “shrug off” poor mental health. Maintaining a “healthy” body weight was sometimes a side effect of engaging in behaviours such as binging and purging; in these cases, it may be only until after the binging and purging has crossed over into restricting that the disorder is noted by significant others.
I stayed I think at a relatively healthy weight the low end of the spectrum but a relatively healthy weight I think for a couple of years. And with that it sort of went unnoticed to a lot of friends that I was even struggling, which made it difficult for me to seek out help because it felt like I almost didn’t deserve it because I was you know technically still at a healthy weight. It wasn’t until after I stopped my purging, my binging and purging, that I actually really lost a lot of weight and was diagnosed with anorexia, and was looking into different treatment options (Alice)

At times, participants described actively avoiding letting their bodies read as disordered by not “fully” acting out disordered behaviours.

And I never really had the guts to fully really go through with a big enough cry for help because I knew that it would embarrass my mother and I just I really didn’t want her to be embarrassed on top of everything else. You know? (Maya)

Not having others notice or acknowledge eating disorder behaviours often led to participants continuing to discount their own feelings of distress. Seeing their bodies through the eyes of others fed into feelings of not being sick enough or not warranting treatment. Disturbingly, these opinions and readings of their bodies were often replicated by physicians:

I went to the doctor to get like blood work done and the doctor’s like… you’re fine. But you have the BMI of an anorexic. And that started getting the wheels turning that like… maybe something is wrong (Andie)

Equally, recovery status was often tied up, in others’ eyes, in the achievement of a healthy body weight. While participants often described weight gain as a necessary first step in attaining recovery, they explained that family members and friends in particular failed to recognize that gaining weight was not wholly representative of recovery.
I think a lot of people seemed to think that once I was out of the hospital I was good to go. And especially my mom, I don’t think that she quite got that […] she wanted to bring me to her class at the gym almost right away, and I was like no I don’t want to go to like fitness class for mostly old people yet, if ever (Gabrielle)

The weight restoration is the first part. And it is really important, because you can’t really think straight until you’re sort of at a healthier state, physically, but the biggest part and definitely the hardest part is the mental component, and that takes a lot longer. Most people aren’t going to look like the typical eating disordered person at that point. And it’s hard because people will often disregard any stress or anything that you’re feeling because you don’t fit that image. And they assume that means you’re better. And that’s so far from the truth (Ella)

Evidently, the reading of bodies as representative of eating problems becomes problematic when we consider those whose bodies never transgressed the “normal.” Individuals who do not “need” to gain weight in recovery, thus, may feel that their struggles and ensuing recovery are not authentic or legitimate in the face of strong messages from others who never read their bodies as disordered in the first place. This played out especially in the stories of participants who were never diagnosed, for example Julie, who still struggles with whether or not she “actually had” an eating disorder. Throughout her story, Julie wavered in and out of understanding herself as normal and abnormal. The way she describes her “recovery,” thus, is somewhat different from the way that diagnosed participants explored their recovery, and is ripe with qualifiers and downgrading. Interestingly, even when friends suggested that Julie was suffering from an eating
disorder, she continued to insist that she was just “being healthy” and even now occasionally doubts the legitimacy of her disorder.

My friend had said all these things, like all these signs pointed to me being bulimic, which I wasn’t; I was never bulimic, never anorexic… I knew I was small, I just wasn’t going to stop my habits. So. It was really awkward then because it actually caused a huge rift between her and I, she didn’t trust me anymore, and I wasn’t lying to her

When asked if she went to the doctor to attend to some of the physical ramifications of her eating and exercise behaviour, Julie replied:

I did go to the doctor in second year because I hadn’t had my period for a year and a half. But it was stress based, a lot of it was… I wasn’t eating enough, based. Like enough calories. That’s what we assumed. Because my weight was normal- it was like 110 to 115 or something- but I just wasn’t getting my period and we didn’t know why, but it was just totally stress-based, that’s what they said. They said it’s probably just an estrogen thing

Her lack of concern about not eating enough and stress was compounded by the doctor’s reassurance that because she was at a “normal weight,” she could not possibly be suffering from an eating disorder.

There is a tension illuminated in terms of knowing behaviour as problematic and who has the right or ability to determine behaviours as problematic. Particularly for participants whose disorders began in early adolescence, these behaviours seemed “normal” until marked otherwise.

It honestly, it didn’t occur to me until, it was a few weeks after I turned 13, that was when I realized that what was actually happening to me- I remember I wrote in my diary “am I anorexic? I wonder if a person actually knows if this is a problem” and how do I know if this is actually what is happening to me? And I had no idea really like until then what
could be wrong or what was wrong, or even that something was wrong. For the longest
time it just felt like kind of a normal thing that I just should be doing (Gabrielle)
Individuals with eating disorders, in some ways, are left at the mercy of clinicians and others to
mark their behaviours as problematic; these behaviours may not ever feel “abnormal” to the
individual. Problematically, however, rather than attending to the meaning participants give to
their symptoms, clinicians and others may interpret illness and wellness using the proxy of
bodily appearance, which may or may not be at odds with subjective experiences of distress. To
greater and lesser degrees, others’ readings of participants’ bodies played heavily into their
feelings of (il)legitimacy in terms of the “authenticity” of their disorders and recovery.

Be/Longing.

Participants relayed experiences of feeling alone both while suffering from an eating
disorder and in recovery. Spaces of belonging and the “type” of aloneness, belonging, and
longing, differed markedly between participants’ accounts. However, the idea of feeling different
and desiring belonging held as a common theme throughout participants’ accounts. For some
participants, communities and belongings were unhelpful during the “active phase” of their
disorders, feeding into their symptoms and supporting behaviours they viewed as detrimental to
their health or even, in hindsight, “crazy.”

I started looking up stuff, because I was a big computer person […] I found communities
of girls who’d just like […] we’d share tips with each other, we’d obsess, like crazy.
We’d share diet tips and exercise tips, it was kind of obsessive. Yeah, there is online
communities for it, too. Where they actually support each others’ eating disorders, which
is pretty crazy (Amy)
As Amy notes, she sought out this online community to discover more tips for enacting behaviour that would lead to weight loss. Though she was, at the time, pleased to find these other young people engaged in similar behaviours, she reflects back on the obsessive nature of this belonging as “crazy,” and her voice denotes incredulity at the existence of these communities. This pursuit of community and belonging is particularly salient when looking at the backdrop of Amy’s story. Earlier on, Amy described extreme bullying and loneliness. She mentions having felt very different from her peers and a strong desire to “fit in.” Thus, it is unsurprising that Amy found solace in an online community of like others. As she continued into her story, Amy noted finding a new community that suited her desire for belonging while also supporting a more nourishing approach to food and exercise: “I got more involved with other people who were vegetarian and vegan, as opposed to like a whole group of anorexic and bulimics. So it kind of helped me get away from that.” This new group helped Amy to negotiate longings for community and sameness in a more moderate and sustainable way than the “craziness” of the online eating disorders community.

Other participants shared a sense of being lost, alone, or lacking community, sometimes turning to symptoms for solace or “just something to do.” For Andie, for example, being alone and without significant others led to re-engaging with behaviours that became comforting and reinforcing:

I moved here and started walking more which made me lose weight, which I shouldn’t have done, and found to be reinforcing […] I didn’t know anyone [here], I was separated from all my family and friends. […] I was really lonely and bored and started the pattern again. And this time the binging got worse and more frequent and I was more and more depressed.
The comfort of engaging in these behaviours was short-lived in the absence of loved ones, which actually helped to drive Andie’s work toward recovery, as she found a new community of others working toward recovery: “I loved the groups. It was extremely validating to be in a room with other people who got how powerfully comforting an eating disorder could be.”

“Being in a room” with others who had experienced similar things was comforting to several participants. In some cases, this sense of relatedness helped them to see their behaviours as founded in logic and as less “abnormal.” Relating to other patients served as a boon for some patients, who were able to negotiate the possibility of recovery with others who had “been there” and gotten through it.

This girl called Kate who had been there for a few weeks and she was in her last weeks of the program and she was a few years older than me, she came and sat down on the foot of my bed and asked me how many years I had had this problem for and I said like you know conservatively like 7 years, otherwise maybe closer to 9, and she says how long do you think you’re going to be here for and you know I thought I’d probably be there for about a quarter of a year and she asked me to do the math and compare that to how long I’d been sick for. And that was an eye opener (Gabrielle)

However, the experience of being around other with eating disorders could also be confusing or even detrimental to recovery. For Katie, treatment not only marked her behaviours as abnormal, but taught her about what it “meant” to be anorexic: “I learned like the tricks, like how to like function in society with like anorexia. How to, you know, stories from other people, which I was eating up.” Margot also perceived groups to be frustrating, as she saw that other members of the group did not want to recover: “I didn’t like the environment, the fact that a lot of the kids there- well, adolescents- didn’t want to recover whereas this is what I wanted.” Being
around others with eating disorders represented, to some participants, a sense of belonging, where as for others it served to reinforce feelings of differentness and aloneness. Longing to belong emerged at various points in participants’ stories while participants sought to find a place where they felt supported and that they “had somewhere to be,” either emotionally or physically or both.

**Fitting/Not Fitting Stereotypes.**

A final major theme to emerge from participants’ stories of having and recovering from an eating disorder pertains to the stereotypes that loom large in talk about eating disorders and recovery. Regardless of whether participants’ narratives resemble, to the outside eye, the “told story” of having and recovering from an eating disorder, participants described moments of conforming to and moments of transgressing stereotypes. This theme is underscored by two subthemes: pretty textbook and missing stories.

*Pretty Textbook.*

Near to the end of the interviews, all participants were asked about what kinds of messages they had received about eating disorders and whether they felt as though their stories fit the stories we hear about eating disorders. Participants were quick to speak about and to debunk common stereotypes around eating disorders, for example that all sufferers are young, white women in thrall to media imagery. Participants did not blame the media for “causing” eating disorders, but cited media representations of eating disorders (and eating disorder recovery) as overly simplistic. Interestingly, however, many participants described their stories as “textbook,” even before this question. The facility with which participants were able to articulate some common stereotypes around eating disorders is telling, as is how they linked their own stories to these dominant (and to some degree, medically-dictated) stories. Many
participants wavered in and out of calling their stories “textbook.” Some participants found their symptoms unique until they encountered others with similar symptoms.

I had no idea what an eating disorder was, like this was very odd things and later on when I first went to treatment I learned that all these people were doing the same things as me, and I was like, they came out of my head, like I don’t understand how all you people are doing this stuff (Katie)

Suddenly as a 16 year old I’m sending emails to this girl in Illinois and mentioning some of the things I do and she’s like I do that too, I think that too. And part of me realized that things that I thought were just me were actually classic eating disorder things? (Gabrielle) Behaviours became coded as “eating disordered” through social or clinical encounters; through encounters such as these, participants came to understand their behaviours as “textbook” eating disorder symptoms, instead of creative ways to manage distress.

Some participants began their stories by identifying the things about their experiences that they perceived to fit the stereotypes around eating disorders, for example Andie’s suggestion that she was typical in her perfectionism and feelings of isolation: “I guess I’m typical in that I’m a very perfectionistic person, and it sort of began during the period- in a period in my life when I was feeling particularly isolated from friends.” Alice, too, began her story by alluding to how her eating disorder is “like a lot of eating disorders”:

I think my eating disorder started… it’s hard to kind of really pinpoint- about when I was 14 or 15 and like a lot of eating disorders it started out you know wanting to lose a little bit of weight, I thought it was, at this point, just exercising and eating well.
To nuance the idea of fitting the stereotypes, particularly the stereotype of the “skinny white girl,” it is important to contrast participants’ current understandings of their journey with what they experienced at the time. Amy’s story, which she mentions she has shared with many different therapists over the years - an experience that has allowed her to make sense of and filter her experiences through therapeutic lenses - illustrates this point:

Back when I was experiencing it, I did not think I was skinny, no one ever said I was thin. No once ever was like oh she’s so skinny, no one ever said a thing to me. Like, I thought I was fat, still, and now I look back at these pictures and I’m like what the hell was I thinking.

Once again, participants’ understandings of how well they fit within eating disorder stereotypes surrounding is mitigated by how others marked their experiences.

*Missing Stories.*

Despite acknowledging how their stories fit, in some ways, with dominant understandings of what it means to have and to recover from an eating disorder, participants also nuanced the simplistic assumptions made about eating disorders. Some overtly expressed frustration with the limiting portrayals of young women with eating disorders, while others described their experiences of not fitting within these stereotypes as having limited their ability to seek help.

I’ve never seen a story about an eating disorder from a Black girl. In my life. Ever.

Oprah’s specials never had Black girls on them; they were always blonde, sometimes they were brunettes, but usually they were blonde. Dr. Phil? No Black kids talking about eating disorders. (Maya)
This kind of critique was a common response regardless of whether participants self-identified as being from minority backgrounds or not. Frequently, participants expressed frustration with the missing parts of stories that led to aforementioned feelings of inauthenticity or inadequacy. This was particularly salient in cases where participants felt as though dominant stereotypes around eating disorders drove others’ responses to their experiences. Margot, for example, critiqued clinicians’ responses to her eating disorder, particularly when she was an adolescent, who assumed that she was in denial or not willing to recover, which was not the case.

That’s kind of how the doctors treated it as well, like oh see Margot like your weight is dropping. And I’m like, you know they’re pointing to a chart with a negative slope and I’m like- yeah, I can read charts, like I know my- and they’d kind of say it in this like well as if my parents are forcing me to be there, and it’s like no, I have to like hide this from my mom.

Maya’s story in particular speaks to the binds that multiple cultural and familial myths can exert on an individual’s subjectivity in the pursuit not only of recovery but of maturing through life in general. Just as participants debunked and nuanced stereotypes around eating disorders as they recovered, Maya struggled to negotiate her identity as both someone who used binging and purging as a means of handling distress within discourses of problems staying in the home and “having nothing to be sad about.” This very active work against the norms not only of her culture and family but of the possibility of having an eating disorder was extremely hard, and required space and attention she was unable to take in the home, accounting for her journey having begun in later life (young adulthood).

When I went into therapy my first therapist was a Jamaican woman and my family is also Jamaican, and so I told her how scared I was to even be there. She was just wonderful
because she just sort of repeated back all of these sort of like cultural responses to what I was going to be doing and dismantled their truth, and so she basically helped me feel ok with going forward into sort of a full blown sessions. When my mother found out that I was in therapy [...] she was like “are they blaming me for everything? [...] You haven’t told them about your father and me, that’s our family business” [...] she was very resistant to it. Eventually she got over it when she realized that it didn’t make me hate her, or say that she ruined my life or these kinds of things. But at the time it was quite difficult, and there just wouldn’t have been space, when I was younger, for that to happen. Because it would require sort of like, someone to first have recognized that there was a problem or that feeling these things and being sad in that way and thinking those things were bad, right?

Working within and beyond dominant and subjugated discourses required, for Maya, a therapist with whom she could relate and explore ways of dismantling truths. While this ongoing work toward and need for deep engagement was most explicit in Maya’s story, other participants explored, to greater and lesser degrees, the need to find their own subjectivity within a socio-cultural environment rich with stories about who is “allowed” to have an eating disorder, and perhaps more saliently, who is able to recover.

**Digital Stories**

The findings described above are crystallized through an analysis of the digital stories created over the course of the workshop. Over all, the digital storytelling workshop provided me with an opportunity to interact with participants on a deeper level through engaging in the co-creation of art. Participants each created a unique and powerful story that reflected their experience as they saw it on the day of the workshop. A prevalent notion in narrative theory, that individuals select
moments of their lives to tell at particular moments to particular audiences (McAdams, 1985; Reissman, 2008) proved very true in the digital storytelling workshop. Though analysis of all three stories is ongoing, in the context of this thesis I will present the stories as “case studies” to illustrate the additional richness added to analysis by including artistic data. However, the digital stories together, as well as the process of holding the workshop, have deeply informed the analysis of the interviews presented above (and see methodology chapter).

**Case Study: Margot.**

From the very beginning of the workshop, Margot was clear about what she did not want her story to be. Margot wrote several versions of her story over the first day and a half. “Finding the moment” (CDS) was not easy; she explored ideas including her frustration with capitalism and ideas of productivity, success, achievement, and “life worth living,” and spoke openly about how sometimes she felt like the whole notion of “full recovery” seemed overemphasized or a “picture perfect, fairytale” idea. She was also very clear that she did not want someone to watch her story and feel like this was “the story” of having and recovering from an eating disorder. It was, she made sure to point out, just what felt most true to her “on the Saturday that [she] wrote it.”

She told me that she was “sick of” recovery stories that told of the “fall from grace” and easy, full recovery; these stories are commonly represented in media outlets and online (Hardin, 2003; O’Hara & Clegg-Smith, 2007; Shepherd & Seale, 2010), as well as on YouTube. Margot has an online presence in the “eating disorder” and “science blogging” world, and so was also very conscious of the type of audience for which she wanted to construct her digital narrative. Like the other participants, Margot seemed to have an audience in mind when writing her story (blog readers, including individuals with eating disorders, practitioners, and fellow science
bloggers). This is one area in which the creation of digital stories differs from the interviews: the narrative orientation to the listener was very clear from the outset. Less than in their individual interactions with me, participants were consciously assembling their stories to portray recovery as “truly” as possible.

Margot told me that she did not want to come off as if she had been someone stripped of all of her “good qualities” during her eating disorder. Rather than taking an externalizing slant toward understanding her eating disorder (e.g. Maisel, Epston & Borden, 2004), she seemed to take on more of a poly-vocal understanding (e.g. Saukko, 2008), seeing her self-with-eating disorder not as a less authentic version of herself, but one who used different coping mechanisms to handle stressors and anxiety. It was very important to Margot to portray this both verbally and through images; she spent hours assembling photos that she felt might represent the words she shared. She noted feeling inspired by digital stories from the New York Times, which were visually streamlined, black and white, and slowly shifting. This influence is evident in her final story; she selected fewer images than other participants and included very simple transitions.

Margot begins her story by unpacking some of the common myths and stereotypes around eating disorders; namely, that girls who suffer from eating disorders are “shallow, vain, or fragile.” By orienting the listener to these qualities, Margot marks her deviance from this script from the outset. She uses another three-part list to exemplify her divergence from the stereotype near to the end of her first clause; she says that she “didn’t much care about fitting in, being liked, or being thin.” Margot takes up a number of more biomedically-oriented discourses in the process of telling her story, including using the term “anxious dysphoria” when she describes how her eating disorder became a coping mechanism. When asked about the use of this phrase, Margot cited a talk by Cynthia Bulik, a prominent eating disorder researcher whose work
focuses primarily on neurobiology of eating disorders (http://www.youtube.com/watch?v=zi2xXEz0J0g&feature=youtu.be&t=9m21s).

As mentioned earlier, Margot continually spoke about her disdain of “capitalism,” and the neurotic pursuit of productivity. She unpacks these notions in the middle clause of her story, as she describes grappling with feeling that she was not “doing enough, accomplishing enough, or working hard enough.” The literal and the metaphorical play out in examining the imagery Margot chose to accompany her words. For instance, in her discussion of productivity, Margot uses visuals to exemplify what she means. When she says she “kept going. Running,” one could take this metaphorically if reading or hearing the words. However, Margot selected an image of her literally running in a race. Using a literal image to augment a metaphorical statement creates tension and draws the viewer’s attention.

This is particularly interesting in the context of eating disorders; by choosing this image of engaging in exercise, which is socially coded as a “health behaviour” in conjunction with a statement about being caught up in the pursuit of productivity, Margot illustrates the detrimental effects of the continual striving-toward-excellence so prized in modern Western society. Margot did note that her running was actually helpful in her recovery; however, the selection of this image resonates with (at least a metaphorical) striving-for-excellence. Margot’s frustration with capitalism and the pursuit of productivity highlights the biopedagogical bind in which many participants felt trapped. The regulation imparted by biopedagogies is focused on the molding of productive citizens through the creation of a self-disciplining population (Harwood, 2009). Population and individual control is done, thus, not by imposing overt force, but by teaching ways of being in bodies (Foucault, 1978; 1979; Foucault & Gordon, 1980).
As her story progresses, Margot describes “divorcing herself” from these dominant notions of productivity: she chose to focus on quitting her PhD at Princeton (notably, a highly-regarded academic institution) as the most overt behavioural action marking the beginning of her “divorce” from these ideas. While she mentioned that she had previously questioned these ideals, this was a moment in which she was able to enact a choice that led to a revisioning of what she “wanted” to want and what she actually wanted. Much of the imagery Margot uses as her story progresses is quite literal; as she “divorces herself” from the external and internal messages around productivity, she appears happier in the photographs she chooses. Near to the end of her story, Margot chooses to show a black screen as she circles back to talking about what “Peter” thought about her experiences and unpacks the function that “symptoms” served for her. She then lists different labels associated with the state of “overcoming” an eating disorder, ending with:

I no longer want to put pressure on myself to live up to the definitions of those concepts, whether externally or internally imposed.

That’s kinda the point.

In saying “that’s kinda the point,” Margot reflects on the idea that avoiding the imposition of labels in her version of “recovery” (a term she decidedly did not identify with) allows her to remain at a distance from the very notions of productivity and “living up” that informed much of her eating disorder.

Margot’s clear articulation of the standards to which individuals in recovery are held helps to crystallize findings from the narrative interviews in a number of ways. Through her story and images, Margot paints a compelling picture of the multiple binds placed on individuals in society, particularly those associated with productivity and the “pursuit of happiness.” In a
neoliberal, “totally pedagogized society,” (Bernstein, 2001, p. 365-366) divorcing oneself from pervasive social norms around productivity, particularly as they pertain to “productive” or “successful” bodies, can be extremely difficult. What Margot’s story reveals, coupled with the interview data, are the ways in which those in recovery from eating disorders are still further urged to adhere to standards of health in order to not waste their “biovalue” (Rose & Novas, 2005, p. 442). Margot resists these pervasive discourses by “scratch[ing] out [her] old definitions of those concepts,” taking up a critical perspective on the standards imposed both on bodies coded as “normal” and thus germane to receiving dominant prescriptions for health and on bodies known to be “recovered” from eating disorders and thus held to different (and opposing) standards. Margot’s selection of images of herself that were neither at her highest nor her lowest weights (a deliberate choice she communicated to me during storyboarding) illustrates the transgressive nature of “recovered bodies,” for which prescriptions for health change depending on context and the knowledge of others.

**Katie.**

Katie came into the digital storytelling workshop wanting to tell in greater depth a story she had begun to flesh out in the interview: her relationship with her twin, who also developed anorexia nervosa in adolescence. In story circle, Katie began to play with some ideas about how to unpack her intertwining relationship with her twin, with whom she had compared herself for her whole life. Feeling solidly in recovery herself, Katie wanted to explore the idea that “she is her own person.” The work toward condensing 24 years of being compared with and comparing herself to her twin was not easily done; Katie started with a very broad sketch of the twin relationship and worked over the course of the workshop to decide which moments were the most compelling. This story seemed to be one that Katie really needed to tell at the time; she said
that it was one that she had been thinking about for quite a while. Other participants helped Katie to focus in on the possibility of framing her story in ideals of radical acceptance (e.g. Theriault, 2012) and dialectics (specifically citing these theories); that is, though she may be doing better and her twin is not doing as well, this is not so intricately tied into her own sense of self or identity.

In her story, Katie changes roles several times: from caretaker, to patient, to daughter, to sister, to independent young woman. She uses metaphors to illustrate her early relationship with her sister, “other half” and “partner in crime.” She remarks, too, on the ways in which others compared the twins; essentially, their bodies were read as two halves of a whole. In a way, the twinship acted as a fascinator for the external gaze. This is particularly interesting as both twins went on to develop eating disorders, and were subject to the clinical gaze. In a sense, the girls were almost used to being gazed at, measured up. To illustrate this point, Katie chooses an image of rulers when she reports on others’ remarks as they tried to make sense of the twins’ bodies. However, Katie makes a point of stating that these comparisons were “not the only reason [she] developed anorexia,” nor “the only reason she did either/but [they] both did.”

She reflects on double standards as she negotiated her ever-changing roles, illustrating her struggle to “keep her [sister] safe.” When her sister went to treatment, Katie allowed herself to engage more deeply in her eating disorder, and eventually ended up in treatment herself. Katie finds a turning-point moment in the middle of her story, literally (through imagery) and figuratively (through language) exploring a trip to Spain that found her at the top of a mountain, feeling free and liberated. She then contrasts this memory, stating that while she was on her trip her sister became hospitalized. A moment of clarity follows, where Katie reflects that she “was angry until [she] realized what might have happened if they hadn’t.” This quote illustrates the
relationship Katie had with her sister during her illness; only at this point did Katie begin to truly believe that she and her sister were not only two sides of the same coin, but independent people, and nothing Katie could do would make her sister “better.”

The operation of gazes in Katie’s story is striking. She reflects on the girl she was, while also reflecting on how her subjectivity often became tied up in that of her twin, a mirror image she could (more objectively) gaze upon. Equally, she felt constrained by the comparing gazes of others in her life, who sought to distinguish the twins in some way and settled on the “fat twin” analogy. A twin’s experience provides a unique opportunity to observe others’ attempts at categorizing individuals. It makes sense, given her history of being compared to her twin, that Katie would feel like “half of a whole,” and thus fluctuate in and out of being the “carer” and the “sick one.” As she notes:

I thought that maybe only one of us was supposed to survive.

With one gone, maybe the other could be whole.

But who was it going to be?

It was anyone’s guess for a while as we both bounced in and out of treatment centres.

Though she begins by saying it was she who wondered whether only one twin was meant to survive, the clause becomes increasingly tied up in relationality, as Katie suggests that it was “anyone’s guess.” At this moment in her story, Katie also shows an image of medical equipment, underscoring the idea that medical professionals, too, were unsure “who might survive.”

Over all, Katie’s story is a strong example of the relational dynamics of eating disorders and how these can come together to place sufferers in inexorable binds. Katie saw herself simultaneously through the eyes of her sister, her family and friends, and medical professionals. She struggled to carve out an image of herself that was not either “the sick twin” or “the fat
twin.” She negotiated the roles she chose for herself with knowledge of the states and reactions of others, which led to the drawing out of her illness and the difficulty of maintaining her recovery. Longings and belongings intertwined in Katie’s story through voice and imagery, which work together to create a story of being both and, as opposed to either or.

Isa.

Isa’s story illuminates a number of the themes emerging from narrative interviews and helps to exemplify the standards to which individuals in recovery are held. Initially, Isa had a different idea for her story, but decided to focus on whether recovery meant that one was invulnerable from struggle as she worked on her script. As a health care professional herself, Isa is well aware of the difficulty of “being recovered” in a culture that prizes not only the slim body but also the pursuit of success, perfection, and productivity. Isa came into the workshop thinking that her story might reflect on changing relationships with her body over the course of her life, and changed her mind as she began to explore the standards of recovery and challenge the dominant representations of eating disorders prevalent in society. She opens her story by questioning what recovery really means:

In saying I had ‘recovered’ from my eating disorder, did it mean I had succeeded?

Was it a way of naively reassuring myself that I could not and would not ever struggle again?

If I did struggle, did that mean I was never recovered in the first place?

As she continues through her story, she begins to answer these questions for herself. Focusing less on the actual behaviours in which she engaged and more on the “journey” of recovery, Isa reveals some of the problematics associated with standards of recovery and how these can feel detrimental to actually feeling “recovered from.”
The idea of struggle surfaces throughout Isa’s story. In exploring her story, I asked Isa to try to focus on specific moments that illuminated her overall point: that in calling oneself “recovered,” there is the danger of feeling like to struggle is, in fact, a bigger loss. Isa chose to contextualize this idea against other struggles she had encountered during her recovery, including depression and obsessive thoughts. Isa was adamant that she did not want to portray these in a “clinical” way, however, as she did not feel like her struggles, particularly with obsessive-compulsive disorder, were recognized as what one might “expect” to see. For example, rather than fearing contamination and thus washing her hands frequently, Isa fought against “intrusive thoughts of killing [her] family.” Going to these places in her story helps to illuminate how not only can struggles with disordered eating challenge the notion of being upheld to some standard, but so too can struggles with other issues. Isa was careful to select images that were somewhat unexpected. Though sometimes her imagery is quite literal, she reveals what she referred to as her “quirky” side through imagery. Much of the imagery is comprised of video footage of frolicking in the snow.

Isa’s story references how labels can “inadequately define [her] journey” and in fact set up a false sense of security, in a way. As she notes, she “want[s] to be aware, as much as possible, of all the aspects and uncertainties it brings.” This is an important distinguishing factor in Isa’s story: while she notes dissatisfaction with the label of recovered, it is not because she does not perceive full recovery to be possible, or slips to indicate a “less authentic” or “less legitimate” recovery. Rather, she acknowledges her ever-changing subjectivity and her unpredictable body, ever in the process of becoming. This sense of transiency is illuminated by her final sentence: “there is no beginning and end as my life will continue to touch people even after I’m gone.”
Chapter 4: Discussion

Narrative interviews and digital stories revealed a number of themes that fit with and expand upon prior qualitative examinations of the experiences of young women in recovery from eating disorders. Participants took up and resisted dominant representations and stories about both having and “recovering from” eating disorders in interesting ways as they navigating their social worlds. Stories were each unique and impacted by social location, including spaces of identity that I did not expect, including religious identity, professional identity and fluid interpretations of other “demographic variables” such as gender and sexual orientation. However, a number of thematic stories were expressed when looking at the data set as a whole. Through narrative interviews, participants told stories about how standards for recovery impacted their subjectivity, as is encapsulated by the theme “Doctor’s Orders: Standards for Recovery.” This theme is underscored by sub-stories of materiality of eating disorders and recovery, beyond biometrics, embodying counter-culture, and recovery is an (embodied) place. Through this narrative, participants complicated the idea of recovery as an objectively attainable plane of being, suggesting that instructions for bodily management imposed in “recovery” intersect with dominant discourses on food, weight, and shape to hold up the idea of “full recovery” as a (perhaps unattainable) imperative.

Participants also told their stories in profoundly relational ways. “Through the Eyes of the Other” reflects this embodied relationality, as participants spoke in reflexive ways about their experiences. Stories of “the girl I was” suggest a reflexive stance on past subjectivity. In the sub-theme “authenticity and in/visibility” participants recount the ways in which their bodies and experiences were read as more or less “legitimately” eating disordered by others in their lives, impacting their sense of self and ability to seek support and/or treatment. “Be/longing” highlights
participants’ orientations toward others in their lives as they fluctuated in and out of aloneness and community with “like” and “unlike” others. Finally, participants expressed both fitting within and falling outside of stereotypes around eating disorders. While many described their eating disorders as “pretty textbook,” they went on to nuance the concept of standard eating disorders through sharing “missing stories.” In the following chapter, I will draw connections between these thematic areas and existing research, highlight how this study is a novel contribution to the extant body of literature, and discuss potential limitations.

**Intersecting Discourses: Biomedical Embodiments**

Participants were fluent in biomedical discourses, which they often used to help make sense of the experience of having an eating disorder. One potential reason for the use of biomedical discourses is the ways in which such explanations are overtly rational, and reinforce the mind-body split so often taken for granted in discourses around human subjectivity, particularly as they pertain to mental health. For example, as illustrated in the results sections, some participants specifically referred to their “brains” as the part of the self requiring “rewiring”; though the brain is evidently a part of the body, explicitly naming it as the element germane to the technology of cure offers insight into how it may be (at times) conceptualized as an entity not “of the body.” We are accustomed to understanding our bodies as fixed and bounded; the mind is assumed to have control over the body; where this control is absent, the individual is assumed to be suffering from a deficit of the mind (Davis, 2013; Shildrick, 1997). The uncontrollable has been heavily feminized over the course of history, through discourses of hysteria and the feebleness of the feminine mind (Battersby, 1998). The irrational, the uncontrollable, and the unaccounted for have thus been controlled through discourses of surveillance, as feminized and disabled bodies have been controlled either through external
forces of control or, alternatively, by internalized discourses leading to self-surveillance (Foucault, 1979). Control over the body is the purview of the mind, ever rational and assumed to be separate from the body (Grosz, 1996). That which cannot be understood is made abject; both terrifying and fascinating (Kristeva, 1982).

Eating disordered bodies have been historically scrutinized, controlled, and rationalized using this mind/body split to justify theorizing that, while prescribing bodily management, profoundly ignores embodied experience (Burns, 2009; Malson, 2009b; Warin, 2010). Participants’ stories echoed these discourses while simultaneously complicating dominant narratives with nuanced accounts of their bodies in space and over time. Participants found biomedical discourses helpful to a certain extent, for example by using this framing to account for the cause of the eating disorder (as rooted in brain chemistry, for example). However, the limits of such a framing become evident when we contrast standards for recovery with the prescriptions for health offered to the general population. Participants were hesitant to subscribe to particular labels. Indeed, participants problematized the very idea of “identifying with” specific labels, whether they related to gender, sexual orientation, ethnic/racial identity, or progress along a trajectory “toward recovery.”

Framing participants’ responses using Fausto-Sterling’s (2000) complex explication of the multi-directional influence of genes and environment illustrated using Russian nesting dolls opens up possibilities for exploring the multi-faceted and alternatively useful discourses operating in participants’ stories. Through participants’ accounts, we can begin to see the multiple layering of discourses that operate to constitute participants’ understandings of their bodies in social context. Using this nested imagery, it becomes possible to see both the utility and constraints of discourses on eating disorders, relapse, and recovery that feature in societal
explanations for eating disorders and in participants’ stories. This affords the opportunity to not simply “throw the baby out with the bathwater” when presenting a critique of more biomedically-oriented discourses surrounding eating disorders. As illustrated in the quotes included in the results section, participants did find biomedical discourses helpful, particularly due to their logic and rationality.

Particularly for participants whose narratives were rich with scientific reasoning, for example Andie and Margot, whose neuroscience backgrounds infused their accounts, understanding, among other things, “the biology of appetite control” (Treasure, Claudino & Zuker, 2010) allowed for self-forgiveness in the face of “relapses.” For those who had received clinical treatment for their eating disorders, articulating a biomedical frame of reference for the amount of time and effort required to “attain recovery” helped to justify being “in recovery,” rather than “recovered.” Citing common statistics such as the only 50% of individuals who completely remit from eating disorders (Steinhausen, 2009) or the idea that recovery takes between 5-7 years (Strober et al., 1997), participants made sense of their stories, at least in part, using popular medical explanations. Labels such as anorexia or bulimia also coloured participants’ stories, particularly when highlighting the seriousness of their conditions.

Participants also understood the commonness of comorbidities they encountered, including suicidality, depression, anxiety and substance abuse disorders (Stice & Shaw, 2004) and discussed the need to deal with these underlying or accompanying factors while in recovery. Some participants expressed comfort in the idea that eating disorders are “heritable” (Trace et al., 2013; Wade et al., 2013). Overall it seemed that biomedical discourses offer comfort in terms of debunking common misattributions for eating disorders. Many participants were eager to point out that they were not simply passive recipients of cultural imagery, as feminist and other eating
disorder researchers and clinicians have pointed out (e.g. Malson, 2009a; 2009b; 2011; Saukko, 2008; Treasure, Claudino & Zuker, 2010). However, participants deployed dominant, as well as subjugated, discourses when articulating this nuance. Thus, it would seem that the “expert knowledge” doled out in treatment settings and, increasingly, taken up in the media, can in some ways be helpful to individuals seeking ways of accounting for their eating disorders.

However, these biomedical discourses intersect with other spaces of belonging in problematic ways, particularly as participants’ bodies began to cross the line into being coded as “recovered.” In some cases, problems with these discourses emerged prior to this point; for example, Maya’s story demonstrated cultural and familial barriers to treatment seeking that gelled with prior literature indicating the ways in which treatment seeking can be perceived as a broaching or breaching of ethno-cultural identity (e.g. Becker et al., 2009; Thompson, 1996).

The individualizing nature of biomedical discourses can be problematic when coupled with, for example, familial and cultural values that require that “problems” be kept within the family or the home. While participants articulated the usefulness of biomedical discourses, as noted above, with respect to their eating disorders more generally, their stories were replete with acknowledgement of the difficulty of adhering to standards for recovery, particularly in the face of the prescriptions for health issued to the general population.

Some participants found the idea of “full recovery” to be overwhelming from the outset. Participants were often able to attain a “healthy body weight” by engaging in treatment programs, meeting the minimum standard criteria for discharge (Bardone-Cone et al., 2010; Gremillion, 2003). However, participants often perceived treatment programs that focused unduly on weight restoration to be inadequate, echoing literature that explores the limited nature of such programs (Boughtwood & Halse, 2010; Eivors, Button, Warner & Turner, 2003;
Gremillion, 2003; Maisel, Epston & Borden, 2004). Though participants did not necessarily gain the weight in treatment as a “means to an end” (the end being getting out of the hospital in order to recommence self-starving or bingeing and purging)(Boughtwood & Halse, 2010), neither did they necessarily perceive themselves to have reached a point of “full recovery” upon discharge. Some participants doubted that they would ever call themselves fully recovered. Interestingly, however, this reticence to claim “fully recovery” as a state of being was not indicative of “giving up” or settling for “less than.” Counter to Shohet’s (2007) suggestion that narrating a “full recovery” is necessary for maintaining a stable life, participants’ stories were rich with descriptions of how their lives no longer revolved around food, weight, and shape, regardless of which “stage” of recovery they most identified with.

This research reveals, importantly, that the idea of “full recovery” may not be useful, particularly as it pertains to this label. Bardone-Cone et al. (2010) suggest that “full recovery” exists, and that the knowledge of the existence of this construct can help to guide investigations into what “full recovery” looks like. While this research certainly does not seek to “disprove” this finding, and participants were able to talk about full recovery in the abstract or as it applied to others, some perceived a single-minded aim toward full recovery as being detrimental to their overall health. For example, participants were hesitant to take up this label for fear that it would require them to be invulnerable, choosing instead to see recovery as an ongoing process, more in line with other qualitative analyses of patient perspectives on recovery (e.g. Federici & Kaplan, 2008). Rather than “forgetting” about the eating disorder or “going back to how they were before,” participants were more likely to see other elements of their lives coming to hold greater significance than eating disordered behaviours in terms of coping with daily life. Some saw the idea of “full recovery” or returning to a state prior to the eating disorder as impossible or
incommensurable with reality; this reflects an orientation toward not seeing one “self” as “replacing” another through growth and “recovery.” Rather, participants seemed to articulate poly-vocal selves (e.g. Saukko, 2008) in the process of becoming (Rice, 2014).

Aspects of treatment participants once found useful, for example meal plans, were not understood in static ways over the course of “recovery.” While for some participants, a meal plan allowed them to “stay in check,” others suggested that meal plans served to reinforce or start problematic relationships with food and control. Participants also struggled against the idea that to be on a meal plan might mean that they were not perceived to be “fully recovered,” despite feeling well and at ease in their lives. Finding themselves in a double-bind, participants mentioned a feeling of being caught in between: the very behaviours encouraged in treatment settings became interpreted differently by family, friends, and doctors as participants continued in recovery. Where following a meal plan could be viewed as compliance with recovery discourses while in treatment, for example, there seemed to be a moment at which participants were expected to shuck off the rigidity surrounding food imposed in both the eating disorder and in treatment. Much like Gremillion’s (2003) analysis of gender and power in the treatment setting, compliance seems valued to a certain extent, until patients are expected to exercise individualism and “rebel”- within set limits.

The binds in which participants felt confined can be laid over an exploration of the messages of bodily surveillance and control that inform everyday lives. Biopedagogies issued for “healthy productive citizens” are internalized as agents become self-surveillers, controlling intake and outputs in the place of external, “state” surveillance (Foucault, 1979). Bodies are routinely offered up for scrutiny to the medical gaze (Shildrick, 1997). Perhaps nowhere is this gaze more evident than when examining the fat body and the “anorexic body” (Lupton, 2013). In
light of a public framing of the fat body as one that is ill, lazy, and ugly (Saguay & Ward, 2011), biopedagogies are issued to control and normalize bodies into productive citizenry, in the name of “public health” (e.g. Harwood, 2009; Rose & Novas, 2005). To a certain extent, dietary restraint and control are thus praised, evidence of the internalization of such discourses and adherence to bodily standards. However, once the body has passed into the “normal,” it becomes unclear to whose standards bodies must be held. Do “recovered anorexics” and “recovered bulimics” follow dominant biopedagogical instructions for the “every person,” or do they fall into some category of “abnormal normal” individuals, continuing to occupy the liminal space between healthy and unhealthy, continually teetering on the edge of “falling back in” to their extreme embodiments?

This tension was heavily felt in listening to and reading participants’ stories. So, too, did the “recovery pressure” emerge from the digital stories they created. The behaviours around food of those with a history of disordered eating are read differently than the behaviours around food of “normal” individuals. The expression of preferences around foods, even for cultural reasons, can be interpreted as indicative of a back-slide into problematic or troubling behaviours.

“Normal eating” is incredibly difficult to define in a society that routinely promises individuals that they can lose weight by subscribing to whichever diet craze is happening. Nonetheless, “normal eating” takes on a very particular orientation when applied to individuals with (and recovering from) eating disorders. Where do individuals in recovery “fit” amidst directly opposing discourses of (clinically-prescribed) “normal eating” and anti-obesity, particularly when their bodies can often pass as “normal”? For example, participants encountered difficulties enacting dietitian or doctor-prescribed meal plans when their bodies were read as normal, especially by those who are unaware of their histories.
Unlike the praise afforded to individuals on “diets” in modern Western society, participants’ rejection of fatty or high-calorie foods was often taken to indicate remnants of pathology. Some participants indicated that they were expected to be “ok with eating anything,” while others in their lives continued to diet or exercise in accordance with more mainstream understandings of health. Participants differed widely in their responses to the “counter-cultural” nature of the standards to which they were expected to adhere; some continued to diligently follow the advice of doctors and dieticians, while others devised their own definitions of health, including but not limited to their relationship to food. Of course, as Lester (1997) notes, we cannot simply make our bodies mean what we want them to mean; efforts toward devising individual scripts for recovery were often contested by others in participants’ lives.

**Relationality and Legitimacy**

Participants of diverse embodiments and backgrounds were acutely aware of discourses for health, or biopedagogies, circulating in society. How they compared and contrasted these discourses to their own embodied understandings of eating disorder recovery varied according to their own social location. Some participants experienced themselves as well only long after friends, relatives, and even medical professionals, coded their bodies as “healthy.” This created tensions in their relationships with others in their lives that led to strained self understandings. Further, some participants articulated that friends or doctors never “believed they were sick” in the first place; one participant even questioned the legitimacy of her eating disorder due to her lack of diagnosis. Nonetheless, she responded to my advertisement for this study and told a story ripe with relationships with food, weight, and exercise that speaks of distress. This begs the question of who has the right to judge the legitimacy of eating disorders and recovery.
The literature highlights the ways in which eating disorders have been classified, over time. With changing iterations of the DSM, so too have the criterion for diagnosing eating disorders changed, quite drastically over time (e.g. Wonderlich et al., 2007). With the recent move from the DSM-IV to the DSM-V, individuals’ diagnoses may potentially have changed, seemingly overnight. As this iteration captures a wider range of symptoms, and has shown greater “clinical sensitivity,” it is likely that the “eating disorder not otherwise specified” category is shrinking (Machado, Goncalves & Hoek, 2013). This could have positive implications for feelings of legitimacy amongst individuals with eating distress; by obtaining a diagnosis not medically and socially coded as a “problem diagnosis” (Helverskov et al., 2011), individuals may feel more justified in seeking treatment. This treatment may also be more likely to be covered by insurance. However, we must question whether diagnosing more individuals is a positive step. Particularly in light of the literature pointing to how individuals diagnosed with eating disorders may reject their diagnoses (Boughtwood & Halse, 2010), simply diagnosing more individuals is unlikely to lead to long-term solutions.

Indeed, even when their disorders were diagnosed and thus coded as “legitimate problems,” some participants struggled with perceiving certain elements of their treatment protocols to be helpful. It could be that their struggles did not fit cleanly within the capabilities of the modes of change imposed in treatment, leading to this support being perceived to be unhelpful, or even being rejected (Becker et al., 2009; Gremillion, 2003; Malson, 2009a; Shohet, 2007). This incongruity between patient needs and treatment modalities is termed problematic in and of itself in the literature (e.g. Malson et al., 2004; Rich, 2006; Ryan et al., 2009). Nonetheless, we cannot ignore the fact that the participants in this particular study identified as recovered, or at least “in recovery.” Therefore, something must have been helpful, along the way.
As the results indicate, participants’ stories were rich with accounts of both positive and negative relations to others, which coloured the degree to which they perceived their disorders (and the recovery) to be authentic. Others provided the lens through which participants understood, at least in part, their movement toward “recovery.”

The earlier-described efforts to devise individual notions of health were complicated by others’ reactions. Participants were aware of the ways in which they needed to, at times, critique the very things that had helped them to get where they were. In some cases, participants aimed for recovery not because they desired it, but because they felt obligated to recover, or felt that they had “no choice” but to recover. On the other hand, some participants never experienced the kind of “denial” that is said to be characteristic of eating disorders. Lacking denial was problematized by some participants’ medical encounters, as doctors seemed to presume a “stages of change” model wherein participants should at some point, deny their behaviours as this is considered, to some extent, a key element of eating disorder psychopathology.

Complicating the Notion of Psychopathology

As participants reflected on their experiences, they related to their “past selves” in various ways. While participants generally took a reflexive orientation toward “the girl they were,” there is a nuance here. Participants did not often understand themselves to be completely different people while they “were ill,” in fact, some participants were quite explicit that while they may have been using different (coded as ill) coping mechanisms, they were not a fundamentally different person. As Malson et al. (2004; 2011) revealed, individuals with eating disorders are often constructed as wholly constituted by their symptoms, which can have problematic implications for recovery, as recovering can thus be seen as an erasure of self. To a certain extent, narrative approaches taking a univocal and progression-through-time orientation (e.g. Maisel, Epston &
Borden, 2004) replicate the obfuscation of the individual by eating disorder psychopathology. The popular uptake of externalization may suggest that in order to recover, thus, one must “divorce oneself” from the eating disorder (e.g. Schaefer). However, as Saukko (2008) suggests, individuals do not simply replace one “self” with another as we move through our lives; particularly with respect to eating disorders, seeing recovery as the attainment of a more authentic self can obscure the complex ways in which individuals relate to various aspects of self. Equally, if we attend to the intertwining of “body” and “mind” along the lines of Elizabeth Grosz’ (1996) Mobius strip, it becomes difficult to see recovery as the master of “mind” over “body”; such a construction mirrors the patriarchal discourses circulating around bodily control and surveillance which themselves may have played into the (logical) development of “eating disorder psychopathology.”

While participants sometimes strove for “legitimacy” or “authenticity,” more evident was a striving for belonging, community, and comfort. Rather than replacing an inauthentic “self” with a “true self,” recovery was conceived of as a (difficult to enact) process, with bumps in the road, conducted in the presence of significant others both with and without similar experiences. Thus, participants constructed the “legitimacy” or “authenticity” of their recovery not versus some other, or “better,” self, necessarily, but partly in relation to others’ reactions to and readings of their bodies and behaviours. However, it is impossible to discount the ways in which discourses of externalization featured in participants’ accounts. Certainly, as some participants took up a reflective stance on their experiences, they described the ways in which “the eating disorder” acted as an agent, suggesting a separation between self and psychopathology. Much as biomedical discourses on eating disorders and recovery were constructed as neither wholly problematic or wholly helpful, however, participants negotiated such discourses in complex and
unexpected ways. Particularly in the digital storytelling workshop, the boundaries of such interpretations were revealed, as participants articulated stories that took up but complicated these understandings.

Participants articulated complex spaces of belonging, at times struggling to determine which sources of support had been helpful to them along their journeys. Again, communities and spaces of belonging were neither solely positive or wholly negative; participants wove in and out of various communities over their lives. Federici & Kaplan (2008) note the importance of social support in sustaining the process of recovery. This finding largely bore out in this study as well; participants actively sought out those with whom they could relate and/or those who could support them in other areas of their lives. Hay & Cho (2013) also note the importance of supportive relationships, whether old or new, in maintaining recovery. Participants distanced themselves from less helpful others who engaged in the type of biopedagogy-of-recovery-endorsing behaviour, for example those who thought they should be “all better” after they had gained weight.

Indeed, participants actively renegotiated their social worlds over the course of their recovery, with individuals fluctuating in and out of their lives. Various “communities” or spaces of belonging were also more or less helpful over the course of their eating disorder and recovery. For instance, while on some level participants noted that being in intensive treatment helped them to feel less alone, these environments could also be unhelpful as fellow patients could be comparators, less motivated, or unfriendly. The potential for social comparison in intensive treatment settings has been noted elsewhere and suggests that patients may inadvertently judge their bodies and behaviours against those of fellow patients (e.g. Long, Wallis, Leung & Meyer, 2011). Thus, while intensive treatment may be warranted, being aware of inter-patient and
patient-therapist dynamics may help to tease out the relational elements of treatment effectiveness and recovery (e.g. Rance, Clark & Moller, 2014).

**Storying Recovery**

As illustrated above, recovery discourses require individuals labeled as recovered to be invulnerable, and set up the expectation that individuals will always remain in recovery. As digital stories illuminated, in particular, this expectation can be constraining. Participants articulated, in their interviews, how being held up to the standard of recovery made them feel as if they were not allowed to struggle. Conceptualizing recovery as a process was much more helpful to many participants, who described “living their recovery every day,” for example. This is more in line with discourses of recovery for other mental illnesses, such as a patient-centric model for recovery posited in consumer/survivor movements. Recovery, evidently, is much more than simply the absence of symptoms (e.g. Bachner-Melman, Zohar & Ebstein, 2006; Bardone-Cone et al., 2010; Hay & Cho, 2013); participants’ accounts highlighted the various facets of their lives that came to intersect with and surpass their eating disorder in importance as they moved through their recovery and matured in general.

Participants grappled with endings that did not wrap up their journeys into a final product. These stories were at times counter to a master narrative of redemption, which features heavily in the social imaginary (McAdams & Cox, 2013). While not all experiences can be redeemed (Breen & McLean, in press; McAdams, 2006) and making meaning is not tied to well-being in all cases, particularly for those in vulnerable or challenging circumstances (Breen & McLean, 2011; Sales, Merrill & Fivush, 2013), the general desire for satisfactory endings (McAdams & McLean, 2013) cannot be ignored. Some participants did select moments that reflected a redemptive orientation, where the negative elements of their lives (e.g. the eating
disorder) were juxtaposed with the positive, current ways in which their lives were evolving. Participants were clear to note, however, that their eating disorders were not the sole defining feature of their overall life stories. While the stories they told me were rich with detail about their experiences of eating disorders, they obviously selected these moments in response to my questions. As narrative theorists suggest, participants were aware that they were telling their story to a specific audience (McAdams, 1985; 1993; 1996).

Interestingly, in speaking to young adults who matured during their eating disorder and continued to learn and grow while they also recovered, we can see the complex and intertwining self-defining moments (Singer, 1996; 1997) operating in participants’ stories. In some cases, participants reported looking back on the “girl they were” and perceiving their memories to be foggy around details, while in other moments intricate details stood out. Notably, these participants’ stories are not yet complete; it is possible that in the future their stories may reflect redemption to greater or less degrees. As I asked participants to reflect specifically on their experiences of having and overcoming eating disorders, they may have sought endings to these (partial) stories of their lives rather than for their life stories as a whole. Further, the life experiences of these young adults varied greatly. As narrative identity theorists argue that redemption narratives may be more or less strongly linked to well-being among groups in difficult circumstances (e.g. Breen & McLean, in press; Sales, Merrill & Fivush, 2013), future research might investigate the degree to which participants from various backgrounds construct redemption in their stories. As Pillemer (1998) suggests, personal event memories may be rich in sensory and bodily imagery; for participants, these embodied memories often took the form of specific challenging emotions felt while in situations with others looking on their bodies. The acute, embodied
memories participants recounted were deeply laden with surveillance; in medical contexts, for example, participants could recall “the day of the baked potato” or the moment when they felt the eyes of the other regarding their abject form (Kristeva, 1982; Warin, 2010). The rich sensory accounts relating to this abjection reveals the operation of power in surveilling deviant, “sick,” bodies. Interestingly, while the surveilling gaze operates explicitly in treatment contexts, and participants recounted both positive and negative experiences of being gazed upon (i.e. by doctors, fellow patients, family members, etc.), abjection and surveillance operate in intriguing ways “post-recovery,” as well.

The biopedagogies for recovery described earlier help to unpack some of the continued and internalized surveillance operating for those in recovery for eating disorders. For those who experienced intensive treatment, it is unsurprising that the kinds of standards for recovery imposed upon individuals in recovery can become internalized as participants begin to self-surveil. This is an expected by-product of re-emerging into the world of productive bio-citizens. The picture is more complicated, however, when we consider those who never underwent formal or intensive treatment. For those who struggled with issues of legitimacy and authenticity in terms of the recognition of their eating disorders, the standards for recovery became less clear. Once again, the bind of being caught in between biopedagogies for recovery and biopedagogies for anti-obesity strongly emerged. The uncertainty associated with not having one’s body marked as “eating disordered” and thus “able to recover” by following set parameters for recovery potentially leads to tension and confusion about what constitutes health and recovery.

Those whose stories were “less textbook” and who did not see their stories replicated in the dominant cultural narrative of eating disorders struggled more with this biopedagogy for recovery and knowing which biopedagogy to follow and internalize. These participants,
essentially, represented the “abnormal abnormal,” neither here nor there, neither sick nor well. All participants articulated the in-between-ness of recovery and following a recovery biopedagogy to a certain extent, but this was especially strong for participants who identified strongly as abnormal abnormal. A piling effect of discourses occurred, to detrimental effects; for example, not feeling like there was the cultural or familial space to seek recovery, coupled with the reading of one’s body as “normal,” combined with an internalized need to uphold a “recovery” as medical professionals might articulate, could combine to form a heavy burden for individuals in recovery.

**Limitations**

Despite its contribution to extending understanding of the diverse, embodied experiences of young women in eating disorder recovery, this study is limited in a number of ways. Firstly, the results may not generalize to other contexts. The sample was relatively small, at 10 participants, and the majority of participants were white, heterosexual women. Nonetheless, participants articulated their identities in interesting ways, complicating the boxes in which we place research participants; this is in and of itself an interesting finding. Still, with this relatively homogenous sample drawing broader conclusions about the pervasiveness of the key themes amongst diverse individuals with eating disorders would be difficult. Future research might seek to replicate these findings in a more diverse group of individuals, including more participants from minority groups (e.g. non-heterosexual individuals, males, trans individuals, individuals of various races/ethnicities and socioeconomic statuses/educational levels). A more representative sample might nuance the concept of the biopedagogy of recovery and reveal how such standards constrain marginalized individuals to greater or lesser degrees.
Further, participants self-selected into this study. Participants chose to respond to advertisements asking for young women to share their experiences of disordered eating/eating disorders. I did not require participants to have been diagnosed with eating disorders to participate. Participants also self-identified as either “in recovery” or “recovered,” but also problematized this category as the interviews and digital stories progressed. In many cases, it was difficult for participants to put timelines on their experiences of disordered eating and recovery. While this difficulty has interesting implications for results and reveals some of the problematics associated with attempting to define recovery (see Federici & Kaplan, 2008; Hay & Cho, 2013; Wasson, 2003 for other examples of the difficulty of defining recovery), it may also limit the generalizability and comparability of results.

Another potential limitation is the relatively open-ended nature of the interview. While this is in some ways a strength, in that it allowed participants to tell their stories as they preferred. However, given that the interviews took a discursive, conversational approach, and I responded to ideas raised by participants, there were some differences in the degree of detail to which participants took their stories and the specific topics they focused on that may have impacted the results. For example, some participants focused more than others on the “background” story (i.e. the “active phase” of their eating disorder) whereas others focused more on the present day (i.e. “recovery”). Of course, there may have also been differences in interviewing style as the interviews progressed, as well, particularly as I transcribed the interviews directly following the interview. This transcribing process helped to improve my skills as an interviewer, but this may have meant that later interviews benefitted from my increased ability to dialogue with participants and follow their stories in their preferred ways.
It is also possible that my lived experience impacted my analysis in some ways. I took measures to reflexively engage with my data over the course of the interviews, analysis, and write up, for example through writing many memos and reflecting on my experiences with participants during the digital storytelling workshop. I paid particular attention, in these memos, to how my own story was similar to or different from participants’ stories. I also tried to attend to participants’ reactions to my embodied self as a researcher. In some cases, my lived experience emerged during the interview, in some cases after the interview. No participants expressed concern about my having “been there,” with some remarking that this helped to increase their confidence in the potential conclusions I might draw being more strongly representative of their experiences. Nonetheless, I needed to remain conscious of my embodied experiences while engaging with participants and, later, data, in order to avoid drawing conclusions grounded more in anecdotal, personal experience rather than themes observed within and across the participants’ narratives.

I also engaged with some participants to greater degrees than others over the process of the research. The digital storytelling research provided an unparalleled opportunity to focus my analytical lens by engaging with participants as a “community of inquiry” or a more intensive form of member checking. However, it is possible that the perspectives of the three participants who attended the workshop may not be representative of those in the larger group. While the narrative approach allows for the recognition that each individual story is unique, and the themes are not meant to perfectly represent the experiences of all participants, it is important to note the differing levels of engagement with three of the participants, whose insights were invaluable in focusing my analysis as a whole. In order to avoid making these experiences the predominant foci, during analysis I made sure to note (via memos) where the insights and experiences
expressed by the digital storytelling group converged with and diverged from the themes emerging from the broader data.

**Implications**

The results of this study add to the literature on eating disorders and recovery in significant ways. As Bardone-Cone et al. (2010) note, there is still significant divergence in terms of how recovery is conceptualized in the clinical literature. Aligning myself with efforts attempting to add the voices of participants to this conceptualization (e.g. Boughtwood & Halse, 2010; Federici & Kaplan, 2008; Hay & Cho, 2013; Ison & Kent, 2010; Malson et al., 2011; Mathieson & Hoskins, 2005; Shohet, 2007), this study opened up the possibility for an examination of the ways in which participants’ accounts are similar to or different from those embedded in clinical and popular discourse. Of particular interest were the ways in which participants both took up and resisted dominant discourses not only of eating disorders, but of recovery. Equally, participants were acutely aware of the broader discourses on health promotion circulating in modern Western society.

Much critical health psychology scholarship has focused on the detrimental effects of biopedagogies of weight and shape (e.g. see Evans & Rich, 2011; Evans, Rich, Allwood & Davies, 2008; Rice, 2007; 2009; 2014; Rich, 2010; 2011). The prescriptions for health offered up to the general population can, paradoxically, have deleterious health effects, as individuals whose bodies are coded as overweight or obese, for example, may actually avoid the very health-promoting behaviours they are “supposed to” engage in (Rice, 2007) or may experience distress-inducing stigma (e.g. Granberg, 2001; Saguy & Ward, 2011; Saguy & Riley, 2005). Meanwhile, bodies are imbued with moral characteristics, associating the fat body as unattractive, unhealthy, immoral, or lazy (Rice, 2007; Saguy & Riley, 2005). Society at large urges consumption, but
also restraint; excess, but also control. A significant body of literature points to the operation of biopedagogies urging adherence to supposedly health-enhancing behaviours.

This study reveals the possibility of a similar but opposite biopedagogy operating for individuals in eating disorder recovery. This biopedagogy of recovery is grounded in potentially health-enhancing, even life-saving techniques and technologies of cure; it is well established that weight restoration and “proper nutrition” can save the lives of individuals in eating disorder recovery (e.g. Accurso, Ciao, Fitzsimmons-Craft, Lock & LeGrange, 2014). However, at a certain point, the standards for recovery begin to contravene the health expectations set for individuals occupying “normal bodies.” Complicating the picture is that once individuals suffering from eating disorders gain weight and occupy “normal” bodies, following prescriptions for health in direct opposition to those issued to the population at large can prove extraordinarily difficult. The “permission” to follow a meal plan, for example, may evaporate once one reaches a “normal weight,” assuming that one was underweight to begin with; those whose bodies never become read as “eating disordered” may face still more challenging negotiations between dominant and recovery biopedagogies.

More challenging still, in examining the biopedagogy of recovery, is how the behaviours of individuals in recovery can be read differently depending on who they are with. As this analysis revealed, individuals in recovery understand their stories in profoundly relational ways; over the course of their illnesses and recovery, participants discussed how they sought to belong, felt alone, or longed for communities. Equally, they noted moments at which their experiences of their bodies contradicted the outward signs their bodies exhibited to significant others in their lives. Occupying a body that is recovered from an eating disorder reveals an interesting tension. For those who did not know participants, behaviours associated with following a “biopedagogy
of recovery,” for example following “normal eating,” may be perceived as different or odd in a culture that prizes restriction and dieting. Additionally, to those who know of the individual’s history, behaviours that might be valued in “normal” individuals may be coded as eating disordered, for example, continuing to follow a meal plan after several years of being in recovery. Participants expressed significant frustration with being held to different standards than others in their lives, as well as the lack of understanding they sometimes felt from others ranging from doctors to friends. The need to be invulnerable and “ok with eating anything” led some participants to distance themselves from the very label of recovery due to the unrealistic standards imposed by the label.

An understanding of the operation of such a biopedagogy of recovery could be helpful in supporting individuals with eating disorders as they explore the idea of recovery. Though to a certain extent it is necessary to impose some kind of structure to recovery, especially in a large treatment context, there may be additional supports required as participants navigate their social worlds in a directly counter-cultural manner. Given the profoundly relational ways in which participants understood their eating disorders and recovery, future research may seek to explore how various “others,” for example health care providers, family members, and friends, understand the concept of recovery and the standards to which individuals in recovery are held. This would help to illuminate the “spaces in between” the understandings of recovery articulated in this research, understandings of recovery identified in clinical literature and according to specific “metrics,” and as-yet under-explored familial and relational understandings of recovery.
References


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10.1017/S0033291799008740


10.1093/heapro/13.1.75


Appendix 1: Ethics Approval Certificate

<table>
<thead>
<tr>
<th>RESEARCH ETHICS BOARD – General</th>
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<td><strong>APPROVAL PERIOD:</strong></td>
<td>June 13, 2013 to June 13, 2014</td>
</tr>
<tr>
<td><strong>REB NUMBER:</strong></td>
<td>13MY014</td>
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<td><strong>TYPE OF REVIEW:</strong></td>
<td>Delegated Type 1</td>
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<tr>
<td><strong>RESPONSIBLE FACULTY:</strong></td>
<td>Rice, Carla (<a href="mailto:carlar@uoguelph.ca">carlar@uoguelph.ca</a>)</td>
</tr>
<tr>
<td><strong>DEPARTMENT:</strong></td>
<td>Family Relations &amp; Applied Nutrition</td>
</tr>
<tr>
<td><strong>SPONSOR(S):</strong></td>
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</tr>
<tr>
<td><strong>TITLE OF PROJECT:</strong></td>
<td>Storying Recovery: Narratives of Young Women in Eating Disorder Recovery</td>
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</tbody>
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The members of the University of Guelph Research Ethics Board have examined the protocol which describes the participation of the human subjects in the above-named research project and considers the procedures, as described by the applicant, to conform to the University’s ethical standards and the Tri-Council Policy Statement, 2nd Edition.

The REB requires that you adhere to the protocol as last reviewed and approved by the REB. The REB must approve any modifications before they can be implemented. If you wish to modify your research project, please complete the Change Request Form. If there is a change in your source of funding, or a previously unfunded project receives funding, you must report this as a change to the protocol.

Unexpected events and incidental findings must be reported to the REB as soon as possible with an indication of how these events affect, in the view of the Responsible Faculty, the safety of the participants, and the continuation of the protocol.

If research participants are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and approvals of those facilities or institutions are obtained and filed with the REB prior to the initiation of any research protocols.

The Tri-council Policy Statement, 2nd Edition, requires that ongoing research be monitored by, at a minimum, a final report and, if the approval period is longer than one year, annual reports. Continued approval is contingent on timely submission of reports.

Membership of the Research Ethics Board - General: S. Banerjee, Community Member; J. Carson, Community Member; S. Chuang, FRAN (alt); K. Chuong, Graduate Student; J. Clark, PoliSci (alt); J. Dwyer, FRAN; M. Dwyer, Legal; M. Elleray; OAC; B. Ferguson, CME (alt); H. Gilmour, Community Member (alt); J. Goertz, CME; B. Gottlieb, Psychology; B. Giguere, Psychology (alt); S. Henson, OAC (alt); L. Kuczynski, Chair; R. Ragan, Legal (alt); V. Shalla, SOAN (alt); R. Stansfield, SOAN.

Approved:

per
Chair, Research Ethics Board- General  Date: __________________________
Appendix 2: Consent Forms

CONSENT TO PARTICIPATE IN RESEARCH- Interview

Please read the following informed consent form carefully before signing.
This form is to request your participation in a research study by Andrea LaMarre, from the Department of Family Relations and Applied Nutrition at the University of Guelph. If you have any questions or concerns about the research, please feel free to contact:

Student researcher: Andrea LaMarre, alamarre@uoguelph.ca, 519 836 6435
Advisor: Dr. Carla Rice, carlar@uoguelph.ca, 519 824 4120, ext. 53921

PURPOSE OF THE STUDY

This research will examine the experiences of young adult women who self-identify as having overcome eating disorders. Participants will have overcome an eating disorder between the ages of 18-25, live in Ontario and self-identify as having recovered from an eating disorder, including but not limited to anorexia nervosa, bulimia nervosa and/or eating disorder not otherwise specified (ED-NOS). Clinical diagnosis is not required for participation, as the aim of the research is to broaden our societal understanding of the experience of having and overcoming an eating disorder. Participants are not required to be biologically female, but should identify as a woman during their eating disorder and recovery. The research aims to give a voice to a group from which we do not normally hear, giving participants the opportunity to explore and share their stories through in-depth interviews and/or the creation of a digital story. This research will be used for a Masters thesis project and may potentially be published in an academic journal.

PROCEDURES

If you decide to take part in this research, you will be asked to participate in a 1-2 hour in-depth, individual interview exploring the experience of having and overcoming an eating disorder. This interview will take place at the University of Guelph, unless you have a preferred location. Alternatively, if an in-person interview is not convenient for you (i.e. due to long travel distance), you may choose to participate in a telephone or Skype interview. During this interview, you will be prompted to share your story of having and overcoming an eating disorder. Though the interview will follow a guide, much of the direction will be dictated by the amount you choose to share. The interview will be audio-recorded and transcribed by the researcher to inform data analysis. If you wish to continue to be involved in the research, you may be invited to participate in a digital storytelling workshop and/or participate in data analysis to check the researcher’s conclusions against your own understandings of your story. Participating in data analysis will entail a one hour session during which you meet with the researcher to discuss primary analysis of your interview (i.e. the researcher will share some themes that have emerged for your feedback.)

POTENTIAL RISKS AND DISCOMFORTS
Potential risks of participation include feelings of discomfort in sharing your experiences with
the researcher. If at any time you feel uncomfortable with any of the questions, you may choose
not to answer or to withdraw from the study. Though you will be guided through the interview
with questions from the researcher, the direction of the interview will be largely up to you, and
based on how much you would like to share about your story.

**POTENTIAL BENEFITS TO PARTICIPANTS AND TO SOCIETY**

Though there are no direct benefits to participating, the research aims to advance knowledge
about the eating disorders and may help to correct social and/or systematic misperceptions about
eating disorders that marginalize those with eating disorders. By sharing your story, you will be
adding your voice to the existing dialogue about what it means to be an individual with an eating
disorder.

**COMPENSATION**

Participants will be given $20 for their participation in the interview, to be given once the
consent form has been signed.

**CONFIDENTIALITY**

All efforts will be made to ensure confidentiality throughout the research to the extent allowed
by law. For example the researcher has a duty to report immanent self-harm or harm to others.
You will be assigned a pseudonym, which will be associated with all of your data. You have the
right to review or edit any recordings taken during the interview and you may request that some
or all of the recording(s) be erased. Data will be encrypted and backed-up files (ex. External hard
drives, paper copies, notebooks) will be kept in locked cabinets. Audio-recordings will be erased
once the study is complete.

**PARTICIPATION AND WITHDRAWAL**

Participation is entirely voluntary and can be withdrawn at any time before, during or after the
research without consequences. Withdrawal can include removal of any data already collected or
choosing not to reply to questions during the interview(s) or choosing not to participate in the
digital story workshop. Data will be stored until the thesis has been completed. Participants may
withdraw data up until 2 months following the final interaction with the researcher (i.e. 2 months
after the interview).

**RIGHTS OF RESEARCH PARTICIPANTS**

You may withdraw your consent at any time and discontinue participation without penalty. You
are not waiving any legal claims, rights or remedies because of your participation in this research
study. This study has been reviewed and received ethics clearance through the University of
Guelph Research Ethics Board. If you have questions regarding your rights as a research
participant, contact:

Director, Research Ethics
University of Guelph
437 University Centre
Telephone: (519) 824-4120, ext. 56606
E-mail: sauld@uoguelph.ca
Fax: (519) 821-5236
By signing this form, I indicate that I have read and understood the above form and have had any questions answered. I agree to participate in the research study.

Name of participant: ______________________________________

Signature of participant: ______________________________________

Name of witness: ___________________________________________

Signature of witness: _______________________________________

CONSENT TO PARTICIPATE IN RESEARCH- Digital Story

Please read the following informed consent form carefully before signing.
This form is to request your participation in a research study by Andrea LaMarre, from the Department of Family Relations and Applied Nutrition at the University of Guelph. If you have any questions or concerns about the research, please feel free to contact:

Student researcher: Andrea LaMarre, alamarre@uoguelph.ca, 519 836 6435
Advisor: Dr. Carla Rice, carlar@uoguelph.ca, 519 824 4120, ext. 53921

PURPOSE OF THE STUDY
This research will examine the experiences of young adult women who self-identify as having overcome eating disorders. Participants will have overcome an eating disorder between the ages of 18-25, live in Ontario and self-identify as having recovered from an eating disorder, including but not limited to anorexia nervosa, bulimia nervosa and/or eating disorder not otherwise specified (ED-NOS). Clinical diagnosis is not required for participation, as the aim of the research is to broaden our societal understanding of the experience of having and overcoming an eating disorder. Participants are not required to be biologically female, but should identify as a woman during their eating disorder and recovery. The research aims to give a voice to a group from which we do not normally hear, giving participants the opportunity to explore and share their stories through in-depth interviews and/or the creation of a digital story. This research will be used for a Masters thesis project and may potentially be published in an academic journal.

PROCEDURES
If you decide to take part in this research, you will be asked to attend a 3-day digital story workshop, resulting in the creation of a short, multimedia film exploring the experience of having and overcoming an eating disorder. This workshop will take place at REDLAB, in Blackwood Hall at the University of Guelph. During this workshop, you will create a digital story about your experiences of having and overcoming an eating disorder. The workshop will involve 2-3 other participants, with whom you will share your story. The workshop facilitator (the researcher) and/or a research assistant will provide technological support during the creation of your story. Stories will be screened to other participants and the research team at the end of
the workshop. The workshop be audio-recorded and sections may be transcribed by the researcher to inform data analysis. The voiced elements of your story will also be transcribed for analysis. If you wish to continue to be involved in the research, you may elect to participate in data analysis to check the researcher’s conclusions against your own understandings of your story.

**POTENTIAL RISKS AND DISCOMFORTS**
Potential risks of participation include feelings of discomfort in sharing your experiences with other participants and the researcher. If at any time you feel uncomfortable with any of the questions, you may choose not to answer or to withdraw from the study. Though you will be guided through the workshop with questions from the researcher, the direction of the workshop will be largely up to you, and based on how much you would like to share about your story, and how you would like to frame it.

**POTENTIAL BENEFITS TO PARTICIPANTS AND TO SOCIETY**
Though there are no direct benefits to participating, the research aims to advance knowledge about the eating disorders and may help to correct social and/or systematic misperceptions about eating disorders that marginalize those with eating disorders. By sharing your story, you will be adding your voice to the existing dialogue about what it means to be an individual with an eating disorder. Further, by participating in this workshop you will learn about digital storytelling and learn to use the software program Final Cut Pro to make a digital story.

**COMPENSATION**
Participants will be given $50 for their participation in the workshop, to be given once the consent form has been signed.

**CONFIDENTIALITY**
All efforts will be made to ensure confidentiality throughout the research to the extent allowed by law. For example the researcher has a duty to report immanent self-harm or harm to others. You will be assigned a pseudonym, which will be associated with all of your data. You have the right to review or edit any recordings taken during the workshop and you may request that some or all of the recording(s) be erased. Data will be encrypted and backed-up files (ex. External hard drives, paper copies, notebooks) will be kept in locked cabinets. Audio-recordings will be erased once the study is complete. The research team, including the student researcher and advisor, will have access to this data. Each participant in the digital storytelling workshop will be asked to refrain from discussing any names or information about other participants outside of the group. Digital stories will include images that you have chosen to represent your story. Your voice will also be used for a voiceover, which may reveal your identity to individuals who see the story and know your voice. Sharing of these stories will be under your control, and you will not be asked to share your story in setting with which you are uncomfortable. Storytellers own their stories; you will be given a copy of your story to use as you wish. The research team will keep a copy until analysis is finished and the thesis is complete. Please check which of the following you permit:

Audio recordings (used to inform analysis)
☐ I do not want to be audio recorded at all.
I consent to be audio recorded and permit recordings of me only to be heard by members of the research team for the purposes of analysis and evaluation of method.

Transcripts of recordings (used to inform analysis)
☐ I do not want transcripts to be made from audio recordings of me.
☐ I consent to have transcripts made from audio recordings of me, but permit transcripts only to be used by members the research team for the purposes of analysis and evaluation of method.
☐ I consent to have transcripts made from audio recordings of me and am willing to have material from the transcripts made public as long as my identity is protected.
☐ I consent for my name to be associated with material from transcriptions made from audio recordings of me.

Researchers taking notes on participation (used to inform analysis)
☐ I do not want researchers to take notes about my participation in the workshop
☐ I consent to have researchers take notes about my participation in the workshop, but permit the notes only to be seen by members of the research team for the purposes of analysis and evaluation of the method.
☐ I consent to have researchers to take notes about my participation in the workshop and am willing to have materials from the notes made public as long as my identity is protected.
☐ I consent for my name to be associated with notes taken about my participation in the workshop

Sharing your story
☐ I consent for my story to be shared by the researcher for educational or research purposes
☐ I consent for my story to be shared for educational or research purposes if I am contacted prior to its screening
☐ I do not wish my story to be shared with others

PARTICIPATION AND WITHDRAWAL
Participation is entirely voluntary and can be withdrawn at any time before, during or after the research without consequences. Withdrawal can include removal of any data already collected or choosing not to participate in or complete the digital story workshop. Data will be stored until the thesis has been completed. Participants may withdraw data up until 2 months following the final interaction with the researcher (i.e. 2 months after the interview).

RIGHTS OF RESEARCH PARTICIPANTS
You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. This study has been reviewed and received ethics clearance through the University of Guelph Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Director, Research Ethics  Telephone: (519) 824-4120, ext. 56606
By signing this form, I indicate that I have read and understood the above form and have had any questions answered. I agree to participate in the research study.

Name of participant: ________________________________________

Signature of participant: ______________________________________

Name of witness:______________________________________________
Appendix 3: Narrative Interview Guide

This interview guide will act as a skeleton for the interview process; the participant will have a good deal of control in terms of the direction the interview will take. These questions may or may not be applicable, depending upon the experiences of participants. Efforts will be made to structure the interview as more of a conversation, and to use the questions listed as bullets as they relate to the overall story being told by the participant. The guide may also be modified over the course of conducting interviews if the questions are not eliciting participants’ stories. Should the questions change, the guide will be submitted to the REB as a change request.

[Research Question: How do young women who identify as having overcome an eating disorder story/narrate their experiences of having and overcoming an eating disorder?
Sub-questions:
- How do these stories challenge or reinforce the dominant discourse about eating disorders?
- Does the content and form of these stories differ based on an individual’s social location (based on sexuality, race, class, socioeconomic status, body size, etc.)?]

Warm up questions:
- Why did you want to be interviewed?
- What is important to you about it?

Please tell me a little bit about what having an eating disorder was like for you
1. Can you tell me what “having an eating disorder” mean to you?
   - What did that look like for you?
   - How did it feel, for you?

2. In what ways did you experiences fit and not fit the messages you received about disordered eating/eating disorders from others (friends, family, doctors, media, etc.)?
   - Maybe we can start with the ways in which it fit?
   - And the ways in which it did not fit?
   - Do you think that this fit/lack of fit influenced your experience?

3. When did you begin to consider the possibility stopping the disordered eating?
   - How did this feel?
   - What thoughts came up for you?

4. How did this possibility move from idea to action?
   - Were there things in your life that you feel supported the stopping?
   - Were there things in your life that made stopping more difficult?

5. Could you please describe the steps you took to stop the disordered eating?
   - What did you do and how did you do it?
   - What did you find helpful?
   - What did you find not so helpful?
6. What does the word “recovery” mean to you?
   - Do you feel it fits with your experience of having and stopping disordered eating?
   - What does recovery look like?
   - What does it feel like?

7. What kind of messages have you received about what recovery is about?
   - From doctors?
   - From friends and family members?
   - From counselors and/or therapists?
   - From the media?

8. Is there anything I haven’t asked me that you’d like to share?
Appendix 4: Recruitment Flyer

Women Needed for Study on Disordered Eating

Do you identify as having overcome an eating problem?

Is there something unique or different about your story that you would like to share?

I am seeking participants to take part in individual interviews and/or to create a digital story (short, first-person film) about the experience of having and overcoming disordered eating. If you are a woman who identifies as having overcome an eating disorder/disordered eating when you were 18-25 (within the past 5 years), I’d like to hear from you. You do NOT need to have been diagnosed with an eating disorder to participate.

For more information please contact
Andrea LaMarre
Department of Family Relations and Applied Nutrition
University of Guelph
alamarre@uoguelph.ca
519 836 6435

Participants will receive remuneration for participating

This study has received approval from the Research Ethics Board at the University of Guelph (REB#13MY014)
Appendix 5: Digital Storytelling Curriculum
Surface Understandings: Representations of Eating Disorders - Script for Introductory Sequence at Digital Storytelling Workshop [Inspired by Project ReVision digital storytelling workshop introductions, focusing on re-storying disability and difference]

As I’m sure you all know, eating disorders have captured the attention of media outlets and the general public, who have become fascinated with how eating disorders come to pass. I’ve talked to all of you now, so I know that your own experiences have been informed in some ways by these “popular” understandings of eating disorders and how they “look.” I recently read an excellent book by Megan Warin (from Australia) entitled “Abject Relations: Everyday Worlds of Anorexia.” In this book, Warin talks, among other things, about how the mass media interpreted her research. In covering her research, they requested that she send in an image to accompany the news item; essentially, they wanted to show an image of a “thin girl”; in fact, it was suggested that “only a skinny one would do.”

I’ve been interested in how eating disorders are represented in mass media outlets for quite some time, but this story really got me thinking about how we position eating disorders in our society. This links in closely to my project: I’m interested in getting a better understanding of the complex and nuanced ways in which my participants (you all) experienced disordered eating and “recovery,” whatever that means to you. In this digital storytelling workshop, I hope that we can create some works of art that go beyond these representations of “the skinny white girl.” I want to be clear that when I say this I’m not trying to discount the experience of individuals who happen to be skinny and white and have suffered from eating disorders. Of course, this too is a story. But what is the consequence of focusing on “reading” the eating disordered body as this (and only this)? In what ways does this close off our understandings of lived experiences, in their various forms?

With this in mind, I’d like to spend a little time talking about representations of eating disorders. You might have encountered some of the representations I am referring to, or maybe you have not. I want to make sure that I’m not just lecturing at you, so of course if anything comes to mind while I’m talking that you want to add please feel free. Again, you all are as much “experts” on this topic as I. I’m hoping that together we can bridge some of the gaps between more “mainstream” representations of eating disorders and more “alternative” ones. Maybe this will also help you to hone in on what you’d like to represent in your own story, hopefully ending up with a digital story that you feel best represents your lived, embodied experiences.

So, if I’m not the expert, who is?
A better question might be: who claims to be the expert? Who is in charge of policing the images we see of eating disorders? Another way of asking is to look at what frames we have available, in our society, at this point in time (and looking back on others) to interpret eating disorders.

Accordingly, what constitutes an eating disorder depends a lot on who you ask. Among the discourses circulating around eating disorders we have:
- Biomedical discourses
- An early feminist discourse
- Postmodern feminist discourses
Other frames and discourses?

I don’t want to sound as if I’m reducing these frameworks to the only ways we have of understanding eating disorders; however, these are some of the “big name” frameworks. There are also a number of sub-frameworks; for example, biomedical and feminist discourses often clash, but within each of these frameworks there is crossover and dialogue. Some feminist discourses acknowledge the biomedical aspects of eating disorders to greater degrees than others; equally, some biomedical discourses incorporate more elements of social environments and constructions of eating disorders than others. To simplify the frames down a fair bit:

Biomedical frameworks essentially see eating disorders as pathology defined by a set of criteria, generally those outlined by the Diagnostic and Statistical Manual (DSM), which is now in its 5th iteration (published by the American Psychiatric Association). This manual now defines anorexia nervosa, bulimia nervosa, binge eating disorder and other specified feeding disorder. These last two used to be encapsulated under a label of “EDNOS.” The criteria were changed largely in response to concerns over the large number of individuals falling under the EDNOS umbrella (roughly 60% according to some calculations). The diagnostic criteria used by the DSM in any of its iterations can be seen as helpful, primarily in their ability to lend “legitimacy” to diagnosis; that is, if one obtains a diagnosis, it will be easier to seek and obtain (covered) treatment. However, there are a number of critiques that have been lodged at the DSM by critical health psychologists and others; some of the critiques of eating disorder diagnoses in the DSM in particular have been lodged from within the mainstream psychological and medical fields themselves. The National Institutes of Health (in the US) have also been moving away from a reliance on the DSM, which they have heartily critiqued. To quote the blog of Thomas Insel, director of the NIMH:

“While DSM has been described as a “Bible” for the field, it is, at best, a dictionary, creating a set of labels and defining each. The strength of each of the editions of DSM has been “reliability” – each edition has ensured that clinicians use the same terms in the same ways. The weakness is its lack of validity. Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure. In the rest of medicine, this would be equivalent to creating diagnostic systems based on the nature of chest pain or the quality of fever. Indeed, symptom-based diagnosis, once common in other areas of medicine, has been largely replaced in the past half century as we have understood that symptoms alone rarely indicate the best choice of treatment” (April 29th, 2013, published on his blog at http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml)

In keeping with ongoing research toward finding better solutions for individuals with mental health concerns, the NIMH has released a “Research Domain Criteria (RDoC)” project, which looks to better integrate ongoing genetic, imaging, and cognitive science research into diagnosing and treating mental illness.

Genetic research for eating disorders is ongoing; initiatives such as the Anorexia Nervosa Genetics Initiative (ANGI) out of the University of North Carolina Centre for Excellence in Eating Disorders is looking to collect blood samples and clinical information from over 8000
individuals diagnosed and not diagnosed with AN in the United States, Sweden, Australia, and Denmark in order to better understand the genetic basis for the disorder. Another initiative in the UK, Charlotte’s Helix, is working to bring this initiative to the UK in collaboration with Kings College London.

While these moves toward better understanding predisposition toward eating disorders are admirable, there are those who take a more social constructivist approach toward understanding eating disorders. Among those who critique a more biomedical approach, some suggest that the labels that accompany eating disorders can serve to reinforce stigma and may not fit with individuals’ lived experiences of disordered eating (e.g. Becker, Hadley-Arrindell, Perloe, Fay & Striegel-Moore, 2009; Gremillion, 2003; Malson, 2009b; Shohet, 2007). They argue that the narrow criteria used in the DSM miss individuals who might wish to obtain treatment for their disorders, for example individuals from minority ethnic groups and individuals with a larger body size, and that individuals’ eating practices cannot so easily be divided into “normal” and “pathological.” Critiques of the DSM from the critical feminist particular argue that basing pathology on a set of individual-expressed criteria might result in “blaming” individuals for their pathology. They also suggest that the above-mentioned socially-constructed and mediated nature of mental illness is ignored in pathologized expressions of disordered eating (e.g. Malson & Burns, 2009).

Importantly, there are again shades of understanding, here. On one end of the spectrum, there are those who claim that eating disorders are solely behavioural phenomena. At the Karolinska institute in Sweden, for example, researchers using the “Mandometer” mode of treatment for eating disorders argue a complete lack of psychological basis for eating disorders; they suggest that eating disorders are solely caused by poor nutrition and excessive exercise, and thus by regulating these (even in the absence of psychological counseling), eating disorders will remit. However, their data is somewhat lacking, despite extraordinarily strong marketing techniques and claims to success somehow published in reputable journals (e.g. Bergh et al., 2013). Though operating from a very biomedical standpoint, these arguments come close to replicating some very social constructionist arguments.

For staunch postmodernists, on the other hand, eating disorders are simply a social construction—essentially, there is no “normal” eating, just eating practices and body sizes that take on different significations depending on social situations.

Luckily, there is a happy medium to be found: to me, the most convincing arguments around eating disorders are those that take into account both the reality of the psychological and biological underpinnings of eating disorders while also placing eating disorders and disordered eating in specific historical and social contexts. But before I get to that I will step back a moment and look at some of the earlier feminist framings of eating disorders:

Earlier feminist work claimed that eating disorders were the result of internalization of media ideals of femininity or, conversely, resistance against these norms (e.g. Bordo, 1993). While this might seem like an impassable chasm between feminist thinkers, these alternative readings of eating disorders are not as disparate as they might seem. Those feminists who understood eating disorders as opposition to norms of femininity saw the control exerted by individuals with eating
disorders over food and their bodies as these individuals exercising agency over their bodies and refusing to conform to aesthetic ideals of curvy, male-gaze-inviting femininity. Those who saw eating disorders as conformity perceived eating disorders to result from an internalization of beauty ideals, such that living in a culture that praises slimness was almost “taken too far.” Thin ideal internalization has become somewhat the “darling” of mainstream understandings of eating disorders; a lot of what we hear about eating disorders might lead some to believe that eating disorders are simply diets gone too far; indeed, there are even some studies suggesting that some individuals with eating disorders themselves perceive this to be what happened.

Newer feminist understandings of eating disorders are emerging that centralize the lived, embodied experience of disordered eating. The book I mentioned earlier, by Megan Warin (2010), is one example. She conducted an ethnographic study of eating disorders; Warin spent time in Vancouver, Australia and Edinburgh interacting with individuals with eating disorders to try to better understand what it is really like to have an eating disorder. While she herself did not identify as having an eating disorder, and acknowledged that this would limit her ability to understand what it truly feels like, Warin’s book opens up the possibility of acknowledging the embodied meaning of eating disorders.

One of the most important things to me is to try to understand, as I’ve mentioned, that biology does play a role; however, we are not DNA in an inert setting. There is a bi-directional (actually, a multi-directional) interplay between genetics and environment (e.g. Fausto-Sterling, 2000). Though I am obviously not a geneticist or a neuroscientist, this is what makes sense to me: environments have an impact on how genes are expressed; however, people are not simply passive objects acted upon by social environments- therein is one of the major flaws in the argument that eating disorders are simply “diets gone wrong” or gone too far. No, individuals are agents in our social worlds; we actively respond to and interpret social environments. To really simplify things, I could use the much-used “genes load the gun, environment pulls the trigger” metaphor. While I know this phrase is over-used in the mental health realm, there is a lot of truth to this saying- just because one has a “predisposition” does not mean that they are destined to express a certain pathology later in life. A nuance that is important here is that the “environment pulling the trigger” does not necessarily have to be a big, life-changing event; often, there might not be one discernable “cause” for the eating disorder.

Now that I have gone off on a big tangent exploring some of the broad framings of eating disorders and lenses through which researchers might explore these disorders, I’d like to turn to the ways in which the media has co-opted some of these frameworks in representing eating disorders.

Last winter, I got pretty into this question of “how are eating disorders represented in the media” question and ended up undertaking a discourse analysis of how eating disorders are represented on Dr. Phil. In writing this paper, I came across surprisingly few studies explicitly addressing how eating disorders are portrayed in the mainstream media. More studies look at how individuals with eating disorders are portrayed in hospitals, among medical professionals and patients themselves. I’ll start by giving a brief history of the representation of medicalized bodies, including eating disorders, and move to a look at modern representations and understandings of eating disorders.
There are some “pat” images of eating disorders that I’m sure you’ve all seen: the extremely thin woman, the medicalized woman, the skinny white girl, the celebrity “fallen from grace.” Often, these images that populate our social sphere are focused on the consumption of food (or lack thereof) and/or the distortion of body image. Importantly, I am not claiming that these cannot be issues held by individuals suffering from eating disorders. Body image certainly can be an issue; not feeling comfortable with the look or feel of the body is a common experience to be sure. However, the sheer number of images of this type that circulate about eating disorders can be problematic and create a “single story.” In one of my favorite TED talks, Chimamanda Ngozi Adiche talks about the danger of a single story. To share a quote from this talk: “The single story creates stereotypes, and the problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story.”

So, if all people see when reading stories about eating disorders are images of ultra-thin, white, female bodies, those images might come to be taken as the only bodies that are eating disordered. This might discount individuals who never lose enough weight to be clinically diagnosed with anorexia, for example, but whose disordered eating significantly impacts the quality of their lives. This might discount black women and even lesbian women, both “groups” that have been claimed, at one point or another, to be “immune” to eating disorders. This might lead some to discount the distressed experiences of individuals suffering from binge eating disorder or bulimia or ED-NOS whose bodies do not physically manifest their disordered eating.

Historically, anorexia in particular has been understood as a “women’s disorder,” going back to Dr. William Gull’s descriptions of cases of “hysteria” and anorexia in the 1860s and 1870s, where the refusal of food was accompanied by a “peculiar restlessness.” Images such as the one on this slide demonstrate the early and pervasive focus on weight in the framing of anorexia. Anorexia in particular continued to capture the collective imagination of doctors looking to find a cause and cure for the disorder. Note that this “cause” and “cure” remain elusive.

In the early 80s, Karen Carpenter, a noted soft rock singer, passed away. With her passing, media interest in anorexia was rekindled. Feminist interest in eating disorders drew attention to scrutiny on bodies that “led to” eating disorders. However, as critical feminist scholars have since noted, there are problematics with these representations that may lead to individuals with eating disorders feeling alienated from and disempowered by representations of eating disorders, rather than comforted or reassured (e.g. Malson 1998). Paramount here is the positioning of individuals with eating disorders as passive victims of thinness ideals or as somehow more susceptible to image culture, which is not always the case.

Looking at the ways in which eating disorders are positioned in media outlets, there are a number of (potentially problematic) trends that we can observe. For example, O’Hara & Clegg-Smith (2007) and Shepherd & Seale (2010) both conducted analyses of the representation of eating disorders in print media sources. Among their findings, they discovered that individuals with eating disorders were often positioned as young, white, affluent women who had simply taken their diets “too far,” crossing over from “normal dieters” to “sick people” placing an undue emphasis on body size and shape. This discourse of body image driven eating disorders abounds and under represents other elements of eating disorder etiology, course, and treatment.
One of the things that surprised me the most about these representations was where in the newspapers and magazines they were positioned. Generally, these representations were in entertainment sections. Beyond the problematics of the simplistic image of the “eating disordered individual,” positioning these stories in the entertainment section strikes me as minimizing and contributing to the spectacularization of eating disorders and the discourse of contagion that surrounds them (e.g. Burke, 2009; Bray, 1996).

As I mentioned earlier, I was intrigued with representations of eating disorders and the simplistic conceptualization of eating disorders in popular media, which led me to a project looking at the positioning of eating disorders on a popular television talk show, Dr. Phil. Though this talk is not all about me, it is worth mentioning that in my discourse analysis (looking at the language and linguistic strategies) used by Dr. Phil on his show strongly reinforced some of these dominant representations of eating disorders, especially through bringing extremely thin young women on his show, frequently emphasizing weight, using many extreme metaphors to invoke shock and awe in the audience.

I want to emphasize again that I am not saying that individuals with eating disorders don’t often lose a lot of weight and wind up emaciated and in severe physical distress. However, what kind of impact does seeing only emaciated white girls as the image of “the eating disordered individual”? What kind of impact does the single story perpetuate? The focus on the bodies of individuals with eating disorders (and even more narrowly, anorexia), neglects to acknowledge the myriad ways in which eating distress can manifest.

Turning to recovery, studies examining the representation of recovery seem to demonstrate that recovery, too, may be simplistically portrayed. A number of books and popular literature is devoted to the idea of “full recovery” and how everyone can achieve full recovery. This idea speaks to some individuals with recovery, as it may promote an emphasis on the ability to escape an extremely difficult experience and achieve a life that feels fuller and more authentic. However, where does the imperative toward full recovery leave individuals who do not attain what a doctor might define as “full recovery”? What about small relapses? Is there room for variation in our understandings of recovery, or are we failing people if we don’t all strive for and support the idea of full recovery?

Importantly, is it realistic to expect that all individuals will be able to come out of an eating disorder “like they were before” or even “better than” they were originally? What if you don’t actually come to love your body?

Now, I know it might seem as though I’m denouncing the idea of eating disorder recovery and I would hate to come off this way. Certainly, some individuals see full recovery as a possibility. As you will see in my digital story, I too have defined myself as recovered. But in thinking about the concept more, reading the literature, and talking to my participants, including you all, I have come to complicate the picture of recovery a little more. Something that I’ve been thinking about a fair amount as I’ve been delving into digital storytelling in general is the idea of the “happy ending” that we all expect to see in stories. Our culture has taught us to expect a fairytale ending, but honestly that fairytale ending doesn’t always happen; what would be the consequences of accepting messier endings? What if things weren’t always wrapped up into a neat bow?
So, rather than saying that the story of full recovery isn’t true, I’m asking us to collectively imagine and question 2 things:

Firstly, what exactly do we mean when we say “recovery”? I asked this question in my interviews, and no two responses were the same. There was a big difference, I found, in what you personally described as “recovery” and the way that medical professionals and others in your lives have talked about recovery. One of the main areas of divergence is around the idea of weight restoration: is one recovered simply when one regains their weight? Though this might be the representation we see a lot of, is it necessarily true? This is where the literature indicates some distance between the experiences of individuals with eating disorders and those who might not “get” the experience; basically, this would lead to that fear of being “anorexic in a fat body,” or having people assume that one is better simply because the weight has been gained, which may not always be the case.

To use two horse metaphors, how do you know you’re “healthy as a horse?” are there different “horses for courses?” What I’m getting at here is that, as you all know, you obviously can’t assume that any two experiences of having and “recovering from” an eating disorder. Of course, some would argue that eating disorders are the “impossible subject,” (see http://www.newyorker.com/online/blogs/books/2013/12/anorexia-the-impossible-subject.html) and suggest that there is no way to write about or portray eating disorders in a way that avoids glamourizing them. I’m not of this mindset, obviously, or I wouldn’t have you all here prepared to make digital stories about your experiences! However, I do think that we can start to add more richness to the discussion and have conversations about eating disorders that recognize the heterogeneity in experiences and challenge viewers to understand eating disorders in new ways, including whether and how it is possible to recover.

Basically, I’m wondering if by going beyond the focus on weight restoration that appears to have captured the hearts of doctors and publics alike, and focus on the nuanced expression of eating disorder recovery, by really asking ourselves about the experiences we’ve had and how those experiences inform the way we relate- to ourselves, to our bodies, to others. Rather than simply replicating oft-portrayed versions of “recovery,” is there room to create new forms of expression around eating disorders and recovery? Of course, I don’t want to ask you to make an Oscar-winning film; but it’s just that that is interesting, in fact. One of my favorite things about digital stories, and I hesitate, as a perfectionist, to admit to this, is that they are imperfect. To be corny, just like we all have cracks in our armour, so do digital stories. The power of imperfection is in and of itself a challenge to the glossy images and stories we encounter on a daily basis.

From the Project ReVision Manual (Rice et al., forthcoming):

Using a narrative approach:

“There are many different sorts of stories by which we live our lives and relationships – including stories about the past, present and future [...] An individual may have a story about themselves as being successful and competent. Alternatively they may have a story about themselves as being ‘a failure at trying new things’ or ‘a coward’ or as ‘lacking determination’...
In this way, the act of living requires that we are engaged in the mediation between the dominant stories and the alternative stories of our lives. We are always negotiating and interpreting our experiences.” – Alice Morgan

See also www.dulwichcentre.com.au (Dulwich Centre in Adelaide, Australia is involved in narrative approaches to therapy and community work, training, publishing, supporting practitioners in different parts of the world, and co-hosting international conferences.)

**Project ReVision Strategies:**

- Telling our stories
- Taking a not-knowing stance
- Asking purposeful questions
- De-centering our expertise
- Creating communities across disability and difference
- Using art-based interventions to increase understanding and break down barriers between people

**Presentation inspired by all references cited in main thesis document, with emphasis on the following books and articles:**


**And the following blog posts/online media:**


ANGI: Anorexia nervosa genetics initiative, University of North Carolina: http://www.med.unc.edu/psych/eatingdisorders/our-research/angi

Charlotte’s Helix Project: https://www.charlotteshelix.net

Appendix 6: Storying Recovery Facilitator Notes

[Adapted from Project ReVision manual (Rice et al., forthcoming), with permission]

Know the space (be familiar with the venue and its layout) ahead of time
Plan and plan again
Provide clear timelines (give start and finish times for participants who use accessible transit, child care, etc.)
Practice flexibility in workshop schedule
Accommodate participants’ individual needs
Be aware of tone of voice, body language and role of the facilitator
Be mindful of group energy levels
Use multiple methods of teaching to encourage participation
Provide multiple opportunities for group to share and learn from each other
Remember that dominant thoughts may not be shared by all in the room
Provide opportunities for feedback and reflection; use these to fine-tune future sessions
Encourage expression of multiple points of view
Remind people not to eat or drink at their computers

AGENDA

Friday, January 24th (1pm-5:00pm)

1pm: Introductions and Workshop Overview

- Have participants sign consent forms and give them their honorariums
- Introduce myself and Christine (who won’t be there yet but will arrive for story circle); have participants introduce themselves and say one thing they are hoping to get out of the workshop/one “teaser” for the story they hope to tell

Introduce the project

Representations Discussion

- Discussing the historical and cultural representations of eating disorders and how they have been portrayed in media and academic discourse (see Surface Understandings “script” and Prezi presentation: http://prezi.com/ff-jymms8ss0/surface-understandings/)
- Includes showing Jen Renaldi’s story and my own

2:30pm: Break

2:45pm: Story Circle

Notes to share with the group:
The Center for Digital Storytelling in California was one of the first organizations to use the digital storytelling method. The centre uses the “story circle” as a strategy for creating a
supportive group environment in which workshop participants can develop, clarify, or structure the digital piece they want to create.

Story circles use the tradition of storytelling as a way to bring people together and build relationships. Having individuals share personal stories within a group process gives everyone the opportunity to explore a range of issues and experiences, which contributes to building a stronger learning community.

The amount of time a story circle will take depends of course on the number of participants in your workshop. There should be about 10 or 15 minutes for each person to share their ideas and get feedback.

Also share ground rules, as below.

Notes:
Key are safety and comfort. Tips from the Center for Digital Storytelling staff:

1. Time frame: Determine and discuss the time allowed for the entire process and for each individual story, as well as for breaks during the circle. Identify a person willing to be the timekeeper if you wish. If the story discussion has not reached resolution or the storyteller is still feeling unresolved, summarize key ideas and remind them that they can get further support one-on-one following the story circle. If participants ask, “Can I just add one more comment?” you can always respond with the question, “Can you share it with the storyteller following the story circle?”

2. Ground Rules: Before beginning any story discussion, establish Ground Rules with the group.

Respect. Everyone’s story is valid; it’s not about competition. Be non-judgmental; no negative facial expressions, body language, or sounds that indicate disinterest or disapproval.

Confidentiality. What is said in the room stays in the room.

Consideration. Let each person talk until they are finished presenting their script/story idea, before jumping in with comments or questions.

Offering Feedback. Let the storytellers begin by telling the group what kind of feedback or assistance they would like. Ask others to start with something positive and supportive; then ask questions. It is best to avoid “should.” Remind the group that they don’t have to feel compelled to comment or to reiterate someone else’s comment; not everyone has to talk each time. Note: Ask the storyteller what kind of feedback they want to receive before starting to pose questions or make comments. The Story Circle works best when storytellers, not facilitators or listeners/witnesses, direct the focus of the feedback.

Step Up/Step Back. It can be useful to suggest that participants use the story circle as a chance to “stretch” themselves in terms of group settings. For the person who is very shy, you might
encourage coming forward and taking space in the group by making a comment or two. For the person who always talks all the time, you might encourage working on deep listening.

The Workshop Space. Cell phones OFF during the discussion.

Emotions. Deep and challenging ones may come up. Tears are OK and don’t need to be apologized for. (Have Kleenex available.)

Silence. Is. OK. If someone is struggling with what to say, don’t make him or her feel rushed.

3. Facilitator Questions: If you’re facilitating a story circle and are struggling with what to say, after someone has shared their story ideas, the following questions may be useful.

Opening Comments: What kind of feedback do you want from us? What would be helpful?

Appreciative Comments: I really liked ______ about your story. A phrase/something that jumped out for me was ______. That was very brave, and I appreciate you sharing that story.

Point of View: Why are you choosing this piece of writing now? Who do you see as the audience for this story?

Dramatic Question: After hearing your story, I can think of many different ways you could write/structure it. I have these ideas ______, but what are you thinking about, in terms of a direction to go in for your script?

Detail: I heard something about _______ in your story, and I’m curious to hear more about that. Is there a specific incident that comes to mind? What would be a way to “create a scene” in your story?

Clarification: It sounds like you’re talking about _______. Is this right, or did you mean something else?

Suggestion for Additional Content: I really like what you’ve shared, and given that our topic is ________ I’m thinking that you could also touch on ________

Creating a Scene: Your story is very powerful, and I feel like what might make it even more so would be to have some detail about a specific moment in time. For instance, you might think about writing a paragraph that really spells out what it felt like when ______ or what happened when ______

Economy: What images do you have in mind for your story?

Support: Are you open to feedback? Is there anything else you would like us to give you feedback on? Do you have enough feedback to move forward?
Summarizing: (To end with, before going on to the next person) Do you have any more questions for us, or for the group? Do you feel like you have enough to work with, to take the next step with your script?

4. Closure: Be sure to end the story circle with supportive and positive comments that thank everyone for their honest and open participation. Let everyone know that they can check in with instructors on an individual basis to continue to develop their script ideas.

4pm: Script development

- Share the seven steps of digital storytelling (participants will also have a copy of this, which has been emailed to them and then also given to them in their workshop packages):


3. Finding the Moment: Is there a single moment that illustrates your insight? Finding the moment of change. Integrating the moment of change.

4. Seeing your Story: How will the images shape your story? What images come to mind when recalling the moment of change/the entire story? What do these images convey?


- Give people time to work on their script. If they prefer to leave early and work on their script at home, this is ok as well.

Saturday, January 25th (10am-5:00pm)

10am: Script development (continued; if people are struggling, ask if they would like any help and use above questions from story circle as a guide)

Voiceover recording (when ready, ongoing)

11am: Final Cut X (Video editing software) Tutorial

- I will be sharing how to use Final Cut using examples from my own story, on the screen in the workshop room; participants can ask questions if they have them at the time (though they may not, a-contextually- these might come later, when they start working with their stories)
• Participants will be given a handout with the basics of Final Cut that may provide a helpful starting point

12:30pm- 1:30pm: Lunch

1:30pm-5pm: Voiceover recording continues (note: all participants should ideally have voice recording done by the end of the day)

Storyboarding/Image Preparation/Scanning
Help storytellers match their scripts with the photographs they brought, and to create art or videos to illustrate their stories. Storytellers who have brought hard copies of images or who have created visual art for inclusion in their stories should be assisted in using the scanner in order to digitise their images. Those who wish to edit or change their images using Adobe Photoshop should be assisted in using the software.

Begin helping storytellers to load their voiceover soundtracks, images, video clips into Final Cut.

Begin Rough Edit of Digital Story

Sunday, January 26th (10am-5:00pm)

10am- 12:30pm
Complete Editing

Explore Transitions/Pans and Zooms (as time permits, may be another opportunity to show on the screen; if people are feeling like they would prefer to work on their own and/or with facilitator, can show individually)

12:30-1:30 Lunch

1:30pm- 4:00pm
Complete Digital Story Production/Music and Titles (ensure that everyone has titles if they wish)

Export Stories

4:00pm- 5:00pm
Premiere of Digital Stories
Appendix 7: Introductory Letter for DS Workshop
[Adapted from Project ReVision manual (Rice et al., forthcoming), with permission]

Dear “Storying Recovery” Digital Storytelling Workshop Participants,

Thank you so much for committing to attend the upcoming workshop, being held at REDLAB on January 24th-26th, 2014. The agenda for the training is attached to this email. The workshop is located at the University of Guelph, in Blackwood Hall, located on Trent Lane. There is parking available on campus if needed; on Friday the price is $2/hour, and I am able to reimburse you for this if you require parking. Parking is free on Saturday and Sunday.

A few other logistical details: the workshop will run from 1-5pm on Friday, the 24th, and 10am-5pm on the 25th and 26th. I will leave the main door to Blackwood Hall open, but if for any reason you can’t get in please text or call me at 519 993 6435 and I will come let you in. Another note is that REDLAB is a scent-free environment, so if you could please refrain from wearing perfume that would be greatly appreciated.

Please forgive the long email to follow… I hope that it will help to let you know what to expect and help you prepare in advance- don’t worry, you don’t have to come to the workshop fully prepared, but in case you want to get a bit of a head start I’ve attached some materials for you to review.

In case you want to watch some stories made in digital storytelling workshops, you can view some at: http://www.storycenter.org/stories

This will give you a feel for what you will be producing at the workshop, though of course how your story will turn out depends on what you’d like to put out there. Digital storytelling is not the same thing as film/video production. During the workshop, you will share your story verbally with a group of other storytellers and receive/give input on content (if you wish); write a final script no more than 350 words in length; read and record this script as an audio file (NOT via an interview in front of a video camera); choose/generate still pictures and short video clips to use in illustrating the story; and learn to use digital editing software that lets you combine these materials into a short (about two-three minutes long) digital story.

Please think about what specific story you want to tell; you’ll want to choose something that is specific and meaningful to you. As all of your digital stories will focus on the experience of having and/or recovering from an eating disorder/disordered eating, one option is to think about whether there was a moment at which you thought of yourself as recovered, or a poignant memory from your experience.

You don’t have to come with your script fully written. If you prefer to bring in a few ideas and work on the script process in the workshop, that is perfectly fine. You can work with me, other participants, or my volunteer to make changes to your script, to ensure that you have a story you feel good about. If you’re working on your script prior to the workshop and want to bounce ideas off me via email and/or a phone call, please feel free and let me know.
As a starting point for your writing, attached is a short description of the “Seven Steps of Digital Storytelling.” I encourage you to write from a place of honesty and emotion, in whatever style works for you; also, it is a good idea to keep your script fairly simple; it’s not a speech or a public service announcement. Just write about what happened, and try to write the way you talk. Digital storytelling scripts are not like essays, reports or proposals. Keep in mind that your written script isn’t the only aspect of your piece that will “tell” the story. You can provide detail through the images you choose and in how you use those images. You will want to assemble about 15-20 images.

Please bring photos and any other images you think you’d like to use; even if you’re not sure they fit with the story, bring them all! Bring any photos, news clippings, and/or original artwork that you feel will best tell your story visually. We can scan things, or, if you have photos/images on a USB flash drive or on CD, that's fine too. Please do not download pictures from the Internet; most web images are not copyright free and thus can’t be used in a story of this kind. Please also do not bring images photocopied from books or magazines, as they are copyrighted as well. However, I have attached a document entitled “online images and sounds” that highlights places to look for creative commons licensed, royalty-free images if you would like to search these for images/sounds to include.

If you’re lacking pictures for your story and you have access to a camera, you may want to take some photos. Think creatively. Often more symbolic/poetic images work best, instead of photos that tell the literal story. If you’re not sure what pictures to take, some ideas include the place where the story happened, from different angles, from far away and close up, inside and out, or people who you talk about in your story, and who agree to be in it (Note: candid photos rather than “staged” photos tend to work best). If you want to take pictures at the workshop, we will have digital cameras available for you to do so.

If you take pictures with a digital camera, be sure to bring the camera and cable with you, so we can download the photos. If you use a 35 mm film camera, please develop the pictures beforehand and bring prints and/or CD copies.

You will need to avoid the use of copyrighted music in your story. If you know someone who agrees to contribute their own original music, please bring it on a USB flash drive or on CD (in .aiff, .wav, or .mp3 format). Other suggestions for copyright-free music are noted in the Online Sounds and Images document.

If you have any questions, please feel free to let me know. I’m really looking forward to the workshop!

Thanks so much,

Andrea