Transforming Bodies: Affect and Collage in Eating Dis/order Recovery

by

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Ontario Institute for Studies in Education
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Abstract

This thesis explores affective experience in the development of eating disorders as well as its influence and potential in the recovery process. Affect is researched within the context of identity and embodied learning. This research also explores the use of creative practices (collage) in eating disorder recovery. Four women between the ages of 18 and 30 who self-identified as having an eating disorder participated in this study. Their participation included two interviews (one individual and one group) and two group collage sessions. This research suggests that eating disorders can be understood as bodily practices (entangled with emotion and thought) that both build and fragment the sense of self. Using Deleuzoguattarian concepts such as “the fold” and “BwO”, I propose a rhizomatic understanding of eating disorder recovery in which the affective body is paramount. I suggest that arts-based practices have the potential to play an important role in the recovery process.
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I dedicate this thesis to those who struggle with eating disorders (may you find well-being in recovery) and to all those who work in this field and support those in recovery (thank you).
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An Entry Point

I have kept a journal for most of my life. Returning to my writing helps me recall events and interactions that have, over time, faded from memory. One of the first courses I took in graduate school sparked an interest in autobiography and storytelling. At that time, I read through some of my old journals in the hopes of finding writing that would help guide (and inspire) me in my academic life. With research interests in body image, I was particularly interested in reading journal entries from my adolescence, when I struggled with an eating disorder. Unfortunately, I found very little writing that explicitly mentioned my eating disorder; the entry dates were sporadic and my writing was quite disjointed (sometimes my writing would end mid-sentence) during this time period. I was disappointed. One particular entry, however, evoked an immediate visceral response. I had dug a pen into my journal and dragged it vertically on the page, applying enough pressure to rip a hole (and most likely ruin my pen). There were no accompanying words, just an entry date at the top of the page. The entry was made around the time I had sought professional help for my eating disorder (for the third time). I vividly remember lying on my bed with my journal wanting, needing to write, but feeling unable to speak. I felt incredibly tense. To me, this entry seems to suggest that some stories live in/through our bodies. According to Deleuze, “that bodies speak has been known for a long time” (as cited in Hickey-Moody, 2013b, p. 79).

Coming across this entry while simultaneously taking graduate courses that pertained to the body, produced in me a desire to learn more about affective experience and meaning-making in eating disorders and recovery. And so, to borrow the words of Holbrook and Pourchier (2014), “my research does not start with a question. It starts with a sensation, a pinch, or, as Foucault (2000) called it, ‘cracks, silent tremors, and dysfunctions’ that are ‘partly a fragment of
autobiography’ (p. 458). And it doesn’t end when a study is completed. There is no end date because the analysis is our lives” (p. 761). Rather than a linear research text that offers a clear analysis of what the data means, my thesis is better understood as an assemblage where theory and data are put to work, becoming “data-as-machine” (Jackson, 2013, p. 113). This kind of methodological approach, Taylor (2013) suggests, “is an illustration of Deleuze and Guattari’s rhizomatic thinking – a form of thinking which is acentred, connective, heterogeneous, non-hierarchical and multiple” (p. 43). This thesis, therefore, like a rhizome, produces “entangled and knotted loops, folding and growing through multiple sites of exit and entry” (de Freitas, 2012, p. 588). And so, I share my journal experience in this introduction not to mark the beginning, but to create an opening – an entry point into this thesis.

Deleuze (2006) suggests that “we will never find the sense of something (of a human, a biological or even a physical phenomenon) if we do not know the force which appropriates the thing, which exploits it, which takes possession of it or is expressed in it” (p. 3). This thesis explores affective experience in the development of eating disorders as well as its force in the recovery process. Affective experience was researched within the context of identity and embodied pedagogy. Hickey-Moody (2013a) suggests that “thinking through affect brings the sensory capacity of the body to the fore” (p. 74). Moreover, turning to affect, according to Wetherell (2012), “leads to a focus on embodiment, to attempts to understand how people are moved, and what attracts them, to an emphasis on repetitions, pains and pleasures, feelings and memories” (p. 2). This research also explores the use of creative practices, specifically collage, in the eating disorder recovery process. Four women between the ages of 18 and 30 who self-identified as having an eating disorder participated in this study. Their participation included an individual interview (focused on their affective experiences in relation to their eating disorder) and attending two group collage sessions and a discussion. The group discussion took place
during the second group meeting and was focused on arts-based practices in eating disorder recovery. The research was guided by the following questions: 1. How are eating disorders affectively experienced? 2. How do individuals affectively experience recovery? 3. How are identities produced, contested, and/or fragmented through eating disorder practices? 4. How can collage, as an affective practice, be used within eating disorder recovery?

The first chapter, “Bodies of Literature”, provides a literature review on eating disorders and affect theory, as well as a brief conceptual framework. The following chapter, “Creating Bodies”, explains my methodology and provides a more detailed outline of the study that was conducted. In the third chapter, “Body Mo(ve)ments” I discuss how eating disorders are affectively experienced by participants. In this chapter, I discuss how eating disorder practices develop within affective (oriented) spaces, how emotion and thought are entangled within eating disorder practices, and how eating disorders can be understood as bodily practices that produce in-between spaces of uncertainty (thresholds or becoming a “Body without Organs”) (Deleuze & Guattari, 1987). Chapter four, “Bodies Be/longing”, discusses how eating disorder practices both build and fragment the participants’ sense of self and their sense of belonging in the world. The final chapter, “Transforming Bodies”, discusses the use of collage and how individuals affectively experience recovery. Drawing on the idea that eating disorder practices produce thresholds, I suggest a “plugging in” of healthier creative and embodied practices (such as collage) – a connection I believe holds the potential to produce new ways of thinking and being (“lines of flight”) in the world (Deleuze & Guattari, 1987). I end this thesis with a proposal of a recovery model that is affective and rhizomatic. I suggest that bringing affective practices (such as collage) into eating disorder recovery holds potential to transform bodies through a creative “becoming” (Deleuze & Guattari, 1987).
Chapter I: Bodies of Literature

Body Image/s

This section offers a brief literature review of eating disorder theorizing within the humanities, drawing on several theorists who work within a feminist framework. I first outline the diagnostic criteria for eating disorders before turning to cultural conceptualizations, which frame eating disorders as images, or visual texts, inscribed by systems of oppression (such as how women are portrayed in and by the media). I then follow with a discussion on how eating disorders are taken up in the literature in terms of habits that are discursively produced.

Following this discussion, I turn to the literature on body image and discuss what is considered to be included or incorporated into this image. Theories of body image as stable and cohesive have influenced eating disorder theorizing and, as such, many theorists have taken up eating disorders in terms of “splitting” – often times reproducing the mind/body dualism. I end with a brief discussion on how this dualistic thinking is further embedded within the literature on eating disorder recovery, which views affect and multiple subjectivities as threatening – a form of excess or chaos that must be controlled and ultimately expunged in order to cultivate a “healthy” contained and singular body image and sense of self.

*The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5)* defines feeding and eating disorders as illnesses “characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning” (American Psychiatric Association, 2013, Feeding and Eating Disorders section). The *DSM-5* outlines the diagnostic criteria for the following feeding and eating disorders: anorexia nervosa, bulimia nervosa, avoidant/restrictive food intake disorder, binge-eating disorder, rumination disorder, and pica. These diagnoses belong to a classification system which is mutually exclusive, preventing
individuals from being assigned multiple diagnoses at any given time (with the exception of pica, which can be diagnosed in the presence of any eating disorder) (American Psychiatric Association, 2013). Revisions made to The Diagnostic Statistical Manual of Mental Disorders (4th ed.; DSM-IV), and since updated in the DSM-5, include the addition of binge-eating disorder (BED) and avoidant/restrictive food intake disorder (ARFID) as feeding and eating disorders, as well as the expansion of diagnostic criteria for anorexia nervosa and bulimia nervosa (American Psychiatric Association, 2000, 2013). Moreover, the previous DSM-IV diagnosis of “eating disorder not otherwise specified” (EDNOS) has been replaced with “other specified feeding or eating disorder” (OSFED) and “unspecified feeding or eating disorder” (UFED) (American Psychiatric Association, 2013). The diagnosis of OSFED applies to individuals whose symptoms are characteristic of an eating or feeding disorder and cause “significant distress or impairment in social, occupational, or other important areas of functioning”, but do not meet the full criteria for any of the eating and feeding disorders previously listed (American Psychiatric Association, 2013). When this diagnosis is given, clinicians are required to record the specific reason the individual does not meet the full criteria for any of the disorders in the diagnostic class (for example, they might write “OSFED” followed by “bulimia nervosa of low frequency”) (American Psychiatric Association, 2013). In a diagnosis of UFED, however, the clinician does not identify the reason the individual does not meet the full criteria for one of the disorders in the diagnostic class, as the individual “includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings)” (American Psychiatric Association, 2013).

It is reported in the DSM-5 Clinical Cases (2014) that prior to the revisions made to eating and feeding disorder diagnostic criteria, approximately 50% of patients in eating disorder inpatient settings had received the diagnosis of EDNOS; this percentage has been predicted to be
even higher within outpatient general psychiatric settings. Despite the high percentage of individuals who did not meet the diagnostic criteria for any specific eating disorder and were therefore left “without a diagnosis that specifically described their condition”, the claim has been made that the revisions were necessary as “the disorders differ substantially in clinical course, outcome, and treatment needs” (DSM-5 Clinical Cases, 2014, Eating and Feeding Disorders section). Studies conducted prior to the publication of the DSM-5 (2013) suggested that using the proposed broader diagnostic criteria was advantageous in that it significantly reduced diagnoses of EDNOS; under this proposed model, a much higher percentage of individuals fit into specific eating disorder categories (Sysko & Walsh, 2011). However, this move toward the elimination of EDNOS as a diagnosis through the implementation of a broader diagnostic system that successfully assigns individuals into specific categories has also been criticized. Nakai et al. (2013) state that while the expanded criteria nearly eliminates the need for a diagnostic category of EDNOS (as suggested by the conducted study), these changes may differentiate eating disorder groups less effectively as this diagnostic system “may have problems capturing the variance of psychiatric symptoms” (p. 330). Moreover, a study conducted by Allan and Gross (2014) suggested that food restricting beliefs and practices (predominately associated with and studied in the context of anorexia nervosa) are reported at clinically significant levels across diagnostic groups. Allan and Goss (2014) thus argue that “transdiagnostic or functional analytic approaches to treatment planning may lead to more effective interventions than current, diagnostically-based, care pathways” (p. 42). Furthermore, a study conducted by Milos, Spindler, Schnyder, and Fairburn (2005) suggested that eating disorder diagnostic categories have a low stability rate. Their study followed a sample of 192 women who were diagnosed with an eating disorder under the DSM-IV, of which 55 were diagnosed with anorexia nervosa, 108 with bulimia nervosa and 29 with EDNOS. They reported that, over the course of 30 months,
“migration between the eating disorder diagnoses occurred in over half the cases” and that “this diagnostic migration was evident in all three diagnostic groups” (Milos, Spindler, Schnyder, & Fairburn, 2005, p. 574). The literature seems to suggest that individuals with disordered beliefs, attitudes and behaviours in relation to eating and exercise do not always fit into or remain in assigned diagnostic classes.

Through medicalization (particularly under psychological frameworks), eating disorders have been produced as distinct clinical entities. This process involves drawing clear boundaries between “healthy” and “unhealthy”. In a dualism, the latter term always emerges as inferior to the former term (for example, good/bad, man/woman, mind/body). That which exceeds the confines of “healthy” is constructed as unhealthy and abnormal – perhaps even becoming that of disease or disorder. Identification, Hall (2000) argues, requires the marking and binding of symbolic boundaries; “it requires what is left outside, its constitutive outside, to consolidate the process” (pp. 16-17). Malson (1997) argues that by emphasising the differences rather than the similarities, eating disorders are produced as distinct clinical entities (p. 223). Through this process of classification, otherwise varied accounts are erased and a “decontextualised and individualistic” understanding of eating disorders is produced (Malson, 1997, p. 223).

Consequently, eating disorder theory and research has been predominantly concerned with producing objective facts about eating disorders as self-pathologies (Malson, 1997). Eating disorders have thus been described in the literature as developing from (or being maintained through or correlated with) a multitude of factors, such as other mental illnesses or personality disorders (Andrews, 2012; Pearson, Guller, & Smith, 2014), family dysfunction (McGrane & Carr, 2002; Wisotsky, Dancyger, Fornari, & Swencionis, 2006), substance abuse (McCormick, Onwuameze, & Paradiso, 2014; Pearson, Guller, & Smith, 2014), neurological factors (Lopez,
Davies, & Tchanturia, 2012; Nunn, 2011) and genetic predispositions (Scherag, Hebebrand, Hinney, 2010; Zerwas & Bulik, 2011).

Medical intervention, Conrad (1975) argues, removes issues from public conversation and places them in a realm where only medical professionals can discuss them. He argues that medicalization should therefore be recognized (and criticized) as a depoliticizing tool (Conrad, 1992). The prevalence of eating disorders is higher among women and some gender and sexual minority groups (American Psychiatric Association, 2013; Diemer, Grant, Munn-Chernoff, Patterson, & Duncan, 2015; Feldman & Meyer, 2007; MacDonald, 2011). As a gendered issue, many feminist theorists have approached eating disorders within the context of oppression. Challenging medical constructs of eating disorders as individual pathologies, many feminist theorists have instead approached eating disorders in terms of cultural diagnoses and solutions (Bordo, 2003; Chernin, 1981, 1994; Fallon, Katzman, & Wooley, 1994; Hesse-Biber, 1997; Lawrence, 1987; MacLeod, 1981; Orbach, 1978, 1988). Within cultural frameworks, however, the body is often constructed as an exterior surface image inscribed by patriarchy. Due to the visibility of the thin body, much of the literature on eating disorders in regards to representation and gender conformity and/or resistance has been written in relation to anorexia. Other eating disorders, such as bulimia and binge-eating disorder, produce a unique challenge for those theorists who have constructed eating disorders as inscriptive surfaces (Burns, 2009). Squire (2003) notes how, unlike the anorexic or obese body, the bulimic body (as a visual text) is difficult to read because the disorder is often contained within a normal-weight body and is therefore hidden or even invisible. Whereas the anorexic body “appears to disappear”, the bulimic body is not visible; it is buried under images of what the eating-disordered body is purported to look like (the emaciated body) (Malson & Ussher, 1997, p. 51). Moreover, it has been argued that the body-as-image is inscribed not only through cultural processes and effects,
but also by other (media) images produced within and by a patriarchal culture. The effects of media images on girls’ and women’s self-esteem has been researched extensively (Becker, 2004; Becker et al., 2002; Derenne & Beresin, 2006). The importance of “media literacy” and its role in the development of healthy positive body image and prevention of eating disorders has also been argued (McVey, 2012; Wilksch, Durbridge, Wade, 2008).

These cultural analyses of eating disorders, however, have been criticized for placing too much of an emphasis on representation (Brain, 2002; Burns, 2009; Lester, 1997; Malson, 2009; Probyn, 2009). Burns (2009) criticizes approaches which privilege pathological image consumption as causal, as such analyses emphasize exteriority and reify “the body as a sign” (p. 125; see also Bray & Colebrook, 1998). She argues that such analyses “potentially render persons as passive and docile rather than (also as) engaging with, resisting and potentially transforming the discourses embedded within those images” (Burns, 2009, pp. 124-125).

Similarly, Springgay (2009) has criticized curricular practices within education that are guided by the belief that body image can be repaired through media literacy as overly simplistic. This type of praxis, Springgay (2009) argues, constructs body image as static and reinforces the idea that adolescent bodies are “unhealthy and in desperate need of control and restoration” (p. 112). Malson (2009) argues that these representational analyses effectively bury women alive under an overwhelming number of body images. Theories of eating disorders developed within frameworks of cultural inscription and representation do not engage with how the body “feels or moves or of what it is like to live in such a body” (Malson, 2009, p. 141). Under such static interpretations, the organic and lived-in body becomes invisible, and the body-as-experienced irrelevant to eating disorder theorizing (Lester, 1997; Malson, 2009).

In unfixing eating disorders from static frameworks, several theorists have reconceptualized eating disorders in terms of habits or embodied practices (Brain, 2002; Burns,
2009; Dyke, 2013; Lester, 1997; Probyn, 1991; Squire, 2003). Burns (2009) emphasizes how a deeper understanding of eating disorders in terms of “being” requires a theorization of the “doing” (p. 129). According to Butler (1988), the body is not solely matter, but a materializing of possibilities; our bodies are performative rather than merely existing. Drawing on the work of Merleau-Ponty, Squire (2003) highlights how any activity we undertake is informed by an “imaginary internal map” of our body’s history in terms of its experiences, movements, and habits (p. 23). Theorizing eating disorders in terms of habit, Squire (2003) argues, allows us to “retain the important connections between the cultural conditions in which habits develop and the discursive conditions through which they are articulated and given meaning” (p. 24). Habits are produced within particular gendered, raced and classed contexts. Many authors, therefore, have turned to corporeal theories of identity focused on production in their analyses of eating disorders. It has been suggested that Foucault’s “technologies of the self” concept can be helpful in theorizing eating disorders, as it disrupts the dualism of inside/outside (Bray, 1996; Bray & Colebrook, 1998; Burns, 2009; Day & Keys, 2009; Eckermann, 2009; Lester, 1997; Malson, 2009; Probyn, 1991, 2009;). According to Foucault, “technologies of the self” produce an embodied subjectivity or existence; the repetition of these body practices materialize a body or produce a self that articulates “a socially meaningful position” (as cited in Burns, 2009, p. 130). Foucault argues in *Discipline and Punishment* that the “soul” is a normalizing idea to which the body is invested, trained and cultivated; it is an historical and imaginary ideal under which the body is materialized (as cited in Butler, 1993, p. 169). Foucault claims that “the soul is the effect and instrument of a political anatomy; the soul is the prison of the body” (as cited in Butler, 1993, p. 169).

Burns (2009) argues that eating disorders are not simply motivated by a desire to be thin, but also by a desire to convey a particular self through embodied practices. Theorizing eating
disorders as embodied habits recognizes the agency of individuals with eating disorders and their “participation in shaping their own existence by their adoption and ‘resistance’ to various discursive/social practices via efforts to transform the embodied self” (Burns, 2009, p. 129; see also Squire, 2003). The bodies of individuals with eating disorders have thus been theorized as both hyper-conformance to and rejection of traditional femininity (Bordo, 2003; Boskind-Lohdahl, 1976; Orbach, 1988; Squire, 2003). Anorexia has been described as a desire to disappear or become invisible (Malson, 2009; Malson & Ussher, 1997; Orbach, 1988).

According to Bordo (2003), maintaining or striving toward a body which lacks feminine signifiers such as breasts, hips and menstruation involves an identification with willpower – a characteristic which has been constructed as masculine. This refusal of traditional femininity, she suggests, can thus be interpreted as a form of freedom (Bordo, 2003). It has been suggested that self-denial through starvation within anorexia “is paradoxically a means to a new and more autonomous self-creation” (Squire, 2003, p. 18). In relation to bulimia, Squire (2003) argues that binging episodes reject “a compliant and passive femininity most obviously signified by ‘eating lightly’” (p. 21).

Taking into consideration the role of habit in shaping identity, Weiss (1999) proposes a model of body image that is produced by (and incorporates) our affective experiences and encounters. She argues that individuals have multiple body images which are shaped by interactions with other bodies, and these body images influence an individual’s movements and gestures without conscious awareness (Weiss, 1999). Body image(s) includes corporeal matter as well as objects. According to Grosz (1994), bodily substances retain the value of a body despite separation and can be coded with disgust, repulsion, desire and envy only “because there is also the possibility (and the prior actuality) of a love of the body and all its substances” (p. 81). Moreover, as Jensen and Moran (2013) note, “I can alienate myself from certain parts of my
body (hair, nails, even inner parts of the body can be removed, e.g. the appendix or gallbladder) without feeling myself altered or changed in any significant way. Yet there are other experiences of my body which are experienced as violations or intrusions” (p. xi). Drawing on the work of Merleau-Ponty and his reading of the “phantom limb”, Grosz (1994) makes the argument that our experiences are not organized necessarily by real objects, but by their meanings and expectations in relation to the body and its capacities. Husserl argues that perception and “phantasy” share similar features (as cited in Jansen, 2013, p. 67). Phantasy, according to Husserl, is a sensory experience of objects despite their physical absence and therefore can be understood as “quasi-perception” (as cited in Jansen, 2013 p. 67). The phantom limb, Grosz (1994) argues, is not a memory or an image of a now absent object, but “the refusal of an experience to enter into the past” and therefore “illustrates the tenacity of a present that remains immutable” (p. 89). Imagining, Jansen (2013) argues, is not simply viewing mental representations, but simulating experiences. Thus, intimate experiences of the body, as Jensen and Moran (2013) note, are “not just sensations and perceptions, but acts of willing, feelings, emotions, mood and the whole affective sphere” (p. xi). Sensational embodied encounters “mingle with visual perceptions to produce fantasy representations that coalesce to form the body image and sense of embodied subjectivity” (Sykes, 2007, p. 135).

While many theorists such as Merleau-Ponty, Husserl, Lacan and Schilder have discussed the role of the imaginary or phantasy in shaping our subjectivities and body images, according to Weiss (1999), “they have failed to offer a critical analysis of the imaginary as an ongoing site of cultural contestation” (p. 66). Body image does not exist as a gender-neutral phenomenon (Butler, 1988, 1993; Grosz, 1994; Weiss, 1999). Bartky (1990) suggests that particular emotions, such as shame and vulnerability, have been coded as feminine within patriarchal culture and these emotions, she argues, have a role in producing subjectivities. Weiss (1999) argues that the
imaginary both “produces and is produced by its own images” (p. 66). Body image stability is thus achieved through *a process of incorporation*; the corporeal schema must accommodate changes to the body and its capacities (Weiss, 1999). Springgay (2009), however, argues that while Weiss (1999) may articulate an active body “engaged in the process of change”, this process is one that works to defend and maintain a “normative discourse of wholeness and unity” (Springgay, 2009, p. 114). Under this model, body image becomes organized “in terms of the implied structure of an ego or consciousness, marked by and as a secret and private depth, a unique individuality” (Grosz, 1994, p. 141). The body, once again, is reduced to a singular image which does not fully engage with the complexity of multiple and fluid corporeal realities, capacities and possibilities.

Springgay (2009) criticizes the literature on body image for constructing the ideal body as one that maintains clear boundaries between the inside and outside. Under this framework, the ideal body (or body image stability) emerges through processes of self-control and containment, and therefore the “soft, loose, excess flesh threatens the borders of the body, the stability of the individual, and the premise that one is normal and in control of his or her life” (Springgay, 2009, p. 114). Sykes (2011) notes how the fat body has been constructed within most Western cultures as “out of control, out of place and out of shape”, signifying unrestrained deviance and desire (p. 49; see also Burns, Tyler, & EDEN, 2009). According to Miller, tightly controlled boundaries are important, as notions of disgust are accompanied by constructions of defilement and danger; matter that is out of place or in flux threatens this order (as cited in Squire, 2003, p. 21). Within bulimia, there exists a movement “towards taking in, filling in, and excess” as well as a desire for “expurgation and the restoration of restraint” (Squire, 2003, p. 24). Such ambivalent and “movement-oriented” body practices disrupt boundaries and “the illusion of self-containment” (Squire, 2003, p. 23). Levens (1995) suggests that anorexics live metaphorically without a skin;
their main concern becomes how to consume food without letting it consume them. When food crosses the boundary of “me/not-me”, Levens (1995) argues, it produces a crisis; it is viewed as dangerous because through assimilation it can become part of the self (p. 45). Body practices such as food restriction or compensatory actions (purging and over-exercising) are therefore interpreted within the literature as practices employed to maintain a stable body image, one where objects (such as food) that violate or threaten this cohesiveness are eliminated.

As practices that threaten body boundaries, eating disorders have thus been theorized within the literature as a splitting. Anorexia has been constructed as a wish to exist as a non-corporeal being (Orbach, 1988). According to Levens (1995), the anorexic holds the belief that mind transcends body and that the body is an instrument or object rather than integral to the self. Bulimia, however, is often constructed within the literature as an excessive embodiment. Squire (2003) argues that “to experience bingeing, to feel one’s stomach distend, and to induce vomiting is to inhabit a profoundly lived body” (p. 23). It has been argued that individuals with bulimia acknowledge their bodies through violent attack (Squire, 2003). These violent attacks, however, have also been interpreted elsewhere as an attempt to transcend corporeal limitations (Levens, 1995). Levens (1995) claims that the extent to which an individual with an eating disorder relies on splitting mechanisms “will affect the extent to which she is able to have any sense of continuity of herself, whether of her psychological self or her bodily self” (p. 32). This splitting or dis/embodiment within eating disorders signifies disorder – an engagement in practices that threaten the sense of self and corporeal containment.

Given the emphasis on body boundaries and splitting within the literature on eating disorders, it is not surprising that eating disorder recovery models are shaped by and reproduce such dualistic thinking. Eating disorder recovery is often constructed in the literature as a linear process with a clear (and achievable) end point of health and wellness (see for example Zerbe,
Most often these recovery models reinforce the Cartesian mind/body split as they frame health as control over the body. Psychiatric treatment models for eating disorders based on this dualistic thinking operate within a framework of normative absolutes, which “may account for the poor recovery rates” (Saukko, 2009, p. 71). Similarly, Gremillion (2002), notes that psychiatric treatment models often define mental health in terms of strength and fitness, which, paradoxically, are often the motivations that have led to the development of anorexia.

Cognitive Behaviour Therapy (CBT) has been used extensively in eating disorder treatment programs, often alongside medical and nutritional support (Byrne, Fursland, Allen, Watson, 2011; Gowers, 2006; Grave, 2013; Hickner & Schumann, 2009). CBT is an umbrella term used to describe a variety of therapies with similar characteristics, based on the belief that by changing how we think, we can change how we feel and act, even if the situation itself remains unchanged (Heslop, 2008). CBT provides cognitive techniques for patients to assess and change their thought processes with the goal of a resulting change in behaviour. CBT is not an open-ended process, but a more structured and directive therapy model that is “brief and time limited” (Heslop, 2008; see also O’Donohue & Fisher, 2012). CBT models that address emotion, however, often only do so in terms of “dysregulation” (Papa, Boland, Sewell, 2012; Safer, Telch, Chen, 2009). Under these frameworks, affective experiences and emotions are understood as a kind of excess – an unruly and irrational force that needs to be controlled, contained and/or eliminated exclusively through the mind. My research project challenges this cognitive model and instead works with this “excess” through an approach that places the affective body at the centre of recovery. As stated earlier in this chapter, eating disorders can be understood as embodied practices or habits and are not solely motivated by cognitive processes, and therefore a model that also encompasses the body and affective experience may be more effective.
While there is some literature about the use of arts-based practices in eating disorder treatment, most of this research and clinical practice has taken a psychoanalytical approach with an emphasis on imagery, symbolism, deconstruction and finding the self (see for examples Dokter, 1995; Levens, 1995; Makin, 2000). Levens (1995) states that through art therapy the patient’s sense of self begins to change; she argues that “an individual identity, secure within the limits of her own body, takes shape. Reflected in the content of her artwork is her increasing ability to structure her impulses and aims in order to communicate with others. A more coherent form starts to emerge from the fragmented, incoherent images” (p. 125). She further argues that a goal of therapy is to help the patient “transcend impulsive acting out and to progress to symbolic representational thought” (Levens, 1995, p. 119). Art-making is an embodied and affective practice, yet under such psychoanalytical frameworks, the emphasis is placed on representation, signification and subjectification rather than bodily capacities. This approach reproduces the notion that a coherent individual identity can (and must) be (de)constructed. Narrative-based therapy has also been practised in eating disorder recovery. Epston and Maisel (2009) present a therapy model of “externalizing conversations” in which eating disorders are constructed “as an influence separate from the person” (p. 215). Externalizing conversations, they argue, allow an individual to identify, objectify and critique their eating disorder as a separate entity (Epston & Maisel, 2009). While these models may help individuals voice their experiences and possibly imagine or construct new identities apart from their eating disorders, I suggest that such approaches fail to engage with affective experience and the functions that eating disorders serve in individuals’ lives.
Affect/ed

The literature on affect spans multiple disciplines within both the humanities and the sciences. Gibbs (2010), however, notes that “there is widespread disagreement both between and within the various disciplines that claim a stake in affect— psychology, the neurosciences, biology, sociology, cultural studies, anthropology, and so forth—about whether to conceive of affect as innate or socially constructed, how to formulate its relationship with cognition, emotion, and feeling, and what these sorts of decisions might entail theoretically and politically” (p. 188).

In this thesis, I focus primarily on the literature within the areas of philosophy, education and cultural studies. In this section, I provide a brief overview of some of the ways in which affect has been taken up by theorists working within these disciplines, as well as note some of the tensions that arise. Seigworth and Gregg (2010) argue that affect and its theorizations “will exceed, always exceed the context of their emergence, as the excess of ongoing process” (p. 5).

This literature review, therefore, discusses conceptualizations of affect while simultaneously acknowledging that affect “exceeds our efforts to contain it, even our efforts to contain its thought in the affective turn” (Clough, as cited in Brown & Tucker, 2010, p. 237). Affect is theorized in this section as productive intensities and capacities, as relational and in movement, and as “gathering” or accumulative.

Clough (2010) highlights how the “affective turn” proposed “a substantive shift in that it returned critical theory and cultural criticism to bodily matter, which had been treated in terms of various constructionisms under the influence of poststructuralism and deconstruction” (p. 207). It has been argued that there is always an “excess” through discursive production that cannot be “captured by notions of signification or representation” (Grossberg, Seigworth & Gregg, 2010, p. 318). Similarly, Brown and Tucker (2010) state: “A vaster range of potential bodily doings always lies beyond and before that which we are aware of” (p. 239). Affect has thus been
theorized in terms of bodily intensities and capacities for action (Brown & Tucker, 2010; Clough, 2010; Deleuze & Guattari, 1987; Gibbs, 2010; Wetherell, 2012). In the words of Gibbs (2010), affect is “intricately involved in the human autonomic system and engaging an energetic dimension that impels or inhibits the body’s capacities for action” (p. 188). Affective theories bring movement to static theories of the body that focus on representation, signification and discursive production. Under affect theories, the body is understood in terms of what it can do – the intensities it produces and passes (Deleuze & Guattari, 1987). Seigworth and Gregg (2010) suggest that bodies are not defined “by an outer skin-envelope or other surface boundary but by their potential to reciprocate or co-participate in the passages of affect” (p. 2). Bodies are thus reconceptualized within the literature as forces, intensities, capacities and passages.

Deleuze and Guattari (1987), influenced by Spinoza, propose the “Body without Organs” (BwO). The BwO is a non-hierarchal understanding of bodies; it is “what remains when you take everything away”, which Deleuze and Guattari (1987) identify as phantasy, signification and subjectification (p. 151). The BwO is “a set of practices” which “causes intensities to pass; it produces and distributes them in a spatium that is itself intensive, lacking extension” (Deleuze & Guattari, 1987, p. 153). For this reason, the BwO is a limit never reached, as “you are forever attaining it” (Deleuze & Guattari, 1987, p. 150). Moreover, the BwO is desire as well as how one desires – it is “the field of immanence of desire” (Deleuze & Guattari, 1987, p. 154; see also Deleuze & Guattari, 1977). A Deleuzoguattarian desire differs from a traditional psychoanalytical understanding, which frames desire in terms of lack. Desire, according to Deleuze and Guattari (1987), is productive immanence and therefore does not interrupt or deliver to “the three phantoms”, which they identify as “internal lack, higher transcendence, and apparent exteriority” (pp. 156-157; see also Deleuze & Guattari, 1977). Becoming a BwO involves “opening the body to connections that presuppose an entire assemblage, circuits,
conjunctions, levels and thresholds, passages and distributions of intensity, and territories and
deterritorializations …” (Deleuze & Guattari, 1987, p. 160).

Bodies affect, just as they are simultaneously affected by other bodies. Affect thus encompasses the body’s capacity “to act and be acted upon” (Seigworth & Gregg, 2010, p. 1; see also Hickey-Moody, 2013a). Bodies include the corporeal as well as non-human bodies, such as “art, music, computer technology, educational and other institutions, and the media” (Bertelsen & Murphie, 2010, p. 155; see also Hultman & Lenz Taguchi, 2010). Thrift (2010) argues that “persons do not exist as autonomous entities but have the capacity to act directly upon one another” (p. 303). This ongoing process of affecting and being affected (affect/ed) is one of transformation or becoming (Deleuze & Guattari, 1987). According to Deleuze and Guattari (1987) every BwO is in communication with other BwOs. As “a component of passage” the BwO is “necessarily a Collectivity (assembling elements, things, plants, animals, tools, people, powers, and fragments of all of these; for it is not ‘my’ body without organs, instead the ‘me’ (moi) is on it, or what remains of me, unalterable and changing in form, crossing thresholds)” (Deleuze & Guattari, 1987, p. 161). According to Deleuze, “it is this capacity for affecting and being affected that also defines a body in its individuality” (as cited in Probyn, 2010, p. 77). The BwO, therefore, highlights the relationality of affect: “The field of immanence is not internal to the self, but neither does it come from an external self or a nonself. Rather, it is like the absolute Outside that knows no Selves because interior and exterior are equally a part of the immanence in which they have fused” (Deleuze & Guattari, 1987, p. 156). Bodies affecting one another produce opportunities for transformation because something changes when “it crosses a threshold, when it changes gradient” (Deleuze & Guattari, 1987, p. 153). This passage between bodies, in smooth space, unleashes lines of flight (deterritorializations) in “an inevitable exercise or experimentation” (Deleuze & Guattari, 1987, p. 149).
The relationality of affect is also taken up through the Deleuzoguattarian concept of “the fold” (Deleuze & Guattari, 1987; see also Deleuze, 1993). Folds are “continuations of inside and outside, and because there is no simple, stable surface on which to stand, they do not engender single points of view or rigid identities” (Holbrook & Pourchier, 2014, p. 755). Folds are “both at once exterior and interior” (Springgay, Irwin & Kind, 2005, p. 901). In a fold, distinct boundaries between a subject and the world dissolve. Deleuze’s model of affect, Probyn (2010) suggests, “does not impinge on the body from the outside, nor does it erupt from the inside. Deleuze’s model makes such distinctions incomprehensible” (p. 76). A concept similar to the Deleuzian fold has been developed by Merleau-Ponty (as “the chiasm” or “the flesh”) (Merleau-Ponty, 1968). Merleau-Ponty (1968) notes that “between my body looked at and my body looking, my body touched and my body touching, there is overlapping or encroachment, so that we may say that the things pass into us, as well as we into the things” (p. 123). A folding disrupts the dualism of self/world, instead embracing “complex affective and intensive exchanges, situated in the broader ecology of the world” (Bertelsen & Murphie, 2010, p. 155).

Affect can be understood as “force” or “forces of encounter” (Seigworth & Gregg, 2010, p. 2). Force, however, does not necessarily imply powerful intensity, because, as Seigworth and Gregg (2010) note, “it is quite likely that affect more often transpires within and across the subtlest of shuttling intensities: all the minuscule or molecular events of the unnoticed. The ordinary and its extra-” (p. 2). Within the literature, affect has thus been theorized as the virtual (pre-individual intensities) and its actualization (the event or forces gathering) (Bertelsen & Murphie, 2010; Deleuze & Guattari, 1987). The virtual and the actual are mutually implicated, which Massumi, drawing on the work of Bergson, describes as the “two-sidedness” of affect (as cited in Brown & Tucker, 2010, p. 236). Affect, as pre-individual intensities, is cross-modal and cross-temporal, moving across sensory modes and time (in movement toward the future or into
the past, as memory) (Bertelsen & Murphie, 2010; Massumi, 2010). Drawing on the work of Massumi, Bertelsen and Murphie (2010) describe the virtual as “the pool of relational potential from which the affective event is drawn” (p. 153). The “perpetually unfinished nature of the virtual”, therefore, can be theorized as potential, producing openings or multiple routes for affect to travel (or accumulate). Affect, therefore, is not only in movement (passing between bodies), but also emergent; Bertelsen and Murphie (2010) argue that “we live affective transitions, the sensations of events as they come into being” (emphasis added, p. 153). To see “the virtual in the actual” is to understand “that reality is making itself and it will continue to, and that therefore there is a contingency about the world that opens up possibilities” (Grossberg, Seigworth, & Gregg, 2010, p. 318). Brown and Tucker (2010) suggest “this ever-present excess of potential relatedness can be seen as a dynamic core of living” (p. 239).

Probyn (2010) argues that thinking about affect generally (as virtual) is not enough and that it is necessary to follow through on what different affects do at different levels because “different affects make us feel, write, think, and act in different ways” (p. 74). Brown and Tucker (2010) similarly suggest that there is a need for the creation of “intermediary concepts” which “should make visible the loop between the actual and the virtual, the way in which actualized perceptions allow for an ‘acting back’ on relations to allow for change…” (Brown & Tucker, 2010, p. 242). Grossberg, Seigworth and Gregg (2010) suggest that affect can be organized into “mattering maps”, which include “will and attention, or moods, or orientations … and the various culturally and phenomenological constituted emotional economies” (p. 316). The accumulation of affect has thus been taken up in relation to habit, orientation and emotion (Ahmed, 2006, 2010). These affective spaces (a gathering of affect), in turn, build subjectivities and worlds (Ahmed, 2006, 2010; Thrift, 2010; Watkins, 2010; Wetherell, 2012). Ahmed (2010) suggests that affect can accumulate in objects and consequently orient space. Influenced by
phenomenologist Merleau-Ponty, Ahmed (2010) argues that, “to experience an object as being affective or sensational is to be directed not only toward an object, but to ‘whatever’ is around that object, which includes what is behind the object, the conditions of its arrival” (p. 33; see also Ahmed, 2006). Similarly, Thrift (2010) suggests that “objects can signal in all kinds of ways that we may only partially perceive, or perceive as ‘magical’ in that they provide associations and conjunctions, dissociations and echoes, that stimulate perception and imagination and, indeed, enjoyment” (p. 293). Emotion and interest have therefore been taken up as important elements in the construction of affective spaces (by way of objects): “To be more and less [sic] open to new things is to be more or less open to the incorporation of things into our near sphere. Incorporation maybe [sic] conditional on liking what we encounter. Those things we do not like we move away from. Awayness might help establish the edges of our horizon; in rejecting the proximity of certain objects, we define the places that we know we do not wish to go, the things we do not wish to have, touch, taste, hear, feel, see, those things we do not want to keep within reach” (Ahmed, 2010, p. 32). Within such a framework, affect “is as much a territory that enables movement as something that keeps everything in its place” (Bertelsen & Murphie, 2010, p. 147).

Affect has been described in the literature as intensities, whereas emotion has been framed as an expression or the capture of affect (Gibbs, 2010, p. 188). Under such understandings, “affect is biology whereas emotion is biography” (Nathanson, as cited in Watkins, 2010, p. 279). Emotion “is the ideological attempt to make sense of some affective productions” (Grossberg, Seigworth, & Gregg, 2010, p. 316). However, drawing on Spinoza’s notion of “affectus” and “affectio”, some theorists have articulated emotion as an accumulation or trace of affect, and therefore implicated within the virtual (Watkins, 2010, pp. 269-270). Watkins (2010) highlights how affect is multi-dimensional, with “ability to function as force and capacity, affectus and affectio” (p. 270). She argues that “while a discussion of accumulation
may seem to emphasize the latter, affectio is very much a product of affectus, and so affect as force or the processual aspect of affect is in fact embedded in a discussion of affective capacity” (Watkins, 2010, p. 270). Again, the “two-sidedness” of affect is explored, with affect, emotion and thought “in a virtual-actual circuit” (Clough, 2010, p. 209). Speaking to the circuitous nature of affect, Bertelsen and Murphie (2010) state that “feelings are complex strings of ideas traversing emotions as they remap them” (p. 140). The work of both Stern and Tomkins on emotion also suggests that “affective and cognitive processes cannot be readily separated” (Stern, as cited in Watkins, 2010, p. 280). Moreover, Bertelsen and Murphie (2010) argue that: “neither is there a natural or necessary progression from affect to emotion or feeling” (p. 148).

As such, affect has been theorized as “sticky”; Ahmed (2010) suggest that “affect is what sticks, or what sustains or preserves the connection between ideas, values, and objects” (p. 29; see also Wetherell, 2012). Highmore (2010) highlights how “the sticky entanglements of substances and feelings, of matter and affect are central to our contact with the world” (p. 120). He argues that these entanglements do not require untangling, but rather “what is required is a critically entangled contact with affective experience. This means getting in among the murky connections between fabrics and feelings, between the glutinous and the guffaw” (Highmore, 2010, p. 120). Watkins (2010) proposes a similar approach, suggesting that we “grapple” with the relationality of affect “as a pedagogic process” (pp. 269-270).

**Eating Dis/orders: A Conceptual Framework**

Within the literature on eating disorders, there is a strong emphasis on body image(s) – the eating-disordered body as inscriptive surface and body image as bounded and stable. Those who have moved away from these static theories of the body and toward more embodied approaches have conceptualized the materiality of the body through frameworks of habit,
performativity and technologies of the self. Under these frameworks, eating disorders are theorized as discursively produced body practices that disrupt the boundaries, or containment, of the body image. As well, eating disorders are conceptualized as dis/orderedly processes that produce dis/embodied identities (bodies seeking transcendence or accepting immanence through a process of “splitting”). Materiality, however, encompasses much more than just human bodies. Matter also includes “non-human forces” such as objects within our relational field that affect us and constitute our “becomings” (Hultman & Lenz Taguchi, 2010, p. 525; see also Deleuze & Guattari, 1987). Within the literature on eating disorders, discourse is understood to transform matter, yet “matter itself is not granted active agency or considered mutually agentic in transforming discourse, discursive practices and human subjectivities” (Hultman & Lenz Taguchi, 2010, p. 526). While some of the literature on body image engages with affect theory, this area of theorizing is significantly underdeveloped in the eating disorder literature (some exceptions include Bray & Colebrook, 1998; Probyn, 2009; Squire, 2003). Moreover, there is a significant lack of research exploring affect and embodiment in eating disorder recovery.

Bray and Colebrook (1998) suggest we turn to “the body's various effects and forces, rather than its capacities to be a sign, theater or image” (p. 52). They suggest that the eating-disordered body is in negotiation with images as well as “with pleasures, pains, other bodies, space, visibility and medical practice” (Bray & Colebrook, 1998, p. 43). Similarly, Springgay (2009), drawing on Deleuzoguattarian theory, argues that “new models of inquiry need to be posed that interrogate body image as immanent and dynamic, informed through interactions and processes rather than maintained by substances and boundaries” (p. 109). Writing in the area of body image, Springgay (2009) presents the concept of “the fantastical body”, which she defines as a body that is “dynamic, creative, and full of plenitude, potential, and multiplicities” (p. 115). The fantastical body is understood through “what it can do: its processes, performances,
assemblages, and the transformations of becoming” (Springgay, 2009, p. 115). Drawing from these ideas, I frame eating disorders in this thesis as embodied and affective practices. Another reason I have chosen to approach eating disorders as practices is because, as previously discussed, many individuals who struggle with disordered beliefs, attitudes and behaviours in relation to food and exercise do not fit neatly into prescribed eating disorder diagnoses (DSM-5 Clinical Cases, 2014). Moreover, I suggest thinking about eating disorders in terms of affective practices, in the words of Wetherell (2012), “builds in ‘ongoingness’ and makes one think about patterns in process” (p. 23). Seigworth and Gregg (2010) suggest that while the various approaches to theorizing affect may never “be easily or fully reconciled, they can be made to interpenetrate at particular points and to resonate” (p. 6). In this thesis, I take the challenge of working with the “thresholds and tensions, blends and blurs” of affect, as affect “emerges out of muddy, unmediated relatedness and not in some dialectical reconciliation of cleanly oppositional elements or primary units” (Seigworth & Gregg, 2010, p. 4).
Chapter II: Creating Bodies

An Affective Approach

I set out to recruit three to five individuals who met the following criteria: they self-identified as a woman with an eating disorder, they were between the ages of 18 and 30, and they currently live and/or work in the Metro Toronto Area. Many eating disorders go undiagnosed and so a formal medical diagnosis of an eating disorder was not required to participate in the study; the requirement was that participants recognized their actions and attitudes toward their bodies, eating and exercise as harmful to their overall well-being (emotional, mental and/or physical). My decision to focus on women from this particular age group (young adult) stemmed partly from the fact that most of the literature I have reviewed pertains to this demographic. While I would have liked to expand my age range criteria to include adolescent girls (around the ages of 16 to 18), I felt it might be difficult to recruit younger participants for ethical reasons, such as the need for parental consent to participate in research. Furthermore, as a young adult myself, I felt more comfortable working with this demographic.

Recruitment flyers (see Appendix A) were posted in a number of relevant and accessible spaces in Toronto, such as in coffee shops, public libraries, buildings where public health services and/or counselling support is offered (some specifically associated with eating disorders), campus buildings at the University of Toronto (St. George Campus), as well as in various other public or community spaces (e.g. street bulletin boards, First Nations House). Individuals who were interested in participating could contact me by phone or email for more information about the study. All participants signed information and consent forms (see Appendix B) which described the purpose of the study, what their participation in the research involved (including privacy measures) and how they would be compensated for their time (upon
completion of the study, participants were each awarded an honorarium in the form of a $50 Visa Gift Card. Before signing the forms, participants were given enough time to approach me, my supervisor, or the ethics board (contact information was provided on both the recruitment flyer and the information and consent form) with any questions or concerns they might have regarding their participation in the study. Participants were given the option of declining a response to any questions they did not feel comfortable answering during their individual interview or the group discussion (see Appendix C). In an effort to create a safe space where participants felt comfortable sharing, I asked participants to respect a number of rules (see Appendix D) during the group sessions. This handout was given to participants at the time of signing the information and consent letter. Participants were also provided with a handout which listed some of the eating disorder support services that are offered in Toronto (see Appendix E).

Participation in the study included attending three sessions held at the Ontario Institute for Studies in Education (University of Toronto), each approximately one hour in length. The first session was a one-on-one interview asking participants about their personal experiences with eating disorder practices (for example, how these practices make them feel physically and emotionally, what feelings or thoughts precede their engagement in these practices, how their eating disorder practices affect their sense of self, etc.). During the one-on-one sessions participants were given the opportunity to choose a false name for the group sessions as well as a false name for the reporting of the data¹. The second session involved meeting in a small group of four participants (and myself) to make individual collages. The third session also involved collaging with this small group, however, in this session participants were asked to make a

¹ Some participants gave me the same pseudonym for both the group sessions and the reporting of the data, and so to ensure their privacy, I have changed some names in the writing of this thesis.
collective collage while discussing the use of creative practices in eating disorder recovery. All collaging materials were provided by me (items such as newspapers, illustrated books/textbooks, maps, craft paper, tissue paper, glue, scissors, etc.). This decision to provide the materials was made on the basis that I wanted to exclude materials (e.g. fashion magazines) that could possibly make participants feel uncomfortable. All interviews, individual and group, were audiotaped and transcribed. The collage sessions were also videotaped, however, the camera recorded the collages as they were created, not the participants’ faces or bodies. I chose to focus the camera specifically on participants’ hands and artwork not only because I wanted to adhere to strict confidentiality measures (by not showing participants’ faces), but also because I felt that videotaping participants’ full bodies could potentially produce feelings of discomfort and/or cause participants to become overly concerned with their appearances. I chose to videotape the group collage sessions rather than simply taking photographs because I felt it was a better way of examining the relationality and flow of affect. Unlike cameras which produce still images that frame, video recording is diagrammatic – resisting borders and “activating tendencies of becoming-form and incipient-figure”; videotaping becomes “a focal point through which the work organises itself in a refrain of infinite unfolding” (Manning, 2008, p. 6). I felt that the videotapes would be a useful supplementary resource I could return to while reading the transcripts.

Wetherell (2012), an affect theorist, poses the following rhetorical question: “Perhaps we ‘live’ not quite in the active chronological moment of the turn-by-turn, but most strongly and personally in the narratives ruminating on some outburst of affect after it has taken place, whether these are narratives told to others, or narratives rehearsed internally to ourselves?” (p. 85). She elaborates further: “Semiotic modes such as narrative and story-telling are likely to become more important as the body winds down, and as the moment of strong affect is carried
forward as a memory or story, with new accompanying affect” (Wetherell, 2012, p. 89). I felt one-on-one interviews would be an appropriate approach to researching how affective experience within eating disorders is understood by participants. It has been important to me throughout this research that I not assign meaning or write my own ideas onto participants’ affective experiences; I felt that using individual interviews provided participants with a space to articulate their own understandings of their embodied experiences and affective practices (past and present) within the context of eating disorders. The individual interviews were loosely structured, as I wanted them to flow more like a conversation. I found that being prepared with guiding questions (see Appendix C), however, was quite useful as it helped foster a space where participants felt comfortable opening up. One participant expressed that the guiding questions provided her with a platform to speak without feeling as if she was dominating the conversation. She felt that “the construct of the interview itself really lends well to just being open and just laying it all out there”. DeVault and Gross (2012) argue that active listening “is a fully engaged practice that involves not only taking in information via speech, written words, or signs, but also actively processing it. It means allowing that information to affect you, baffle you, haunt you, make you uncomfortable, and take you on unexpected detours” (p. 216). The process of sharing these embodied experiences was an affective practice in itself; within the interviews there was laughter and even some tears. I also felt that conducting the individual interviews provided a space where I could develop a level of trust with participants before holding the group collage sessions.

Following the one-on-one interviews, participants took part in two group collage sessions which were held approximately one week apart. The aim of the first collage session was to introduce participants both to each other and to collage-making. During this session, participants were provided with materials to make their own collages. The next collage session, which
involved making a collective collage and partaking in a group interview, was a way of producing and researching affective experience through arts-based practices within the context of eating disorder recovery. I felt that conducting a group interview while participants were collaging would encourage or increase awareness of embodiment. I was interested in researching how participants experience their bodies while engaging in creative practices, and particularly how this can be understood within the context of eating disorder recovery.

I decided to use collage in my research for a number of reasons. Collaging often involves appropriating others’ images to create something new; in this sense, collage is a fairly accessible art practice as it does not necessarily require previous experience or skills. Collaging can also take place within a shorter time span in comparison to practices such as painting or modelling, which require the drying or setting of materials. I would also argue that collage is a non-linear and perhaps even disruptive practice; as an assembled collection of bits and pieces, a collage often rejects representation and signification. A collage does not have to make sense.

Historically, collage has been understood as a “theatre of the irrational” as well as a form of protest expressing “a thorough disgust with political affairs” (Digby & Digby, 1985, pp. 18-22). Holbrook and Pourchier (2014) describe collage as a practice that works with both chaos and order – a practice that involves both thinking (selecting particular images to convey an idea) and feeling (gravitating toward certain images or colours throughout the process). Lastly, and most importantly, collage is an affective and embodied practice. From the sounds of cutting or ripping paper to the different textures of the materials, the process of collaging engages the senses.

Greene (1995) argues that “participatory involvement with the many forms of art does enable us, at the very least, to see more in our experience, to hear more on normally unheard frequencies, to become conscious of what daily routines, habits, and conventions have obscured” (para. 4). I approached collage in this research not in terms of psychoanalysis or as a form of therapy, but
rather as an affective creative practice within the contexts of eating disorder recovery and embodied pedagogy.

**An Assemblage**

My decision to employ interviews, videotaping, and arts-based practices (collage) stemmed from my desire to approach affective experience and meaning-making at the threshold. Springgay (2008) suggests that embodied stories “exist at the intersections between narrative, visual, and tactile experiences” (p. 11). In this research, I take the “challenge of working with those ‘bits of things’ – affects, ideas, sensations and movements – which are often disregarded under usual methods of working” (Dyke, 2013 p. 160). Rather than individually discussing participants’ collages in terms of representation and signification, I have threaded their work throughout this thesis. Challenging traditional masculine approaches to research which privilege “rationality” and “objectivity”, I adopt a feminist approach which recognizes partiality and shared experience. Approaching affectivity and embodied experience at the threshold, I use Jackson and Mazzei’s (2013) “plugging in” methodology to work the data (see Jackson, 2013). This method, developed from Deleuzoguattarian theories, is “a machinic process that works against conventional coding in qualitative data interpretation and analysis” (Jackson & Mazzei, 2013, p. 261). Both data and theory are positioned as machines with “potential to interrupt” (Jackson & Mazzei, 2013, p. 261). This working of the data “is an activity to provoke, explain and elaborate the assemblage”; within the threshold “the divisions among and definitions of theory and data collapse” (Jackson, 2013, p. 116; for similar approaches see Holbrook & Pourchier, 2014; Springgay, 2008). Wetherell (2012) suggests that the discursive “provides the means for affect to travel” (p. 19). In this thesis, I work my data using Deleuzoguattarian concepts such as “the fold”, “Body without Organs” and “rhizome” (Deleuze & Guattari, 1987).
I also work the data with/through theories of affect and embodied pedagogy. Through this working of data and theory, I develop new ways of thinking about eating disorders and eating disorder recovery.

**Un/tangling Selves**

In this thesis, data and theory are put to work, and in this process, identity is fragmented, multiple, fluid and messy. This undoing and unfixing is necessary to produce new ways of thinking and being in the world, however, it is important to emphasize that while participants’ (and my own) identities may “get lost” in this process, our agency should not be erased. In this “Un/tangling Selves” section, I introduce each of the four participants. These brief descriptions of the participants have been constructed from the conversations and interactions we shared throughout the study. I also discuss my role as a researcher and the “selves” that I bring into (or that inform) the research process. I discuss how my approach to research (in the collection and presentation of data) is rhizomatic, with my own personal experiences and thoughts entangled within/throughout the writing of this thesis.

This research project is situated and partial, as an objective approach is impossible, for “one’s identities, experiences, privileges, investments, and so forth always influence how one thinks and perceives, what one knows and wills not to know” (Kumashiro, 2000, p. 39, see also Haraway, 1988; Harding, 1993). Moreover, Kumashiro (2000) argues that “to accept the possibility of such detachment is really to perpetuate a ‘mythical norm’ that assumes a White, heterosexual, male perspective” (p. 39). According to Hesse-Biber (2012), feminist praxis and research, “disrupts traditional ways of knowing” through a process of becoming both insider and outsider; it involves “taking on a multitude of different standpoints and negotiating these
identities simultaneously” (p. 3). So, who am I as a researcher? What selves (identities, roles, past experiences) inform and shape this thesis?

Surtees (2009), in her writing on working with individuals with eating disorders, suggests that the “boundaries between the professionalized One and the pathologized Other may be slippery and porous” (p. 164). While I take on the role of researcher and facilitator for this project (“professionalized One”), I also bring into the research my past experiences with an eating disorder (“pathologized Other”). I was diagnosed with an eating disorder as an adolescent and I struggled with eating disorder practices into early adulthood. My experiences in relation to support and recovery also influence my approach to the research. I received support on an outpatient basis at eating disorder clinics offered through hospitals. I was placed into programs that required me to attend weekly group therapy meetings that adopted either a CBT or DBT approach. In many ways, I found this medical and psychiatric approach supportive and helpful in my recovery, however, I continued to struggle with eating disorder practices (or “relapsed”) after completing these programs. It has been years since I struggled with eating disorder practices. While I am wary of using the term “recovered” (discussed in later chapters), by medical standards I no longer fit the criteria for an eating disorder diagnosis. I live a full life free from eating disorder practices.

Who I am as an academic (a student) also shapes this research. I completed my undergraduate studies in the area of gender and sexuality and I am currently a Masters student in the department of Curriculum, Teaching and Learning. This thesis, therefore, has related theoretical underpinnings. I place the body at the centre of learning. Furthermore, my interest and investment in creative practices (playing guitar, songwriting, dance, painting and collage) also greatly informs (and inspires) this research. It is important to acknowledge and continue to examine the ways in which my “selves” (personal, academic, creative) influence and shape this
research. These identities and histories affect my research from the questions I ask (or do not ask) to the kinds of theories I work with in developing this thesis.

More than simply acknowledging my positionality, I felt it was important to share this information with my participants so they could better understand my approach as researcher. I introduced myself to participants before beginning the individual interviews and explained how my interest in eating disorders research partially stems from my own history. I felt that being honest and disclosing my past to participants helped create a space of trust, sharing and solidarity. Davies and Gannon (2009) suggest that vulnerability “becomes a resource to be opened up, something to be worked with, rather than an experience to be dismissed, shut down or foreclosed. It becomes a strength in a pedagogical encounter” (p. 64). Moreover, I felt that disclosing this information (and therefore implicating myself within the research) disrupted the dichotomy present in traditional approaches to research – the constructed dualism between the “researcher” and “object(s) of study”. An aim of feminist research should be to transform research practices in ways that empower both the participants and the researcher. Through this process “feminist researchers not only hope to transform organizational practices, policies, and philosophies, but are also open to personal transformation” (Wahab, Anderson-Nathe & Gringeri, 2012, p. 469).

In some respects, this research has been collaborative; participants collectively made a collage and participated in a group interview. I have relied heavily on the interviews and often quote participants directly in an effort to preserve voice. However, while I disclosed to participants my past experience with an eating disorder, I did not discuss this in detail, as the purpose of the interviews was to better understand participants’ affective experiences and meaning-making in relation to eating disorder practices and recovery. I participated in the first collage session with participants by making my own collage while they did the same. I chose not
to participate in the second group session (making a collective collage) as I was afraid that my role as facilitator would affect how participants engaged in the activity; I did not want participants to be influenced by the materials I contributed and assume there was a particular or “right” image or theme to build from or (re)produce. Yet, while I did not fully participate in the activities of this study, threads of myself (my “selves”) are entangled throughout this thesis (as I have explained in greater detail in the previous paragraphs). As an assemblage of art, conversations, and theory, this thesis is an entanglement of bodies. Similar to Saukko’s (2000) patchwork quilt methodology for studying eating disorders (which does not search for a “cause” but instead gives rise “to more disjunctive or ‘rhythmic resonances’”), my rhizomatic approach to presenting and working the data emphasizes “how the voices of the author and the characters are always entangled with one another and are shot through with social voices that speak through them” (Saukko, 2000, pp. 302-303).

Each of the four participants self-identified as a woman between the ages of 18 and 30 with an eating disorder. All participants lived and/or worked in Toronto. Participants included: Emily, an international graduate student (she did not share her exact age), Debbie, a 26-year-old waitress, Catherine, a 24-year-old bartender and recent undergraduate student, and Casey, a 19-year-old professional actress and freelance journalist. While the majority of participants had sought support for their eating disorders in the past, only half of the participants expressed that they were currently committed to eliminating their eating disorder practices. Participants’ history of eating disorder support also varied: hospitalization (in-patient treatment), counselling, self-help workbooks and art therapy.

During the initial one-on-one interviews, I asked participants if they felt that their eating disorder practices are shaped by (or shape) certain aspects of their identity such as their gender, race, class and/or age. Categories of difference, (re)produced through systems of oppression,
affect our lived experiences, which, in turn, shape our positionality. Grosz (1994) argues that “the body and its privileged zones of sensation, reception, and projection are coded by objects, categories, affiliations, lineages, which engender and make real the subject’s social, sexual, familial, marital, or economic position or identity within a social hierarchy. Unlike messages to be deciphered, they are more like a map correlating social positions with corporeal intensities” (p. 140). I wanted to give participants the opportunity to share how (or if) they felt that their positionality shapes (or is shaped by) their affective experiences in relation to eating disorders. I have been cautious about including intersectional analyses of participants’ eating disorder experiences as I have little to no knowledge about how they identify (this information varied, depending on how much participants shared with me during the interviews). While a selection criteria for this study was that participants self-identify as women, class and race identifications were not explicitly addressed and the decision to share these identifications was left to the individual participants. That being said, it must also be understood that this environment, dynamic and method, for some individuals, may not have been the most comfortable or conducive approach for sharing this personal information.

Affect, however, is always relational, and so the interviews must be engaged with as more than individual narratives. Studying affect as an isolated event or activity “rules out commentary on the history of an affective practice and the power relations it might sustain or disrupt, which are not obvious to participants” (Wetherell, 2012, p. 100). While I acknowledge and discuss in the literature review how oppression and categories of difference shape our corporeal experiences, I also strongly take into consideration and work with the idea that identities are fluid, changing and emergent through affective practice. Once again, to borrow the words of Wetherell (2012), “… affective practices will routinely effloresce over the conventional, demographic boundary-lines of class, gender, ethnicity, religion and nation,
communal life and personal life. The associations between organised affective practices and social groupings will not be tidy, and this lack of neatness will be important in understanding the ways in which affective practices travel and change” (p. 117).

There was also one other participant, Laura\(^2\), who participated in half of the study but was asked to withdraw due to an incident during the first group session where she was disrespectful to other participants (such as making inappropriate comments about weight) and exhibited disruptive behaviour (shouting, aggressively moving around the room). Laura was asked to withdraw from the study following this incident and received an explanation as to why she could no longer be allowed to participate. I spoke with her in person as well as contacted her again through email to arrange her payment; she was compensated in full as if she had completed the entire study. While her individual interview was excluded from the data after asking her to withdraw, I feel it is important to mention her presence during approximately 15 minutes of the first collage session as it shaped the remaining time in that session. During the individual interview with Laura, she disclosed that she was currently receiving professional help for other mental health concerns. I did not see this as a basis to exclude her from the study, as I recognize that eating disorders can present with comorbid conditions (this was also expressed by other participants during the individual interviews). For these reasons, I felt that exclusion on this basis would be discriminatory and reinforce the stigma surrounding mental illness (and not fully engage with the complexity of eating disorders). I checked in with each participant following the incident at the group session to make sure they were still comfortable participating in the study and to give them an opportunity to ask any questions or voice any concerns they might have. Participants were overwhelmingly understanding during and after the incident; while participants

\(^2\) Pseudonym.
grew quieter during the incident, a couple of participants tried to talk to Laura and make her feel more included in the session. I was left with the impression that some of the participants may have helped diffuse similar situations in the past while in treatment programs for their eating disorders.

I believe this incident with Laura highlights how affect surpasses boundaries of containment. Affect does not always flow evenly and sometimes can be experienced in terms of interruptions or outbursts. Laura’s outburst instigated a group conversation about the powerful feelings experienced while struggling with eating disorder practices. After Laura left, Casey commented on how she often feels the same way in terms of intense frustration, but she is better able to control it without acting out in front of others. Other participants agreed with Casey’s comment. The conversation that subsequently took place did not work to isolate or “other” Laura and her behaviour, instead, her affective outburst generated a space of connection. Participants, while disapproving of Laura’s behaviour, could relate to the frustration and anger she expressed during the incident. On some level, Laura’s emotionally charged outburst was an external display of what many individuals with eating disorders internalize, acting out in the realms of their own bodies (Levens, 1995). Wetherell (2012) suggests that “in learning how to perform affect in socially recognisable and conventional ways, people also learn how to talk about and evaluate affect” (p. 93). While Wetherell (2012) is specifically writing about group psychotherapy sessions, I feel her words are applicable within this context; she writes that these group sessions “often move between moments of strong emotion expressed through the bodily perturbation of tears, shouts and laughter and moments of recapitulation where the burst of affect is narrated, discussed and contextualised” (p. 93).
Chapter III: Body Mo(ve)ments

In this chapter I discuss how eating disorders are affectively experienced by participants. The term “mo(ve)ments” is borrowed from Gannon and Davies (2012), who describe it as “the doubled action of dwelling in particular moments of being and moving toward new possibilities of seeing and of being” (p. 79). The term “mo(ve)ments”, Gannon and Davies (2012) argue, stresses “that opportunities for agency, for ways of moving into different discursive frameworks, open and close in unexpected liminal spaces” (p. 79). In this chapter, I discuss how participants understand the development of their eating disorder practices. I consider how affective experiences build affective spaces which orient individuals. I then follow with a discussion on how eating disorder practices exist as an entanglement of physical experience, emotion and thought. Following this, I use Deleuzoguattarian concepts (the “fold” and the “BwO”) to show how eating disorder practices produce immanent in-between spaces of uncertainty (thresholds).

Fleeting (andDirective) Moments

While half of the participants had received a formal medical diagnosis, all participants spoke about their eating disorders generally rather than referring to or strongly identifying with a specific diagnosis. It became evident through the interviews that participants’ experiences with their eating disorders could not easily be contained in one specific category, which is not surprising, considering that prior to the recent changes to the DSM-5, the majority of eating disorder diagnoses fell into the category of “Eating Disorder Not Otherwise Specified (EDNOS)” (DSM-5 Clinical Cases, 2014). Participants reported engaging in a variety of eating disorder practices (such as food restriction, binging, purging and over-exercising) that span diagnoses. Catherine, for example, reported that she has been diagnosed with both anorexia nervosa and bulimia nervosa at different points in her life. She explained that now she is “hanging out in the
middle” which she described as “equally as bad”. Catherine offered the following description: “…it’s just been a teeter-totter at different times of my life, different ends of the spectrum, one more than the other”. Casey and Catherine both felt that people are narrow-minded in their understanding of eating disorders. Catherine expressed that eating disorder diagnoses were just “a categorical organization”, and that everyone has eating disorder qualities to some degree. Catherine’s statement seems to highlight that while eating disorder practices develop from our everyday affective and embodied experiences, they vary in frequency and intensity for different individuals.

All participants reported they were either diagnosed with, or acknowledged having, an eating disorder during the span from early to late adolescence (approximately age 12 to 16). However, while reflecting on their childhoods during interviews, participants were able to identify disordered attitudes and practices around eating and exercise developing even before the beginning of adolescence. Often they were able to identify particular triggers, such as comments from others about their bodies or specific embodied incidents, that were catalysts to changes in their affective practices. Casey, for example, spoke about this, saying “I have very vivid and clear memories of when someone commented on my weight from when I was, like, seven. Just fleeting comments, like ‘oh, those pants are probably not the best for you’”. Affect both moves people in new directions, or toward alternative embodied practices, as well as subjects them to prescribed habits or routines. Wetherell (2012) suggests that “practice draws attention, both to a transpersonal ‘ready-made’ we confront and slip into, as well as to active and creative figuring. Routines do in some sense ‘land on’ people and ‘subject’ them. And ‘forms of encounter’ or social relationships arrive with the affective slots for actors already sketched . . .” (p. 125; see also Ahmed, 2006; Butler, 1988, 1993). Affect gathers, producing particular spaces or worlds. Thrift (2010) suggests, that “a world will be a series of lines of association crisscrossing those of
other worlds but occupying some of the same spaces, even if fleetingly” (p. 295). Eating disorder practices never develop within a vacuum. Affect is always relational, and so practices are produced by (and produce) thoughts, expectations and societal standards. Our encounters with other people shape the practices we develop and these affective practices continue to change in relation to a variety of external and internal triggers which are always interconnected.

Catherine and Casey spoke about how despite little change in their eating and exercise practices, there came a point where other people’s reactions to and comments about the appearance of their bodies drastically shifted. Casey described herself as being “a little bit overweight”, “chubby”, and “awkward” prior to adopting what she felt was a healthier lifestyle. Casey expressed that her initial weight loss was praised; she explained: “society is messed up a little from media, so you can go to a certain point and be revered”. Casey noted, however, that the comments soon changed from “You look fantastic!” or “How do you stay in shape?” to “Oh my god, like what is wrong with you?” She commented that “it’s just confusing because you don’t think you are doing anything different…”. Casey remarked that these changes in feedback affected her attitude toward her body, and that she went from being excited about wearing new jeans that show off her body to feeling self-conscious because “people are staring at you ‘cause you’re so thin”. She said this made her hate her body once again and think: “I’m disgusting again, in a different way now”. Catherine similarly noted how comments of praise soon turn into comments of disgust and concern once a particularly low weight has been reached. Participants’ stories emphasized how comments about body weight, shape and size (despite the commenters’ best intentions) can reinforce particular eating disorder behaviours in certain individuals. Moreover, Ahmed (2006) explains how “spaces are already oriented, which makes some bodies feel in place, or at home, and not others. Orientations affect what bodies can do: it is not that the object causes desire but that in desiring certain objects, other things follow, given how the social
is already arranged” (p. 563). Eating disorder practices develop through affective practices that are relational and emergent. Participants’ engagement with eating disorder practices was influenced not only by societal expectations and norms, but also by their encounters and conversations with others. In their initial desire to look or feel a certain way, space was already oriented in a way that encouraged these eating disorder practices.

Figure 1. Debbie’s collage³

**Gut Feelings**

Eating disorder practices exist as an entanglement of sensory experience, emotion and thought. Wetherell (2012) suggests that “an affective practice is a figuration where body possibilities and routines become recruited or entangled together with meaning-making and other social and material figurations. It is an organic complex in which all the parts relationally

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³ Text on this collage has been “blurred” out for privacy reasons as it could identify the participant.
constitute each other” (p. 19). Our affective experiences shape our thought processes. For example, Catherine felt that she could talk about particular physical symptoms “logically and rationally” when they are not immediately affecting her, but explained that “I really think I’m, like, 700 pounds when I look in the mirror”. She said “there are things that I know that I don’t know when I am in the midst of certain feelings”, which highlights the power that physical feelings have in crafting our emotional and mental responses, which then construct our experience of our bodies in the world. How we feel about things influences how we can think about them (Hickey-Moody, 2013a, p. 83). Casey expressed this in saying, “You know when you’re, like, having your period and you’re just super bloated and disgusting? I just constantly feel like that”. She further explained “it literally feels like, or what I’d imagine it feels like, to be a 400-pound person walking around”. How participants visualized their bodies spatially was a direct response to how they felt physically. Drawing on the work of Whitehead, Shaviro (2009), states that “space and time are basic forms of affectivity; they cannot be pre-assumed, but need to be constructed in the process of experience” (p. 59). Participants expressed that what they knew “rationally” was overpowered by particular body experiences and by the emotions that resulted. They often spoke about being “delusional” or having thoughts they later termed “irrational”. Casey commented “when you speak it out loud, it sounds ridiculous, but it’s like, ‘Yeah, that makes perfect sense to me’ when you’re in the heart of it”. Participants’ accounts suggested that their sense of embodiment is directly constructed in and through affective experience.

Affective experiences are threaded through personal and social histories, and therefore some affective experiences circuit back to pre-established routines or habitual practices (Ahmed, 2006; Butler, 1988, 1993; Wetherell, 2012). In this way, particular sensory experiences can trigger a response already coded by societal norms and expectations as well as the individual’s
past experiences. Casey identified “day-to-day bloating” as a physical feeling that instigates eating disorder practices. She explained that feeling the tightness of pants that fit the previous day caused physical discomfort, which she then associated with powerful emotions, such as anxiety. Casey also expressed that wearing particular costumes on set can trigger her eating disorder practices and gave the example of a dress she had to wear for a role that felt “like wearing skin” as it fit her body so closely. She said the feeling of discomfort was exacerbated by eating a meal: “we had lunch, which made it ten times worse . . . I think before lunch and after lunch I probably didn’t look any different . . . but I definitely felt different”. She explained how feeling uncomfortable in her clothing influenced how well she performed, and led to further food restriction in order to avoid feeling that way again. Affective experience, however, cannot be contained within singular events, as it shapes our sense of embodiment and therefore travels through other areas of our lives. Casey reported having thoughts such as, “maybe if I am fatter from eating this apple, I am not going to write as well”, which demonstrates that a physical feeling also shaped her perception of her abilities. She recognized this as “obviously” not the case, but to her, she said, “It’s a very real thing”.

Participants expressed that particular physical experiences influence their success when it comes to eliminating eating disorder practices. Both Casey and Catherine spoke about the physical discomfort that comes with increased food consumption after periods of restriction. Casey spoke about how eating disorder practices “wreak havoc” on the digestive system: “it slows down because it doesn’t get enough food, so I have a really slow metabolism now, so that’s another trigger”. Catherine also spoke about feelings of physical discomfort that she associated with gastroparesis, a medical condition involving the motility of the digestive system which is not uncommon in individuals with a history of disordered eating practices. Catherine explained, “your digestive system is SO SLOW, so food you ate a week ago is still in your
stomach, so you’re super bloated . . . your abdomen is distended”. These feelings of discomfort hinder their efforts to eliminate eating disorder practices because they contribute to their belief that they are excessive in size. Drawing on the work of Husserl, Melero (2013) argues that “all external explanations (medical, etc.) that subsume or explain what has happened (for example, a pain) under a theory, can never eliminate the original anomalous appearance of the experience lived” (p. 112). Casey and Catherine continued to feel (and respond) the same way despite understanding the medical explanation for their discomfort.

While affect can instigate emotion, it can also function as a disruption to current emotional or mental states. Participants articulated that feeling anxious, bored (restless) and/or stressed-out triggered their eating disorder practices. Debbie, for example, expressed that “extremes of emotion” or “a lot of stimulation” can trigger her binging practices. She explained that these extremes also include positive emotions. Debbie expressed, however, that there are particular emotions or situations which are more likely to trigger her eating disorder practices, such as when she feels a loss of confidence or a great deal of stress. She offered examples such as feeling “overwhelmed”, “overstressed” or “overtaxed”. She said she finds her eating disorder practices help “dampen it down” to make her emotions or thoughts more tolerable and manageable. Debbie explained her need to binge begins with “just a feeling of discomfort, like, just general discomfort that’s not really attached to your body”. She said it starts with “mental static and then it becomes real through the action”. The act of binging puts her back in touch with her body: “you’re aware of how your stomach is distended and you’re aware of how, um, your throat hurts . . . you’re aware that that’s your body and that’s, like, part of everything”. Debbie described binging as a “disjointed” or, on some level, “catatonic” process that produces feelings of embodiment. Here, affect functions as an interruption, producing new feelings, and subsequent emotions and thoughts, which the participant found more tolerable
and/or manageable (even if temporarily). The production of this affective experience served to produce (physical) intensities that overpower the feelings of discomfort and disconnection. Levens (1995), suggests that within the context of eating disorders, these emotions (i.e. anxiety, boredom) can alternatively be understood in terms of aimlessness or “a loss of connectedness and relatedness” (p. 57). Therefore, food might function as a means of connecting Debbie to something. Similarly, Squire (2003), in her autobiographical writing, explains that “by taking in food and then taking it out I extended and stretched what I was, elasticising myself, showing myself that I still existed” (p. 61). Furthermore, Debbie’s account emphasizes how affective practices can have a degree of automaticity where acts “are suffered rather than acted” (Wetherell, 2012, p. 22). Her account illustrates how “we only become conscious of how our bodies and minds have been recruited and entangled after the event” (Wetherell, 2012, pp. 21-22).

Paradoxically, participants reported that some feelings of physical discomfort are emotionally comforting. Both Casey and Catherine explained that hunger cues, such as their stomachs growling, were welcomed because they provided confirmation that they were still in control of their eating. Catherine understood hunger cues, albeit “painful and uncomfortable”, as “flags” marking accomplishment; she said the following: “Pat yourself on the back; you don’t have to hate yourself today. You don’t have to punish yourself”. Similarly, participants’ accounts also suggested that eating disorder practices can be used to produce cathartic experiences which help clear thinking processes. Catherine described using binging and purging as her “pre-exam routine” during university, as it helped “ground” her. She explained: “…as I am eating, I wouldn’t be thinking. My head would be clear; it would be, like, numbing and then as soon as it’s out it would be like almost metaphorical for what I’m feeling. It would be like…I’d just feel different. I’d feel exhausted and drained and I’d hate myself, but I felt like I was clean of that”.
Squire (2013) suggests that eating disorder practices afford individuals a sense of comfort when they lack “an embodied mourning ritual” (p. 61). Furthermore, because eating disorder practices are often so closely tied to other life activities, they can develop into coping mechanisms through the production of feelings associated with comfort and control.

It is evident that physical feelings, emotions and thoughts are mutually constitutive, entangled with and through one another. Moreover, this entanglement is further threaded through personal and social histories. Referencing Butler, Ahmed (2006) notes how “what bodies ‘tend to do’ are effects of histories rather than being originary” (p. 553). This entanglement highlights the ways in which affective practices are both produced and productive. While those individuals who deal with eating disorder practices have agency, eating disorders are not a choice. Day and Keys (2009) highlight the complexity of agency, resistance, control and docility in eating disorders. Referring to the work of Foucault, they assert that these “micro-processes of disciplinary power are even more powerful when we understand ourselves to be acting out of choice” (Day & Keys, 2009, p. 93). Casey and Catherine both expressed that there were times when they felt as if they were acting out of choice. Food restriction and excessive exercise were common eating disorder practices among participants. These actions are often framed by a North American diet-obsessed society as normal, healthy and even desirable. For these reasons, participants found it difficult to initially recognize how their eating disorder practices were harmful. Casey explained that it’s difficult to “realize what you’re doing” until it’s “way far gone”.

As this section has illustrated, eating disorder practices have the power to produce, interrupt and replace particular physical feelings, emotions and thoughts. Therefore, approaches to eating disorder recovery that focus solely on emotional dysregulation (DBT), thought (CBT) or nutrition not only fail to recognize the complex interconnectedness of physical, emotional and mental health, but also disregard the tremendous force of physical (sensory) experience in
regards to cognition and emotional response. A comment by Debbie highlights the power of affective experience and how a failure to address this in recovery can further feelings of hopelessness. She explained that while she was able to identify particular “thought patterns . . . afterward you still feel that way, but you realize why it’s stupid to feel that way”.

Living In-Between

As the previous sections illustrated, affect has the power to both gather (producing habitual practices threaded through personal and social histories) and to move people into new directions, toward new affective practices and meaning-making. Eating disorder practices are immanent and immersive processes; individuals who engage in these practices live metaphorically without a skin, they become open, exposed and vulnerable to and by way of their affective practices. As the eating disorder actions of participants solidified into practices through repetition, and as the affective rewards or dis/comfort of these practices became increasingly more apparent, participants began to construct boundaries. The term “black-and-white thinking” has often been used to describe the thought processes of individuals with eating disorders (Lethbridge, Watson, Egan, Street, & Nathan, 2011). Such thinking involves viewing and constructing the world in terms of absolutes or dualisms. In engaging in black-and-white thinking, participants are afforded a sense of control (albeit illusory); their rules and expectations help them navigate, measure and regulate their affective experiences. Moreover, participants gain a sense of control not only over the bodies, but over their emotions and thoughts as well. However, given that eating disorder practices are not only of the body, but fragile and disruptive, I propose instead an understanding of black-and-white thinking as a “folding”. I suggest that eating disorder practices produce “in-between spaces of uncertainty” where “dualisms become clear before blurring, interconnecting, blending one into/through the other, only to return to
clarity and then ambiguity/complexity again, in an endless hermeneutic circle” (Springgay, Irwin & Kind, 2005, p. 901). Eating disorder practices produce a threshold, or a BwO, where dis/order and dis/comfort converge, coalesce and collide. Despite participants’ desire to ignore or avoid their bodies, they remain hyper-aware of their inescapable embodiment. The threshold is the space where black-and-white thinking is formed, collapses and is then rebuilt in an endless cycle. This cycle is always immanent, using the body and those objects that are extensions of the body (i.e. food and physical activity) to produce intensities. Springgay (2009) suggests that “the threshold differs from a boundary in that it is not a limit that holds things in place, but is the experience of being exposed, open, and folded” (p. 121).

Participants reported identifying “safe” and “unsafe” foods. Casey and Emily were quick to label foods of low nutritional value as “junk food”, making clear distinctions between “good” and “bad” foods. Many participants spoke about how their eating disorder practices developed from habits that they presumed to be part of a healthy lifestyle. Both Emily and Casey spoke about how they were knowledgeable in the area of nutrition. Casey, however, expressed that this awareness, over time, developed into obsessive thoughts. Similar to Casey, Emily’s restrictive eating disorder practices seemed to develop from prescribed societal notions of what healthy eating and bodies should look like. Emily explained that after speaking to her physical education teachers and subscribing to the websites they suggested, she started eliminating all foods that were linked to obesity. She spoke about her fears of consuming these foods, as she felt they were directly linked to weight gain. She also held the belief that “if you eat at night you become obese”, and so, during the hours she would study at night she engaged in food restriction.

Drawing on the work of Sayer (2005) and Archer (2003), Wetherell (2012) argues that habitual practices do not develop solely from processes of conditioning, but rather they are “reinforced by the churning over of internal conversations inside the head, as people ponder and suffer angst
over the patterns in their lives, make resolutions and resist the forces that seem to be moving them in what feels like the wrong directions” (pp. 105-106). This reflective process is evident in Casey’s account of how her inner dialogue has changed in response to her eating disorder practices. When Casey first started making dietary changes, she reported having thoughts such as “you can do it, stick to being healthy”, however, as she engaged more frequently in eating disorder practices, her thoughts progressed to: “….don’t eat it. Don’t eat it. Don’t eat it. You’re going to ruin everything. Don’t eat it. You’re going to ruin everything. You’re disgusting”. Casey reports having invasive thoughts such as “your whole self-worth is resting on if you’re going to eat this bowl of oatmeal right now”. A comment made by Catherine further illustrates the uncertainty that is produced through food restriction (and often times binging and purging as its consequence): “It’s that hot and cold, that anxious ambivalence about life. This is what I want (no, it’s not what I want). You know? This will make me feel good (no, now it’s in my stomach and I hate myself). So it’s like that uncertainty and that . . . lack of clarity that I have about things…”.

Yet, the labelling of foods as either “good” or “bad”, “safe” or “unsafe”, gives food significant affective power. Food has the potential to both nourish and contaminate. Food (or particular amounts or types of food) is understood in terms of threat. Massumi (2010) offers the following reading of threat: “It will have been real because it was felt to be real. Whether the danger was existent or not, the menace was felt in the form of fear. What is not actually real can be felt into being” (pp. 53-54). It is not surprising then that participants also reported understanding food in terms of reward or punishment. As affective objects, food is given the power to either build or diminish individuals’ sense of power and control. After consuming “restricted” or “unsafe” foods, Casey and Emily report feeling overwhelmed with guilt. Casey described this guilt as “inhibiting” as it can prevent her from fully engaging in her usual day-to-
day activities. Emily reported that in these incidents, the guilt served as a reminder not to consume such foods again; in this sense, guilt functions to reinforce particular restrictive eating disorder practices. Casey and Emily also expressed that they experience particular emotions, namely anxiety, around food choices. Emily reported that “there’s always emotions between whether to eat or not”. Moreover, restricting food intake often leads to imbalances in blood sugar levels which, Casey notes, lead to “extreme cravings” which “then set off other behaviours” (binging). Casey explained that there are times she will restrict all day and then instead of preparing a balanced meal which she expressed her “body wants”, she will instead consume foods such as ice cream. She said “the let-down of not being able to control it is worse than if I had just given in in the first place and, like, treated it well”. Emily similarly explained that there are times following a period of food restriction where she will consume “everything without control”. She expressed that she will binge on particular foods to the point where she feels physically ill. Catherine spoke about how her eating disorder practices changed over time from food restriction to binging and purging. She commented: “…binging and purging is, essentially, a loss of control: you’re eating, you’ve failed and now you have to throw up, it’s your punishment”. This experience of being “out of control” has been described in the academic literature as well as numerous personal accounts of eating disorders. Eckermann (2009) explains how individuals reported a “loss of certainty” and “loss of control” when unintended consequences emerged from their food restriction (p. 15). These individuals have finally gained a sense of control of their bodies, “only to find their palpable bodies ‘turn nasty on them’ at the zenith of their power”; their bodies become unpredictable and out-of-control (Eckermann, 2009, pp. 15-16). Catherine further explained that food had the power to make her feel “unclean”. She commented on feeling “dirty” which she described as “a feeling like not being able to get something off of your hands and you just feel…like it’s a stain that penetrates your soul,
essentially. It’s an unclean feeling”. Here, food is given the power not only to contaminate her body, but also threaten her sense of self. This black-and-white thinking around food and compensatory eating disorder practices is more of a folding, in the sense that participants use their bodies (restricting food, binging, purging and over-exercising) to move between feeling in and out of control. Although participants move between dis/order and dis/comfort, these places or states are never stable, but fluid, fragile and fleeting. Therefore, participants do not experience a splitting so much as they do a folding, where the boundaries between apparent exteriority (food) and interiority (the body) dissolve.

Producing “in-between” enfolding spaces of uncertainty, eating disorder practices can also be understood as a threshold of the BwO. Deleuze and Guattari (1987) argue that what is produced on the BwO “is already part of that body's production, is already included in the body, is already on it (but at the price of an infinity of passages, divisions, and secondary productions)” (p. 152). According to Deleuze and Guattari (1987), the BwO “is always swinging between the surfaces that stratify it and the plane that sets it free” (p. 161). The major (or also referred to as molar) includes organizing bodies which signify and subject, whereas the minor (or molecularity – “becoming”) is an act of experimentation, a process of transformation (by way of assemblages, BwOs connecting to each other) (Deleuze & Guattari, 1987). Becoming a BwO, however, entails a degree of caution, as it must be carried out in a particular way. Deleuze and Guattari (1987) state that “There are, in fact, several ways of botching the BwO: either one fails to produce it, or one produces it more or less, but nothing is produced on it, intensities do not pass or are blocked” (p. 161). A comment made by Catherine about binging and purging illustrates how eating disorder practices must be carried out in a specific way in order to produce particular intensities: “. . . if I ate too much or, like, binged for too long then it would be, like, I’d just feel dirty, so it would be counter-productive.” Deleuze and Guattari (1987) further warn that “in dismantling the
organism there are times one courts death, in slipping away from significance and subjection one courts falsehood, illusion and hallucination and psychic death” (p. 160). Individuals with eating disorders court these dangers when constructing BwOs. Catherine said the following about food restriction: “it gets to a point where if you do that for too long you, like, lose touch with reality, and binging and purging almost grounds you, and then you start from the beginning again”.

Moreover, eating disorder practices provide participants with a sense of self-containment or self-fulfillment, erasing the need for external stimuli through interpersonal relationships. Catherine said the following in relation to restricting practices: “. . . and then when I feel a little bit fulfilled, then I feel like it moves on, like I don’t need anything . . . I feel like I don’t need food, I don’t need friends”. While the BwO itself is “intensive, lacking extension”, it is also a “little machine, ready when needed to be plugged into other collective machines” (Deleuze & Guattari, 1987, p. 161).

Figure 2. Casey’s collage
Chapter IV: Bodies Belonging

In the previous chapter, I discussed how affective practices and meaning-making (emotion and thought) are intricately connected. Barad (2007) suggests that knowing (which occurs at the threshold of affect and perception) and being cannot be separated, as they are mutually implicated (as cited in Hultman & Lenz Taguchi, 2010, p. 539). Moreover, Hickey-Moody (2013a) suggests that “our subjectivity is the embodied accumulation of our actions” (p. 82). Affective practices, according to Wetherell (2012), “build psychologies, identities, reputations and subjectivities as they make meaning, just as they build social orders, histories and institutions” (p. 90). This chapter explores how participants’ eating disorder practices build and fragment (or even consume) their sense of self. Within the context of affective eating disorder practices, the “self” can be understood as “a complex and ever-evolving social interface” (Gibbs, 2010, p. 196). Affective experience also builds worlds (Ahmed, 2010; Thrift, 2010). This chapter also discusses the ways in which eating disorder practices isolate individuals from their social circles, particularly through the production of powerful emotions such as shame.

Losing (and Gaining) a Sense of Self

As eating disorder practices invade or replace other life activities, a new sense of self is built, and, for some participants, this initial transformation produced feelings of mastery and competence. Several participants likened their eating disorder experiences to the high of drug use that leads to addiction. Debbie described eating disorder practices as producing a “kick” and Catherine said eating disorder practices are “essentially a drug”. All participants agreed that eating disorder practices provide perceived benefits, such as avoidance or distraction from bigger problems and uncomfortable social situations. Catherine said “it lets me avoid things, it gives me
a sense of achievement, um, it gives me mastery over one thing in my life . . . it gives me an excuse for being fucked up, um, it lets me delay maturity, it lets people drop their expectations of me, so I just fade away”. Similarly, Casey expressed that her eating disorder practices provided her with a sense of achievement and control. She described being at an open call audition where she thought “I’m never the tallest in the room, and I’m never going to be the prettiest in the room . . . but I used to be the thinnest in the room”. Casey said that, at the time, being the thinnest was “a crutch” and “even if I wasn’t going to get the part, I would have that on people”. Emily felt that her eating disorder practices helped her develop coping skills that could be transferred to other aspects of her life. She felt that if she could control her food choices and consumption, she could have similar control over her emotions in dealing with being away from her home and her family while she was a student abroad: “. . . if I can do it with food, I can also apply it to homesick[ness]”. The perceived benefits and skills that eating disorder practices provide, although illusory, build participants’ sense of self. Moreover, this sense of control or mastery produced through eating disorder practices illustrates “how embodied experiences might contribute to a certain kind of agency that is not reducible to the social structures within which bodies are positioned” (Papoulias & Callard, as cited in Hickey-Moody, 2013b, p. 127).

Participants, however, also felt at times that their investment in their eating disorder practices eroded or fragmented their previous sense of self. Debbie explained that while, for the most part, she feels that her eating disorder practices are only a part of her, or influence only some aspects of her identity, “sometimes it’s, like, more fatalistic and it’s, like, this is who I am”. Similarly, Emily felt that her eating disorder practices have become increasingly integrated in her life; she said, “I think now it is a part of my being”. Casey explained that while she can conceptualize her self as “apart” from her eating disorder practices, she still feels that “they merge sometimes”. Catherine echoed this sentiment, expressing that there was a period of time
when she felt that she was her eating disorder, but over time she has been able to separate her self from her eating disorder practices. Catherine, however, also commented “. . . there is a huge part of me that still feels like it [the eating disorder] is me. There was two, and then there was one, and now, I’m just – it’s difficult to explain”. All participants, in their accounts, suggested that their sense of self, in the context of their eating disorder practices, was uncertain, fluid and fragile. As eating disorder practices intensify and become more frequent, the sense of identity that depends on other life activities disintegrates. For example, Catherine explained “I am a student with an eating disorder”, yet, “sometimes it feels like I’m not even a student because I spend so much time with the eating disorder”. She described a period of approximately six months where she was binging and purging approximately 10 to 12 times a day. Catherine said “I dropped out of school. I wasn’t working. I was on disability and literally, I would get up, go to the grocery store, and spend the entire day binging and purging. And that was a really hard time for me. And that was a time where I felt like I completely, like, lost control”. Casey’s account also reflected that loss of sense of self. She commented that an eating disorder “takes away your identity when you are deep in it . . . like, that’s all you are”.

Figure 3. Emily’s collage
Eating disorder practices affect an individual’s interpersonal relationships and can, over time, isolate them from their social network. Because these practices are centred on the body, it becomes less necessary for individuals to seek outside support or stimulation. Levens (1995) argues that individuals with eating disorders use “incorporation and fusion to achieve the desired intimacy and to experience a particular feeling, such as being soothed” (p. 53). This form of comfort, she argues, cannot come from other human beings “capable of independent thought” because, at any moment, these individuals can exclude the patient (Levens, 1995, p. 54). As eating disorder practices become more invasive, the individual’s world becomes smaller; the eating disorder practices become a larger part of their life and identity. This can produce feelings of separateness and isolation. Taylor (2013) suggests that social encounters are “hybrid, emerging and relational” and are “always constituted by the social assemblage we find ourselves in” (pp. 53-54). Moreover, Ahmed (2010) argues that “if our bodies change over time, then the world around us will create different impressions” (p. 31). When an individual is immersed in eating disorder practices, it becomes increasingly more difficult to separate their identity from their eating disorder sufficiently to allow them to relate to other people. This isolation further intensifies the eating disorder practices, as the individual returns to these practices for comfort and fulfillment.

One of the ways eating disorder practices create feelings of separation or disconnection is through the production of powerful emotions, particularly guilt, shame and anxiety. In addition, participants also reported feelings of bitterness and jealousy when they witnessed others interact with food seemingly without the same powerful emotional and physical discomfort that they experience. For example, Catherine expressed the following about her eating disorder (practices): “it’s like a shadow hanging over my every interaction with other people. Instead of
rose-coloured glasses, they are grey-coloured glasses. I feel like it has made me very bitter. It’s made me look at people with contempt and envy”. She felt that her eating disorder practices cause her to judge others, sometimes feeling pity for them (“Poor you! Do you know what’s in that?”) and at other times envy (“They look so happy eating it and enjoying it”). Catherine expressed that she experiences longing because food still appeals to her, but that her response to it is too complicated with guilt and control to enjoy eating a meal with others. On the rare occasions where she will eat with others, Catherine explained that she still feels isolated. She narrated her internal reaction during these situations: “Oh, that’s right, I forgot. The rules of life don’t apply to me. You can enjoy it, but I can’t”. Ahmed (2010) suggests that when “we are disappointed by something that we expected would make us happy, then we generate explanations of why that thing is disappointing. Such explanations can involve an anxious narrative of self-doubt (why am I not made happy by this, what is wrong with me?) or a narrative of rage, where the object that is ‘supposed’ to make us happy is attributed as the cause of disappointment” (p. 37). In these moments, Ahmed (2010) suggests, we become “strangers” or “affect aliens” (p. 37). Catherine reported that these kinds of experiences distance her further from others. She said “. . . I don’t even want to associate with people because then it’s like watching people have what you will never be able to have, that peace and serenity”. When she spends time with other people, Catherine reported feeling like she exists outside of “their” world: “. . . How can I relate to other people when there is such a disconnect as to how you interact with your world and how I interact with mine?”

Feelings of shame are also powerful blocks to developing and nurturing meaningful relationships with others. Casey said that simply eating at a restaurant with others can bring on intense feelings of shame and anxiety, and that the entire experience is coloured by her emotional turmoil. She described her shame: “All I want to do is hide . . . if I could hide from myself, I
would”. According to Bartky (1990), shame requires an audience: “Shame is the distressed apprehension of the self as inadequate or diminished: it requires if not an actual audience before who my deficiencies are paraded, then an internalized audience with the capacity to judge me, hence internalized standards of judgement” (p. 86; see also Probyn, 2010). Bartky (1990) further argues that shame is weakening: “The need for secrecy and concealment that figure so largely in the shame experience is disempowering as well, for it isolates the oppressed from one another and in this way works against the emergence of a sense of solidarity” (p. 97). Wetherell (2012) similarly suggests that “Even in a rumination rehearsed entirely in one’s head, the internal affective dialogue may go back and forth in the same way with an imagined other, or with a subdivided self as, for instance, an accusing self and a guilty self act out turn and counter-turn . . . affective meaning-making, in other words, is dialogic and typically addressed as if to someone. It is a communication” (p. 87). The shame experience, as a relation or communication, can be disempowering and significantly isolating for individuals.

The powerful feelings of guilt, shame, and anxiety which are experienced by individuals with eating disorders are usually invisible to others within their social circles; this invisibility deepens their feelings of disconnection and their loss of relatedness. In addition, there is a wide misconception that only people who are extremely underweight are likely to have an eating disorder. Casey explained that her eating disorder practices were kept secret for quite some time until her body appeared visibly underweight. She said, “For years, it was just me who knew.” As the social connection with others diminishes, the relationship with food and exercise becomes more essential in providing a sense of connection with something, if not someone. A change in how we experience our bodies can alter our standing in, and perception of, the world. Drawing on the work of Sartre, Ratcliffe (2013) suggests that “a change in bodily feeling can also be a change in one’s experience of worldly possibilities” (p. 226). Thus, the feeling of isolation is not
limited to situations involving food; the loss of connection is felt in every aspect of social interaction. Debbie said that when a person struggles with eating disorder practices, it “changes the way you relate to other people . . . it changes everything about your life, like basically, like it comes out in every single possible way . . . and it manifests in, like, everything you do”.

Figure 4. Catherine’s collage
Chapter V: Transforming Bodies

In the previous chapter, I suggested that eating disorder practices are not so much about absolutes (black-and-white thinking) or splitting, as they are about a folding, entering a threshold where dualisms dissolve before being reinstated in an ongoing cycle. I argued that eating disorder practices are always immanent and therefore can be understood as a BwO. Moreover, I argue that eating disorder practices must be understood as productive desire, because, as Deleuze and Guattari (1987) note, “even when it [a BwO] falls into the void of too-sudden destratification, or into the proliferation of a cancerous stratum, it is still desire. Desire stretches that far; desiring one’s own annihilation, or desiring the power to annihilate” (p. 165). I suggest that an understanding of eating disorder practices as “in-between” spaces necessitates a recovery model that advocates “plugging in” to these thresholds. Jackson (2013) states that a threshold, by itself, “has no function, purpose or meaning until it is connected to other spaces. That is, a threshold does not become a passageway until it is attached to other things different from itself” (p. 116). I propose creative embodied practices, specifically collage-making, as an alternative assemblage (BwO) that can be plugged into this threshold to help move individuals out of the cycles (thresholds) of their eating disorder practices.
Un/containable Bodies

In suggesting that creative practices can be plugged into the threshold, I frame artistic practices as a non-human body with the potential for “touch”. Touch, according to Springgay (2009), “displaces the measured and distant gaze with a desire that immerses the subject in fluid continuity and a folded relation with the world. Touch ruptures the containment of the body as unified and discrete, rendering the body permeable and porous” (p. 118). Similar notions of “touch” have been posited by Merleau-Ponty (1968) (“chiasm”), and Weiss (1999) (“intersubjectivity” or “intercorporeality”), as well as by Deleuze and Guattari (1987) through their concept of “the fold”. Drawing on the work of Merleau-Ponty, Grosz (1994) writes: “Between feeling (the dimension of subjectivity) and being felt (the dimension of objectivity) is a gulf spanned by the indeterminate and reversible phenomenon of being touched, of the touching, the crossing over of what is touching to what is touched, the ambiguity which entails
that each hand is in the (potentially reversible) position of both subject and object, the position of both phenomenal and objectual body” (p. 100). Moreover, Weiss (1999) argues that “the experience of being embodied is never a private affair, but is always already mediated by our continual interactions with other human and non-human bodies” (p. 5). Art, as a non-human body, can enter the threshold, producing a collective space where body boundaries are renegotiated and both self and other can be transformed through a creative becoming. Building creative practices into eating disorder recovery, I suggest, “is a way of living in the world as being-with, of touching the other, not to know or consume the other, but as an encounter that mediates, constructs, and transforms subjectivity” (Springgay, 2008, p. 39).

Art is a form of communication and is therefore always relational. Catherine described art as “a vessel for expression” where she can bring her “idea to life”. Collage, as an assemblage of fragments, seems to present more than it represents. Others’ images are appropriated and repurposed in a way that troubles the links between representations, categories, desires, acts and identities (Miller, 2004, p. 219). Such a practice can be framed as a “queering” as it resists the production of “predictable, stable and normative identities” (Miller, 2004, p. 219). Catherine felt that collage, specifically, is a great artistic practice because it does not require any prior experience, skill or talent “to actually produce an interesting, thought-provoking piece”. Catherine expressed that, because you are using others’ images, “it’s less threatening because you don’t have to actually put something out there and be, like, this is me, I wrote this, this represents my soul – it’s more like, oh, I collected pieces”. She explained, however, that “those pieces, in a way, also, indirectly, represent your soul because you selected it, because you felt a connection with a certain piece or it spoke to you in a certain way or represented what you were feeling in the moment”. Catherine’s description emphasizes how the collages are not simply objects of signification but are monuments, blocs of sensation, assemblages of affect in recovery.
According to Deleuze and Guattari (1991), “fabulation” is the act of making the invisible visible (as cited in Hickey-moody, 2013b, p. 124). Deleuze and Guattari (1991) state that: “It is true that every work of art is a monument but here the monument is not something commemorating a past, it is a bloc of present sensations that owe their preservation only to themselves and that provide the event with the compound that celebrates it. The monument’s action is not memory but fabulation… (as cited in Hickey-Moody, 2013b, p. 124). In this way, collage is a “transitory space” that is “never intended to be fixed, never intended, in fact, to conclude or even convince” (Holbrook & Pourchier, 2014, p. 760).

Participants voiced that the two collage sessions were very different experiences (making their own collages in a group setting and then later making one collage together). Casey and Catherine explained that working on their own piece produced a desire to control all aspects of the collage and create a “good” piece of artwork. A stronger emphasis seemed to be placed on the finished product. This sense of ownership resulted in Catherine asking to stay past the scheduled time in order to finish her collage. She explained that sometimes making art on her own makes her feel “really impatient and frustrated” as she ends up “re-doing things a billion times”. Casey agreed with this sentiment and said the following about personal creative projects: “I can’t get started because I’m too scared of how bad it’s going to be”. Holbrook and Pourchier (2014) describe collage as a process that works with both chaos and order (p. 758). Some participants struggled with opening up to chaos during the individual collage session and reported that the environment of the collective collage session was more conducive to getting lost in the process of art-making. While Casey approached the first collage session more in terms of order and representation, the group collage session allowed her be more open, affected by the materials that she encountered. She said: “well, I started to draw an eyeball and then I was like why don’t I just glue some eyeballs and then I just see something and I’m like…like this guy, he
made me laugh ‘cause he’s like wearing a little thong and he’s strong and he’s like ahh! So then I just put him there and then…I don’t know [Laughs]”. Casey explained that she can take pride in herself most during the process, because she can reassure herself “see, you could do it, you just had to make yourself do it”. Debbie expressed that she mostly selects images that she finds amusing. She explained that “sometimes, over time, you’ll be like oh, that’ll look cool with this, but, like, generally…like, I don’t put too much thought into it before I start doing stuff.” These descriptions illustrate how collective collage-making encouraged participants to let go of control and open up in a way that allowed the materials to affect them and their art-making process. Catherine spoke about the uncertainty of art-making and how it can take an individual “out of their comfort zone”. She said, “…art is all about letting go, taking risks and just going with the flow. And it depends on what sort of eating disorder you have, but, sometimes, you know, that can be very difficult for people”. Collage-making in eating disorder recovery produces in-between spaces of uncertainty that work with both order and chaos. In this sense, I argue that collage can be a healthier way for individuals to affectively negotiate dis/order in relation to their bodies and bodily capacities.

**Becoming Well**

Carel (2008) claims that “it is not only physical possibility that suffers in the hands of illness. It is ways of being and ways of being-with that suffer” (p. 53). As discussed in previous chapters, eating disorder practices shape everything from an individual’s sense of self to their social interactions. Eating and exercise are sometimes engaged with in ways that produce a sense of connection or produce feelings of dis/embodiment. Because art-making is an affective and collective process and practice (emphasizing what the body can do), I suggest that it can be implemented in eating disorder recovery as “a purposeful activity” that functions to connect
individuals to someone or something, providing a sense of relatedness in ways other than through their eating disorder practices (Levens, 1995, p. 67). Catherine articulated that the shared activity provided a “sense of connection” and offered the following description of the collective collage: “it could express, like, the relationship we all have or it could express our individual things that come together as one piece um, ’cause either way we have to account for everyone else’s pieces and, like, add to it or build on it, so, it is, in a way, voicing something that we’re…it’s all of our voices”. In this respect, the collective collage can be understood as “the second psychic skin”, which, Davies and Gannon (2009) suggest, “is not just an extension of already established individualized subjects, or a representation of those subjects or of others external to them, but is an other in relation, and generative of new relations andbecomings” (p. 7). Furthermore, Hickey-Moody (2013a) suggests that “art has the aptitude to change a body’s limits. Art can adjust what a person is or is not able to feel, understand, produce, and connect. If an affect is a bodily change, it is registered as a sensible experience that, in the instance of affective pedagogy, is produced though art” (p. 88). Thus, the intercorporeal space of art-making in eating disorder recovery not only provides a sense of connection, but it challenges an individual’s sense of embodiment; participants are pushed to (re)negotiate body boundaries (and, by extension, space) in relation to others (both other participants and the materials). In this sense, collective art-making in eating disorder recovery has the potential to open up pedagogical spaces where both self and other are transformed through a creative becoming.

Eating disorder practices both build and fracture participants’ sense of self. Hickey-Moody (2013a) states that “while we need to acknowledge and understand the points at which places fold in to constitute our subjectivity, we should not lose sight of the potentials held within places and selves that exist outside these points of connection” (p. 131). Collage produces spaces of uncertainty, as “art making allows entry into and expression of the not-yet-known” (Davies &
Gannon, 2009, p. 65). Plugging collage-making into the threshold created via eating disorder practices produces an intensive space where habits can be disrupted through a “making strange”. Greene (1996) states that: “To dis-identity and to denaturalize, to make one’s object un-natural is to strategically produce difference out of what was once familiar or the same” (p. 327). According to Springgay (2008), “…we need to examine the in-between as a space where bodied encounters and the relationality between beings produces different knowledges and produces knowledge differently” (p. 40). I argue that incorporating artistic (affective) practices in eating disorder recovery produces something different, exceeding the threshold and unleashing “lines of flight” through a creative becoming (Deleuze & Guattari, 1987). These lines of flight, as deterritorializations, are new ways of thinking and being in the world. Collage, as a form of art-making, “opens up lines of flight which take the artist into the world of chaos and return her a transformed subject” (Davies & Gannon, 2009, p. 14).

Using group collage in eating disorder recovery as an embodied affective practice, rather than as a platform for psychoanalysis, challenges the notion of a fixed “self” to be interpreted. Such an approach recognizes and celebrates bodies for what they can do. Here, the focus is not about finding or uncovering a “self” which is “rational, coherent, autonomous, unified, fixed and given”, but is instead about producing identities, perhaps multiple selves, by way of affective (and collective) embodied practices (Miller, 2004, p. 219). Art becomes a mode of producing subjectivity (Hickey-Moody, 2013a, p. 87). In speaking about the process of art-making, Catherine said the following: “I wouldn’t as much be focusing on, like, the negative aspects of my body, like oh I feel so uncomfortable or I feel like unattractive or ugly, or whatever. Um, it would be more like focusing on, like, okay, I have to cut this a certain way or I have to paint this a certain way, like, move your hand in this way”. Catherine felt that artistic practices can help individuals struggling with eating disorder practices “reconnect with their bodies in different
ways”. She felt that art provides possibilities for producing “something positive and beautiful instead of something . . . negative or harmful”. Debbie expressed that, even if you are not a skilled artist, creating something is still “another thing that you can do” other than engaging in eating disorder practices. She described it as “a more practical application of your body”. Casey also commented on how collaging can produce a shift in her thinking; she reported thinking less about her body in terms of appearance and more in terms of its capacities. By using creative practices in recovery, an individual with an eating disorder can become a “body subject” – someone who “is not mesmerized by appearance but situated in her body in a material, sensual world that becomes meaningful as it is transformed into a ground of possible activity” (Grumet, 1989, p. 228; see also Merleau-Ponty, 1962).
An Exit (and Entry) Point: Moving into a Rhizomatic Recovery

Rather than approaching recovery as a linear process developed from and reproducing dualistic thinking (i.e. healthy/ill, ill/recovered), I posit a model of recovery that is fluid, emergent, rhizomatic and “becoming”. Such a model, I argue, acknowledges the body and affective experience as paramount in the production of knowledge and subjectivities. In framing recovery as “becoming”, and therefore ongoing (a limit never reached), I am in no way suggesting that symptom-free living is impossible or not the goal, but, rather, I am advocating an approach where the ongoing cultivation of affective self-care practices is imperative. It has been suggested that personifying eating disorders or framing them as external forces can be beneficial in recovery, as it helps individuals distinguish between themselves and the disorder (Epston & Maisel, 2009). However, as I have discussed in detail, participants’ identities are intimately connected to (and produced by) their eating disorder practices. Therefore, the elimination of eating disorder practices can precipitate a complete loss of sense of self. Treating the symptoms without an understanding of how these practices function can cause the individual to experience profound discomfort, a loss of control and significant changes to their social functioning. Debbie expressed that while engaging in eating disorder practices she often thinks: “Why am I doing this? This is awful”, but commented how she does not “really have anything to replace it with”. Similarly, Catherine expressed that it is very difficult “to give something up that is literally like the only thing that gives your life meaning and structure”. She said: “I’m sick – that sucks; but if I’m not sick, then I’m nothing”. Moreover, Emily explained that because her eating disorder practices are so integrated into her life, she felt it was impossible to “just lose it”. I argue that a more empowering approach might be to build in affective practices that can (re)connect individuals to their bodies and others in healthier ways (such as through art). I posit a recovery
model that entails opening the body to other assemblages and intensities – wherein lies multiple possibilities for transformation.

While some participants reported that there had been short periods of time when they did not engage in eating disorder practices, they were hesitant to ever identify as fully recovered. In speaking about her experiences following treatment in hospital, Catherine said the following: “It wasn’t like I feel better, it was more like don’t think, don’t think, don’t move, don’t go in the kitchen. It was like I was super restricted and . . . there was no healing; there was just containment”. Casey expressed her skepticism about recovery models that emphasize weight gain as a marker of recovery: “I think there needs to be, like, some better way they do that because, like, I get it, when you have a kid or like a friend who is underweight, you just want to make them eat, right? But, like, that is such a small part of the issue”. Catherine felt that “there’s something missing in terms of what is needed . . . so this is just a Band-Aid solution because what else is there?” Catherine and Casey felt there was a disconnect between medicalized models of eating disorder treatment and how they navigated recovery in their everyday lives. Catherine said “it’s different in a hospital, and when you come back outside it’s, like, LIFE and it’s not safe anymore”. She commented further: “it’s a very institutionalized environment and it’s not really supportive, it’s more, like, forceful and they don’t have the time to really ease you into recovery”. Casey expressed that her therapy sessions became less and less frequent as she “kept going on with life”. Debbie also articulated a desire for a more integrated approach, commenting how she preferred “gentle methods” and “slow change”. Turning to a rhizomatic recovery model emphasizes entangled networks; a rhizomorphous becoming that “takes place in the World As We Know It . . . Bodies in flight do not leave the world behind . . . they take the world with them – into the future” (Massumi, 1992, p. 105, as cited in Jackson, 2013, p. 115). Therefore, building affective self-care practices (such as art-making) into eating disorder recovery might be a more
sustainable and holistic approach, as it can perhaps more easily be incorporated into the individual’s life. Moreover, participants expressed that eating disorder recovery involves “an integration of so many things” (Debbie) and “a little bit of everything” (Casey). While I recognize the importance of medical intervention and psychiatric support, particularly when eating disorders become life-threatening, I argue that a more embodied model is needed; one in which the affective body is paramount. Catherine expressed that: “the treatment out there is . . . not long enough, it’s not intensive enough and it’s not collective, communal . . . it’s not holistic enough”. A rhizomatic recovery is one that is multidirectional, working with/in and through a shared system. A rhizomatic recovery is about creating and expanding networks of ongoing support.

Traditional frameworks of eating disorder recovery posit “an end point to pathology and a starting point of normalcy” (Dyke, 2013, p. 158). However, a rhizomatic recovery, I suggest, moves “from cure to care” –a model, according to Carel (2008), that aims “to change healthcare practices by reconceptualizing the health-illness distinction and offering a more holistic perspective on health and health experience” (pp. 78-79). A rhizomatic recovery model challenges notions of eating disorder recovery as a linear process with an attainable “healthy” end point and instead understands recovery as “a robust, embodied intentionality” (Grumet, 1989, p. 228). Understandings of recovery as “becoming” recognize that “there is radical possibility in the unfinalised” (Jackson, 2013, p. 123). Casey expressed the following about recovery: “I think it’s a super long thing that is not over if it ever will be achieved properly”. Similarly, Debbie felt that it was “too final” for her to ever say she is “recovered” and described recovery as a “day-to-day” ongoing process. Debbie expressed that choosing recovery has, in some ways, been a very positive experience for her. She explained that through seeking support through art therapy-based programs she has met “amazing people”, learned new things about
herself and gained self-confidence. In speaking about the recovery process, she said, “there’s just been a lot more self-awareness and a lot more, like, me”. A rhizomatic recovery, therefore, not only moves individuals beyond the threshold of eating disorder practices, but into new directions, continually expanding life. Recovery does not stop at the elimination (or replacement) of eating disorder practices; it is a life-long process of practising wellness through affective and collective body practices.

Davies and Gannon (2009) argue that “the shedding of individualism and the openness to movement toward a new way of thinking and being is not easily accomplished – it is a painful and peculiar process in which the static striations of identity are peeled open” (p. 15). Affective body experiences in recovery can produce pedagogical moments. Entering eating disorder recovery takes tremendous courage as eating disorder practices are intricately entangled with an individual’s sense of self and their standing in the world. Choosing recovery requires an individual to let go and open up to psychical and emotional transformation. Jiménez (2011) describes perfectly this pedagogical moment of “letting go”: “Led by my body, I submitted to uncertainty. I had no control, no answers” (p. 304). She describes her body as curriculum, “a curriculum of shame and pride. A curriculum of humility” (Jiménez, 2011, p. 306). Debbie felt that having an eating disorder and going through recovery involves asking yourself difficult questions that you otherwise would never have to ask. She said it forces you to really “examine what’s not working” in your life. A recovery which is rhizomatic and becoming is one that recognizes rupture and experimentation; it is not a process of making-the-same, but one that is immanent and unfolding. Becoming well necessitates an understanding that “our bodies and their affective registers are the flesh of pedagogy” (Hickey-Moody, 2013a, p. 126).

There are certain aspects of lived experience that are invisible to those who do not possess the language or cultural reference to understand that experience (Hesse-Biber & Brooks,
2012, p. 514). Due to the very intimate nature of eating disorder practices, it is not surprising that participants articulated feeling more comfortable opening up to and seeking support from individuals who had a similar past. Casey expressed that, at first, she found it very difficult to see a therapist about her eating disorder practices as it made her feel very vulnerable. She explained that, over time, she decided “okay, this is the one stranger” and said the following about her therapist: “she was really cool because she had had an eating disorder”. Debbie similarly expressed her hesitancy to disclose to others about her eating disorder practices unless they, too, faced a similar struggle. Debbie explained that there have been times when she has shared this information and later regretted it. In speaking about times when she has heard acquaintances or even friends make comments about individuals dealing with eating disorder practices (not knowing that she struggles with an eating disorder), Debbie recalled thinking: “I know I can’t tell you about this because even if you look at me with love and you try to understand it as best you can, I know that you . . . don’t understand it, you’re not going to understand it. And that’s cool, it’s not up to you to understand it. That’s fine, like, it’s cool that you don’t understand it because that means you haven’t dealt with it”. Debbie’s words emphasize significance of lived experience in understanding the complexity of eating disorder practices. Goodley (2007) suggests that rather than viewing certain bodies as “the stuff of shame or deficit”, we should recognize these bodies for their pedagogical and political possibility (p. 327). I believe that the lived experiences of individuals who previously struggled with eating disorder practices should be recognized for its potential; their perspectives and knowledge from these experiences are resources which could help support others in recovery⁴.

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⁴ This type of support system is used in Alcoholics Anonymous and Narcotics Anonymous (sponsors and group meetings). I think a similar model might be useful in eating disorder recovery as it emphasizes the value of lived experience and the importance of building networks, as well as posits recovery as an ongoing day-to-day process.
Conversations with participants suggested that eating disorders are not linear progressions with clear, definitive beginnings, but rather are rhizomatic, with multiple elements entangled with and through one another. The literature on eating disorders seems to suggest a variety of underlying factors or predispositions that influence the development of eating disorders; I suggest that these factors are better understood as rhizomes rather than roots. Participants’ body experiences unfold within particular contexts or environments which are always political. Oppression lives in and through the body. Factors such as identifying as a woman, having a history of sexual assault and/or abuse, and having a history of dieting, are not simply points of departure, beginnings (roots), in the development of an eating disorder, but, rather, are points of both entry and exit; they are part of a larger system (patriarchy) that individuals continue to navigate. Individuals with eating disorders continue to navigate these systems of oppression during the recovery process, and, therefore, I argue that the goal of eating disorder recovery should not only be to transform and heal the individual, but to also disrupt and challenge molar institutions. Kumashiro (2000) argues that the goal of education should not be final knowledge but “disruption, dissatisfaction, and the desire for more change” (p. 34). Building from this statement, I suggest that a rhizomatic recovery that is becoming not only works to eliminate eating disorder practices through the implementation of new affective practices (such as in the arts), but in this process, it has potential to help destabilize some of the molar structures and apparatuses that work to subject, contain and control affect and bodies.

The molar includes that which signifies and subjects, massive and governing bodies, such as institutions or identity categories (Jackson, 2013, p. 117). Constructions of health as well as the mind/body dualism are examples of molar structures. Drawing on the work of Massumi (1992), Jackson (2013) states that “The Molar Gaze is not a static but a productive process: a making-the-same” (p. 119). Feminist scholars such as Young and Weiss are critical of the
dominant model of health which “assumes that the normal, healthy body is unchanging” (Young, as cited in Weiss, 1999, p. 53). Models that frame the healthy body as existing in a state of equilibrium reproduce hegemonic masculine ideals as “only a minority of persons . . . namely adult men who are not yet old, experience their health as a state in which there is no regular or noticeable change in body condition” (Young as cited in Weiss, 1999, p. 53). Moreover, Saukko (2009) argues that psychiatric treatment for eating disorders is often complicit with “a fixated pursuit of normative absolutes” (p. 71; see also Gremillion, 2002). I further argue that current psychiatric treatment models often reproduce the mind/body dualism by privileging the mind over the body. Cognitive Behavioural Therapy (CBT) and Dialectical Behavioural Therapy (DBT) both advocate the control of the body (and, by extension, emotions) by the mind (through the recognition of and modifications to particular thought processes and/or core beliefs).

Historically, women have been constructed as more embodied, as those “who are not allowed not to have a body” (Haraway, 1988, p. 575). According to philosophers from the 19th century and onwards, “rational thought” requires an objective mind which is detached from the body; the physical body has historically been constructed as an impediment to knowledge – our senses misleading and our emotions and desires interfering with our “pursuit of the good” (Chanter, 2006, p. 74). The mind/body dualism was constructed as “stronger distinctions were made between reason and emotion, with emotion seen as natural, biological, feminine and primitive, and reason or cognition as moderate, controlled, masculine and rational” (Wetherell, 2012, p. 95). Therefore, a recovery model that focuses on the body and its affective capacities is also, I would argue, a feminist model that challenges oppressive dualisms. A recovery model that is rhizomatic and becoming embraces and works with that which is always immanent, desiring and productive; it locates the body at the threshold of meaning-making and recognizes the entanglement of affective experience, knowing and being in the world. A rhizome “operates by
variation, perverse mutation, and flows of intensities that penetrate systems of classification, putting them to strange new uses. It creates the unfamiliar. To be rhizomorphous is to become, a becoming that effaces stable identities” (Springgay, 2008, p. 5). Therefore, a recovery of becoming works to disrupt the molar, “break[ing] apart dichotomies that organise bodies, experiences, institutions and histories” (Jackson, 2013, p. 120). The becoming (the minor, or molecularity), is the newness that is generated through deterritorialization; it is not the production of difference, but the process of always becoming different. I suggest that it is here, in the middle of things, where endless potential for personal and political transformation can be found.
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Appendices

Appendix A: Recruitment Poster

Eating disorders

PARTICIPANTS NEEDED FOR RESEARCH ON EATING DISORDERS

I am looking for volunteers to take part in a study about creative practices and embodiment in eating disorders. Selection criteria is as follows:

1. You self-identify as a woman with an eating disorder*
2. You are between the ages of 18-30
3. You currently reside in the Metro Toronto Area

*A formal medical diagnosis is not required to participate in this study. Any individual who self-identifies as a woman with an eating disorder and meets the other outlined requirements is welcome to participate.

Your participation in this study would involve attending three sessions, each approximately one hour in length. You would be asked to make collages as well as participate in an individual interview and two small-group discussions. All collage materials will be provided.

Compensation will be provided.

For more information about this study, or to volunteer for this study, please contact:

Olivia Strohschein
647-773-7096
olivia.strohschein@mail.utoronto.ca

Study conducted through the department of Curriculum, Teaching and Learning at the Ontario Institute for Studies in Education, University of Toronto.
Dear Participant,

You have been invited to take part in a research study about holistic and embodied approaches to eating disorders. You have been selected as a potential participant for this study because you meet the following criteria: you self-identify as a woman with an eating disorder who is between the ages of 18 and 30 and you currently reside in the Metro Toronto Area. Many eating disorders go undiagnosed and so a formal medical diagnosis of an eating disorder is not required to participate in this study; the requirement is that you recognize your body actions and attitude toward your body and eating as harmful to your overall well-being (emotional, mental and/or physical). The personal benefits of participating in this study might include the opportunity to engage your body in new and healthier ways through creative practice (making collages) with other individuals who also have eating disorders. Your participation in this study may also allow you to express and voice your experiences of having an eating disorder and the recovery process. While the personal benefits of participating in this study may be very minimal, your participation in this study is important to the eating disorders research. A goal of this study is to identify more effective ways of approaching eating disorder recovery and provide richer understandings of the development of eating disorders in relation to body experiences.

This study and its data collection is coordinated by myself, Olivia Strohschein, as my Master’s thesis research project. The overall purpose of this study is to examine the role of emotional and affective experience (experience related to the senses/physical body) in the development of eating disorders as well as its influence in the recovery process. These affective experiences will be researched within the context of identity and physical and emotional well-being. This research also explores the use of creative practices in/as eating disorder recovery. Your participation in this study would include attending three sessions held at the Ontario Institute for Studies in Education (University of Toronto), each approximately one hour in length. The first session will be a one-on-one interview asking about your experiences with eating disorder practices (e.g. how they make you feel physically and emotionally, what feelings or thoughts precede your engagement in these practices, how your eating disorder practices affect your sense of self, etc.). During this session you have the opportunity to choose a false name for the group sessions as well as a false name for the reporting of the data. Your real identity (your name) will only be known to myself. The second session will involve meeting in a small group (with two to four other participants) to make collages. The third session will also involve collaging with this small group, however, in this session participants will be asked to make a collective collage while discussing the use of creative practices in/as eating disorder recovery. Collaging materials will be provided (items such as newspapers, illustrated books/textbooks, maps, craft paper, tissue paper, etc.).

The individual interviews and group sessions will be audiotaped and transcribed. The collage sessions will also be videotaped, however, the camera will be recording the collages as they are created, not the participants’ faces or bodies. As principal investigator I will maintain strict confidentiality. There are, however, some limitations to this confidentiality; if there is reason to believe that you will harm yourself or others I am required by law to report this to the
appropriate authorities. By signing this consent form, you also agree to keep the identities of other participants confidential. Please note, however, that while all participants are required to sign this agreement, confidentiality can never be 100% guaranteed.

All data from this study will be secure, stored on an encrypted and password-protected computer which only I can access. A report of the findings of this study (upon completion of data collection and data analysis) can be made available to participants upon request. The risks of participating in this study are moderate and might include experiencing emotional and/or social discomfort while discussing your experiences with an eating disorder during the one-on-one interview and/or the group discussions. To minimize this risk, you have the option of declining any questions you do not feel comfortable answering during the individual interview or group discussions. I can also provide a handout listing some of the eating disorder support services that are offered in Toronto upon request.

Your participation in this study is completely voluntary. Please note that you have the right to withdraw from this study at any point throughout the research process without penalty or any personal consequence. You have the right to review the audiotape and transcript of your individual interview and request the omission of any (or all) of your personal contributions from the research data. There are some limitations, however, when it comes to your participation in the group sessions. While your creative contributions to the group collage will not be destroyed (as that would entail destroying the group collage), the details of your individual contributions to the collage will not be included in the research data. Moreover, any comments you make during the group sessions can be omitted from the transcript upon your request. While your verbal and creative contributions will still exist on the audio and video recordings, these contributions can be excluded from the transcripts and data analysis upon your request.

You will be given an honorarium (a $50 Visa Gift Card) for your participation in this study. If you choose to withdraw from the study, you will receive partial compensation. TTC tokens for transportation to and from these sessions can be provided upon request.

Please feel free to contact me with any questions that you might have while participating in this study:

Olivia Strohschein
olivia.strohschein@mail.utoronto.ca
(647) 773-7096

You may also contact my faculty supervisor:
Dr. Stephanie Springgay
stephanie.springgay@utoronto.ca
(416) 978-0195

If you have any questions about your rights as a participant please contact:
Office of Research Ethics (University of Toronto)
ethics.review@utoronto.ca
(416) 946-3273
Consent to participate:

I have read and fully understand the information and conditions outlined above. I have had the opportunity to ask any questions I might have regarding my participation in this study. I, ___________________________ give my consent to participate in this study. By signing below, I also consent to being audio recorded and videotaped as described above.

______________________________________________  ______________________
Signature of Participant                          Date
Appendix C: Interview Guide

Eating disorder practices are defined in this interview as harmful body management methods that you engage with on a regular basis and that you feel are part of your eating disorder. These include (but are not limited to) behaviours related to food consumption (restriction and/or binging), eating patterns or rules (the identification of “safe” or “bad” foods, following particular rules concerning the combining and measuring of food and/or timing of food consumption), compensatory methods (over-exercising, purging) and “checking” behaviours (excessively weighing and/or measuring your body). Interviews are generally unstructured but guided by the following questions:

Individual Interviews

Background: Eating Disorders and Identity
1. When did you first identify as someone with an eating disorder? Describe this situation.
2. Have you ever (past or present) received medical and/or psychiatric support for your eating disorder? If they respond with “yes”: Can you describe this/these experience(s)? How were they helpful? Unhelpful?
3. Have you ever at any point considered yourself recovered from an eating disorder?
4. Who or what has supported you in your eating disorder recovery?
5. Have you ever (past or present) engaged in artistic or creative practices as part of your recovery process? If so, describe these practices and how you have found them helpful/unhelpful.
6. What function did/does your eating disorder have in your life?
7. How do you think about your eating disorder in terms of identity? (For example, do you consider it to be a distinct identity? Part of your identity? Erasing or consuming your identity? Giving you identity?)
8. Does your eating disorder affect how you interact with or relate to other people? If so, how?

Affect and Eating Disorders
1. What often precedes your engagement with eating disorder practices? (For example, a thought, an emotion, a physical feeling in your body)
2. When you hear the expression “listening to your body”, what comes to mind?
   a. Can you think of a time when you listened to your body? Please describe this experience.
   b. Can you think of a time when you ignored your body? Please describe this experience.
3. How did eating disorder practices initially make you feel (either physically and/or emotionally)?
4. What bodily sensations do you associate with comfort? Discomfort? (For example, fullness after consuming a large meal, feelings of hunger or emptiness due to food restriction or purging)

Affect and Recovery
1. How do eating disorder practices make you feel now that you’ve chosen recovery?
2. How would you personally define recovery? How do you think recovery feels?
a. Can you describe an incident when a particular body sensation/feeling helped support you in your eating disorder recovery?

3. How would you personally define relapse? Can you describe how relapse feels?
   a. Can you describe a time during recovery when a physical sensation (such as how your clothes fit or particular digestive symptoms/experiences) caused you to relapse (i.e. turn back to eating disorder practices)?

Focus Group

1. Have you found collaging helpful in your eating disorder recovery? Unhelpful? Can you please describe your experience with these collaging sessions?
2. Do you think you will continue to make collages after this session?
3. We made individual collages last session and made a collective collage this session. Do you have a preference when it comes to collaging? If yes, describe why you feel this way.
Appendix D: Rules for Group Sessions

It is important that these group collage sessions are an inviting and safe place for all participants. As such, certain rules must be followed.

1. Please refrain from having detailed discussions about eating disorder practices. This includes conversations about numbers (such as weight, body measurements, nutritional values of food, exercise goals, etc.) or eating disorder “techniques” (such as those related to food restriction, binging, purging, etc.). While conversations of this nature are acceptable within the individual interviews, I please ask that you do not discuss such sensitive material during the groups sessions as these kinds of conversations can be very triggering for some individuals.

2. Only water will be provided at these sessions. This is because I understand that having particular foods available or offered can be triggering for some individuals. You are allowed (and encouraged!) to bring your own snacks and non-alcoholic drinks to these sessions.

3. You are expected to uphold the confidentiality agreement as outlined in the signed consent form.

If at any point throughout this study you have questions or concerns regarding these rules or the group sessions, please do not hesitate to contact me:

Olivia Strohschein
Olivia.strohschein@mail.utoronto.ca
647-773-7096
### Appendix E: Eating Disorder Support Services

| Central Toronto Community Health Centre | Free (OHIP) Through Intake | 168 Bathurst Street, Toronto, ON M5V 2R4 | Phone: (416) 702-6326 | Fax: (416) 703-8479 | Website: www.ctchc.com |
| Centre for Addiction and Mental Health (CAMH) | Free (OHIP) Referral from doctor & Self-referral | 100 Stokes Street, Toronto, ON M6J 1H4 | Phone: (416) 535-8501 ext. 6482 | Fax: (416) 595-6821 | Website: http://www.camh.ca/en/hospital/care_program_and_services/addiction_programs/Pages/guide_eatdis_addiction_clinic.aspx |
| Sheena’s Place | Free Self-referral | 87 Spadina Road, Toronto, ON M5R 2T1 | Phone: 416-927-8900 | Fax: 416-927-8844 | Website: www.sheenasplace.org | Email: info@sheenasplace.org |
| Toronto General Hospital | Free (OHIP) | 7 Eaton South/8 Eaton North, 200 Elizabeth Street, Toronto, ON M5G 2C4 | Contact: Penne Charest (Intake Coordinator) | Phone: (416) 340-3041 | Fax: (416) 340-4198 | Website: http://www.eatingdisorderuhn.com |
| Annex Therapy Centre | Sliding Scale Self-referral | 176 St. George Street, Toronto, ON M5R 2M7 | Contact: Rowesa Gordon | Phone: (416) 488-1928 |
| Hillcrest Centre for Health | Sliding Scale Self-referral | 832 St. Clair Avenue West, Toronto, ON M6C 1C1 | Contact: Misha Capler | Phone: (416) 660-6415 | Website: www.hillcresthealthcentre.com/our-team.html |
| Room for Growth Counselling | Sliding Scale Referral from doctor & Self-referral | The Annex Neighbourhood | Contact: Arno Lowi | Phone: (416) 532-4769 | Website: www.roomforgrowth.com |

### OTHER FREE COUNSELLING AND HEALTH SERVICES

| Centre Francophone de Toronto | Free Referral from doctor & Self-referral | Two locations: Bay Street & Fairview Mall Drive | Contact: Catherine Couture | Department: Health Team | Phone: (416) 922-2672 ext. 242 | Website: www.centrefranco.org |
| Native Women's Resource Centre of Toronto | Free Self-referral | 191 Gerrard St. E., Toronto, ON M5A 2E5 | Phone: (416) 963-9963 | Fax: (416) 963-9573 | Website: www.nwrct.ca |
| Women's Health in Women's Hands | Free Self-referral | 2 Carlton Street, Suite 500, Toronto, ON M5B 1J3 | Contact: Linda Cornwell | Phone: (416) 593-7655 ext. 416 | Fax: (416) 593-5867 | Website: www.whiwh.com |
| YWCA Toronto | Free Self-referral | 177 Caledonia Road, Toronto, ON M6E 4S8 | Contact: Dawn Philips | Department: Choices for Living | Phone: (416) 961-5446 | Fax: (416) 961-6822 | Website: www.ywcatoronto.org |

Many colleges and universities offer free counselling to registered students. Please visit your school’s website for more information if applicable. The resources listed in this handout have been collected from the National Eating Disorder Information Centre (NEDIC) website. For more information about eating disorders and support services offered in Toronto, please visit the NEDIC website at: http://www.nedic.ca/providers/on/toronto.