

**DISORDERING 'ORDER'; LEARNING HOW TO EAT IN RECOVERY FROM AN EATING
DISORDER**

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ABSTRACT

This ethnographic study explores the everyday experiences of recovery from an eating disorder. The fieldwork took place in Toronto and Ottawa, Ontario, Canada over a 4 month period in 2013. It involved interviews and participant observation with 12 women who were in various stages of recovery, as well as a reflexive component based on the researcher's own experiences of recovery. The aim of the study was to uncover what it meant to recover from an eating disorder in terms of everyday eating. Specifically, "How did those in recovery learn to eat?" and "Were they learning to eat in an 'ordered' way?" The findings reveal there is a complex and challenging route to 'ordered' eating in Canadian society. Contemporary dietary practices compete for authority and popularity while simultaneously offering completely different ways of relating to and knowing food. Those in recovery are therefore lost in a maze of options telling them how to eat 'right' which further isolates them. The study shows however that learning to eat in recovery is not about eating in an 'ordered' way but more so about situating one's self in contexts and within relationships; moving with food. It suggests that a way of moving forward in recovery is to let go of the correct 'order' to eating and to move forward in its continual making and unmaking.

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*

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~

What does it take to grow, to learn, to become something more;
Its takes the nourishment of a mother who understands you completely,
The intelligence and passion of a mentor who inspires you
and the good humour and intellectual challenge of a community.

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I've grown into someone that I was scared to be before
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PREFACE

When I was 16 I couldn't eat food 'normally' any more. In fact every meal was a battle, and I only ever won after forcing the food back out of my body; it was the only time I felt soothed. I knew I was bulimic, and I knew I was horribly unhappy, but I just could not stop. For 6 years I tried to stop. In fact, I would say that I had an eating disorder for 2 years of my life, while I tried to escape one for the following six. In fact, sometimes I still get cravings for the sensation of binging and purging, as if my whole being would just feel so at home if I could go back to it. But I won't go back. Something has irrevocably changed in how I can sense that craving. This is how I know things have changed.

In the past 5 years I have done a lot of writing and reflecting on life after an eating disorder. I just didn't know whether I was recovered. I certainly didn't think that I ate 'normally'. In fact, the way I learned to eat in treatment made me feel extremely abnormal. I planned and organized everything I ate into food guide recommendations. I never let myself over-eat and I never skipped a meal. I made "healthy" choices, but I always worried they were perhaps too healthy and were therefore too close to my old disordered ways of thinking. I had to refuse or strategically attend a lot of social situations and workplace environments with food and I often felt like the only person in the room who needed to eat every few hours. I started to question everyone around me and how they ate. And then I started to question who was normal.

This is where I gained a firmer grasp of recovery. Certain experiences with food stand out and have become, for me, important testaments of not just eating normally, but eating well. They are moments in which I felt a subtle transformation in the way I related to the world, especially the world of food. The ways in which I felt my body and sensed the food I was eating changed. I noticed new ways of experiencing the senses, especially hunger and fullness, and often these

experiences were connected with the people and things around me. I stopped seeking a pre-existing 'normal' way of eating by trying to locate what was normal in context. I started to understand both food and the experiences of my body in a wider context of relation and place. And I relearned how to eat with ease, with gusto, with empathy, with compassion and with joy. I look around me, however, and I see a lot of people not eating in this way. I worry about the prevalence of disordered eating, as well as the general anxiety about 'eating right' that seems to characterize popular health discourse in the North American context. For that reason, I turn to the once disordered, now recover-ed/ing to see what they have learned. What is *ordered* eating?

INTRODUCTION

“Will I ever eat ‘normally’ again?” “Will I ever be recovered?” These are questions commonly posed by those in recovery from an eating disorder, including ones I posed myself. An eating disorder severely disrupts one of life’s most common activities, eating, and even after one no longer *has* eating disorder behaviors, they may continue to question whether their eating is ‘normal’. Yet it is difficult to know what is ‘normal’ or ‘ordered’ eating in Canada. In fact, those in recovery interact with a variety of competing dietary approaches as they struggle to change their eating practices. What is a ‘healthy’, ‘natural’ or ‘ethical’ diet is contested. It is also a topic of immense popularity as every year more information about food and health is propagated through research, media, and government institutions (Coveney 2006, 94). Since many dietary approaches set themselves up as the ‘correct’ or ‘healthy’ way to eat, it can sometimes seem unclear then which ‘order’ to follow.

One discipline does stand out though as having the most authority on the ‘healthy diet’ in North America and that is the discipline of nutritional science. Nutritional science is used to teach particular practices of learning about food based on biochemical and epidemiological research (Mol 2013, Rappoport 2003). It is for example taught in eating disorder treatment programs with tools such as the Canadian Food Guide (Appendix I). This guide recommends how many servings of food an average person needs to meet minimum nutritional standards. The approach assumes that simply having information on food will make one eat accordingly, regardless of how this information unfolds in everyday practice.

More recently, alternative dietary approaches that offer a more ‘bodily’ focus have both challenged, as well as been integrated, into the field of nutrition. These approaches offer practices of attuning to bodily and sensory cues in order know how to eat (see Tribole & Resch 1995, Croll

2010, 130-140). In fact, an 'Intuitive eating model' has recently gained recognition in eating disorder treatment (Tyla & Wilcox 2006). Yet Mol, along with other authors, has demonstrated that these dietary techniques are rooted in very different ontological and moral assumptions about health, food and the human mind & body than are the dietary techniques in nutritional science (2013, Coveney 2006). In effect, important contradictions are at stake for those in recovery as they attempt to navigate the waters of 'healthy' eating in practice.

Following Mol, I will therefore explore how different dietary techniques and practices frame food and the human body in unique ways and how difficult it is for those in recovery to make sense of these practices (2013). I wish to demonstrate how the 'order' of eating is not pre-existing but rather comes into being by doing. For this I draw from a phenomenological approach in anthropology in which, "Life is not the revelation of pre-existent form but the very process wherein form is generated and held in place" (Ingold 2000, 173). This perspective takes as its point of departure "the agent in its environment" creating the world as it is lived, as opposed to the self-contained individual confronting a world 'out-there" (ibid). From this perspective, to learn to eat is therefore not to apply information to an already established reality, but rather to situate information in particular environments through a bodily and relational engagement with the world.

Ingold argues that meanings are not attached by the mind to objects in the world, rather these objects take on their significance in their incorporation into a pattern of day-to-day activities (ibid, 168). The only way to explore how those in recovery learn to eat is therefore through an engagement with their day-to-day eating practices. It is my hypothesis that contemporary approaches in dietary advice perpetuate an ideal 'order' of eating, and not only that, but an order that is circumscribed within the individual mind/body as against the world out

there. Since food is however a largely social domain (Lupton 1996) and eating practices are always changing (Rappoport 2003) I will use this theoretical framework to reimagine recovery as a process of situated and skilled activity in which 'orders' are always being made and remade. I have attempted to better understand and bring light to experiences of learning to eat by asking the following questions:

What is 'ordered' eating?

How do those in recovery learn how to eat?

And, How can recovery be conceptualized as a forward movement with food?

Ingold makes a distinction between two orientations of research; one looking forward and one looking back (2011) . The backward looking glance is more common in that it allows the researcher to look back analytically at the stillness of discernible patterns and end-points. The forward looking orientation is one in which movement continues, reality is always in flux, and in the process of becoming. Conventional research with those with eating disorders uses participants to extract information and then describes that information, recreating models to apply in the lives of others. I would like to advocate an approach in which both the researcher and the participant continue to look and work forward towards new ways of becoming. The goal of this approach is not to observe, and then describe a world that has already taken shape, a reality that exists out there, but to "join with things in the very process of their formation and dissolution" (2011, 2). I hope to join into this movement by asking how recovery from an eating disorder can be understood as a process of learning with food rather than learning the 'ordered' way to eat. This project is inspired by my own journey with bulimia and the difficulty of recovery.

It is consequently an ongoing conversation, one which, I believe, continues to fundamentally change both researcher and researched.

The thesis will be organized in the following way. In this first chapter I introduce classical and alternative dietary practices as the types of eating 'orders' which those in recovery are taught in Canada. Here I will attempt to uncover different assumptions about food and the mind and body, that inform these contemporary dietary techniques. In the second chapter I will develop a theoretical framework to explore what it means to learn and know food. I will attempt to place learning about food and eating within a more sensory and environmentally-situated context. In particular I elaborate on Tim Ingold's theory of learning within an environment (2001, 2013) in order to imagine learning to eat as more than a particular ordering of food, but rather as a development of skills in practice.

In the third chapter I will address the field site, field experiences, and the use of participant observation, interview and reflexivity for this project. The fourth chapter, the first section of analysis, will draw the reader into the confusing experiences of recovery as participants and myself attempt to make sense of how the mind, the body, and food are experienced in learning the 'orders' of eating. The contradictions in dietary techniques and our interactions with them will be made clear. In the fourth chapter I will address the ways participants situate themselves in environments and with particular skills, a process of learning which allows them to transcend these contradictions, including ways to look forward in recovery. I will then conclude with how this process of learning is significant not only to a better understanding of recovery, but also to our relations and interactions with and around food..

CHAPTER 1 EATING 'ORDERS'

My interest in how people with eating disorders come to recover, as they establish 'normal' or 'healthy' relationship with food requires me to first situate what these terms mean in North American society. Since nutrition has become the dominant discourse connecting food and health in the past century, it is where I turn first. After providing a brief introduction to the diagnosis of eating disorders, I will explore how nutritional science has come to be the dominant discourse around food in treatment, as well as in society more generally. I will then offer alternatives in nutritional science which have become quite prominent in their influence on treatment and how those in recovery talk about food. I hope to compare both classical and alternative approaches in order to see what this means for food and bodies as well as for those in treatment.

1.1 Classical Approaches to Eating Disorders & Food

1.1.1 Diagnosis & Recovery

Eating disorders are diagnosed as mental disorders according to the American Psychological Association Diagnostic & Statistical Manual of Mental Disorders (APA 2013). There are three major subtypes: anorexia nervosa (AN), bulimia nervosa (BN), and binge-eating disorder (BED was added in 2013; DSM-5 Fact Sheet, 2014). Although these disorders are different, they share common symptoms. They are all associated with an intense preoccupation with eating, shape and weight, a fear of gaining weight, and/or a distorted body image. Those with eating disorders exhibit a tendency for self-appraisal based entirely on their weight and body shape (Fairburn et al. 2003). This preoccupation can make it difficult to function in every day situations, notably those around food.

Those diagnosed with anorexia exhibit excessive dieting that leads to severe weight loss

and is accompanied by an intense fear of gaining weight. Until the 2013 edition, one of the symptoms of anorexia was amenorrhea, loss of menstrual cycle, which has since been removed given its exclusion of men and non-menstruating women (DSM-5 Fact Sheet 2014). Bulimia Nervosa is diagnosed when someone has repeated episodes of bingeing on larger than normal amounts of food followed by acts of purging, such as through laxatives, vomiting, or prolonged periods of exercise. Binge eating disorder is diagnosed by the repeated incidence of eating larger than normal amounts of food followed by feelings of lack of control and intense emotional distress (Devlin et al. 2010). These are ways the disorder is classified by the biomedical profession.

That being said, some authors argue that biomedicine can neither adequately explain, nor rigorously define eating disorders (Agras et al. 2004 in O'Connor & Van Esterik 2008, Kraatz 2006). Overlap or movement between diagnostic categories, say from anorexia to bulimia, is common (Devlin et al. 2010). Until the most recent edition of the DSM, Eating Disorders Not Otherwise Specified, EDNOS, was a category in itself. Those with eating disorders are also frequently treated for other mood disorders including depression and obsessive-compulsive disorder (Walsh 2002). More importantly, there is no etiology or set cause of an eating disorder, and there is no agreed upon cure (Rumney 2009). Professionals in the field continue to debate the degree of psychological, genetic, and socio-cultural influences on the disorder.

The original name of anorexia nervosa, the first eating disorder diagnosis, comes from an earlier genre of hysterical disorders and was first diagnosed in the 1860s (Brumberg 1989). The disease then all but disappeared in the 20th century until the 1980s when its incidence started increasing at a rapid rate, inspiring one of its most dedicated researchers to label it a 'new disease' which "selectively befalls the young, rich, and beautiful" (Bruch 1978, xix). The criteria

of the disorder changed, as hysteria was no longer a scientific classification, but its name remained the same. Bulimia was also created as a diagnostic category in the 1980s in order to accommodate the compensatory behaviors that patients would use when they did eat food (Brumberg 1989). The classifications continue to change as new symptomology and criteria for recovery are developed.

According to Garrett, research on recovery from an eating disorder tends to be in two types, “‘empirical’ (attempting to measure recovery) and ‘phenomenological’ (understanding recovery in terms described by those who experience it)” (1998, 63). For the former, measurable criteria is notably difficult to define (Bardone-Cone et al. 2010). The most widely recognized strategy for determining “clinically significant change” in recovery was created by Jacobson and colleagues (Anderson & Murray 2010). There are two criteria. The first is measurable change in symptomology; i.e. the reduction of behaviors such as restricting, bingeing or purging. The second is more psychological.

The second criteria, one which is perhaps more interesting anthropologically, is that, “By the end of treatment clients should end up in a range that renders them indistinguishable from those in the normal population” (Jacobson et al. 1991 in Anderson & Murray 2010). This brings in a host of further complications when measuring normal, which in a clinical example, would be found through a random sample of the population. For example, body image dissatisfaction is a symptom of both AN & BN. Yet some level of body image discontent is normative in the general population (Rodin, Silberstein, & Striegel-Moore 1985 in Anderson & Murray 2010). So although many psychologists agree that, ideally, recovered patients will not have a high level of body image dissatisfaction, others suggest this is not a necessary criteria for recovery (Anderson & Murray 2010).

Numerous studies have shown for example, that those recovered from eating disorders still maintain an elevated level of perfectionism (Bardone-Cone et al. 2010). According to Bardone-Cone et al. many studies “have defined recovery based on physical measures (e.g., weight, menses) and behavioral measures (e.g., no binge eating) with no mention of cognitive aspects related to eating disorders (e.g., body image concerns)” (2010, 140). Some studies, such as the one by Bardone-Cone et al. use a combination of physical measurements as well as a specific score on the Eating Disorder Examination- Questionnaire (EDE-Q) which assesses psychological aspects of eating disorders based on the general population (2010). These are however the clinical assessments of recovery, used predominantly to measure the success of treatment models and although they are often given more weight epistemologically, they may not be entirely relevant to those actually suffering from an eating disorder (Garrett 1998). In fact most of my participants, including myself, had no idea which official criteria rendered them ‘recovered’.

Clinical markers of recovery around eating are concerned mainly with symptomology. That is, namely, the absence of behaviors that classify an eating disorder in the first place; such as dieting, bingeing and purging (Tylka & Wilcox 2006). As Kraatz argues, an eating disorder diagnosis should be mainly understood as engaging in certain behaviors, a person is not themselves disordered, but rather engages in practices of disorder eating (2006). Recovery involves the lengthy process of stopping these behaviors, although many would argue that the psychological and spiritual aspects of recovery are where those with eating disorders actually learn to live in healthy way (Kraatz 2006, Garrett 1998). Although it is debatable whether eating disorders ever ‘end’, in certain estimates the average life-course of bulimia is 8.3 years (Hudson et al. 2007) and for anorexia, it is more than a decade (Keel 2010). From more of an anthropological perspective, recovery means not only a cessation of symptoms, but also a degree of re-integration in life. As

Good has argued, “Disease occurs not in a body, but in life” (1994, 133) and this is particularly relevant for those with eating disorders as they learn to eat ‘normally’ in everyday situations. In order to understand recovery I am attempting to study it ‘in practice’, ‘in life’. The fact that dietary techniques are very complex in practice makes the concepts of ‘recovery’ and ‘recovered’ eating an important area of exploration.

1.1.2 Nutritional Science; Training the Mind to Train the Body

Those with eating disorders are not the only ones who struggle with eating. In fact nutritional science, the science of food, has a significant place in the 20th century. This is precisely because from a public health perspective, the Canadian population is not, or has not been, eating enough ‘healthy’ food. As those in recovery embark on a journey of ‘healthy’ eating, it is necessary to situate ‘healthy’ in this larger social context. Currently nutritional information and standards saturate much of public life, from bus ads to food labeling. Yet, the saturation of the public with nutrition is a relatively recent phenomenon, as the science of nutrition is itself quite young.

This science of food was founded in the late 18th and early 19th century in a collaboration of scientific developments, moral ideologies, and increasing government institutions (Coveney 1991). Developments in organic chemistry, as well as calculations of the essential food needs of humans in institutions such as jails, armies and workhouses, led to the creation of universal standards of food and health. At the time, certain moral discourses around diet were prevalent. Coveney argues that a Christian ethic of self-perfection had a significant impact in positioning eating non-nutritious or ‘sensuous’ food as gluttonous and immoral (1991). Combined with the influence of new scientific understandings a moral economy of nature was thus created around

food (Aronson 1983 in Coveney 1991). In other words, to eat too much, especially too much 'sensuous' food, became both sinful and inefficient; it was wasteful. It is within this framework that the first regulatory standards were developed to control how populations ate.

Nutritional science grew in importance for North American governments in the early 20th century as their populations started showing signs of malnourishment despite being well-fed (Levenstein 2003). This coincides with the growth of an industrial food system supplanting local and market-based food supply chains. Highly processed foods became more affordable, and more desirable, than fresh produce. In effect, populations seemed to be eating not enough nutritious food and not getting enough basic vitamins (other than basic vitamins and caloric requirements little else was known about nutrition at the time). It was t in the second World War that nutritionists came up with the "Basic Seven food groups" - a forerunner of the modern food pyramid (Bentley et al. 2002). Dividing food into seven groups was meant to teach people to eat food from each group, and not just some of the groups, in order to address the problem of malnutrition. Specific amounts were later added as seen in the version in use now.

The current Canada's food guide is published by the Government of Canada's Department of Health. It exists to teach Canadians the proper way to eat (Appendix I). It is taught not only in eating disorder treatment programs, but in schools, daycares, health centers and public institutions such as hospitals and cafeterias. According to the Food Guide's official website, it exists to "help you and your family know how much food you need, what types of foods are better for you, and the importance of physical activity in your day" (Health Canada, *Eating Well with Canada's Food Guide, 2011*). The guide is based on both nutritional science as well as epidemiological data. Hence, it relies on scientifically established nutrient standards for each person, as well as evidence linking particular diets to a reduced risk of chronic diseases (Katamay

et al., 2007). The Food Guide has been adapted into different cultural versions¹, is required in product labeling, and has been taken up by numerous marketing campaigns presumably all to help Canadians make better choices². The food guide is meant as a general guide for all of Canadian society.

From a Foucauldian perspective, Coveney argues that nutrition is a technology of power, one that should be seen not as oppressive or restrictive, but rather productive in creating ever more particular subjectivities for individuals, populations and governments (2006, 109). I am interested in teasing out these new subjectivities that are produced by nutrition, especially as they continue to change in light of new ideas and food movements. Mol addresses the same issue, but with an ontological focus. She therefore looks at how dietary techniques such as those of nutrition shape what type of matter food is, as well as what type of bodies and health are enacted in its practices (2013). I find these approaches particularly useful in exploring how North American society came to understand and 'enact' food in particular ways with the advent of nutritional science. This is in turn important in understanding the context for how eating practices take shape in recovery.

1.1.3 Ontological & Moral Questions

The current version of the Canadian food guide is working off certain assumptions about how we know food that need to be explored. For one, nutritional science operates on the premise that the population is not eating the right food for the function of their health. Mol argues this is a biophysical break-down of food in which food is fuel. Take for example, how we measure it as

¹ Interestingly enough, all of the culturally-adapted food guides include peanut-butter

² My favourite example being the *Guiding Stars* points system available at my local supermarket in order to simplify nutritional information into a scale of 1,2, or 3 stars. <http://guidingstars.ca/>

energy (Mol 2013, 383). Put simply, (and it has been put this way to me by a sports educator) if more energy is brought in than used, one gains weight. This situates all bodies as measurable within universal categories, akin to machines. In fact, there are very minimal differences in the recommendations of serving sizes according to age and gender within the food guide. It is assumed that all men or all women require the same amounts of, and types of, food. Certain body weight indicators, such as the BMI, are then used by medical professionals to analyze whether the individual has followed these guidelines or not. The individual or subject, is made into an object through knowledge about the size and shape of their bodies as well as the portions and types of their food (in relation to recommended values) (Coveney 2006, 104).

Eating 'right' requires calculation and self-monitoring. As Mol points out, the biophysical model assumes that without this information bodies inherently overeat (2013). Which means, food must be more than just fuel or else humans would have no problem eating efficiently. Which is true, food is not just an energy source, it is also part of an aesthetic domain. Food is also located in the realm of pleasure. Mol thus concludes, that based on this guide, and according to nutritional science, if food is both fuel and pleasure, one must over-rule the other. The ontological assumption of nutritional science is that the mind must over-think the "pleasure-seeking body" in order to not waste (Mol 2013, 383). As we can see, this enacts a particular type of efficiency in eating.

In nutrition, food is notably also categorized into health risks. Using epidemiological research, foods are turned into objects and thus correlated with health variables such as chronic disease or long term survival (Mol 2013, 384). These food objects are then 'listed' into healthy or unhealthy categories, notably 'good' or 'bad' foods. Even within the current food guide, one can note the small box to the side meant for oils and fats; as if purposefully excluded from the

balanced diet. Warin argues that this is an example of delegitimizing foods that are seen as 'unhealthy'. In this case it suggests that fats are not a valuable part of daily consumption (Warin, 2001,103). This division exists because fat has been linked to disease. One might also notice that there is no space for dessert foods or beverages on the guide, suggesting these are the 'bad' foods which should not be eaten regularly. Mol explains that the values of healthiness and desirability in this model, "Are staged as being in tension" (2013, 384). What is good has to be worked for, what is bad, needs to be resisted or outright ignored.

Coveney argues that individuals in many Western societies spend more time than ever before considering the nutritional values of food choice (2006). With each new discovery, foods become known for their vitamin or antioxidant levels, and then becomes a means to an end for say, strong bones, or healthy teeth (Lupton 1996, 7). In this biochemical model, foods are not foods anymore, they are nutrients (Pollan 2008) and the mind must know nutrient guidelines or the body will inherently tend towards the 'wrong' foods (Mol 2013, 385). It is necessary that people read labels of simplified scientific measurements to make sure they get such vitamins and fiber, or protein and starches, from multiple sources. In fact, the information about food and health available augments every year with an increased flow of research, government and media attention (Coveney 2006, 94). Nutritional advice is now propagated through a variety of professions and groups from community leaders, social workers, pharmacists, dentists, and physical educators. The information 'out there' steadily increases as does the type of professional involved in its dissemination and, this information is presented as the only way to mediate food choice.

In fact, with increased epidemiological data that linked food practices to health outcomes, Coveney argues that the individual subject of nutrition was re-conceptualized as "naturally

unhealthy”, prone to poor choices due to these ‘risky’ behaviors (Coveney 2006, 100). Hacking has shown, the idea of ‘normal’ which comes from epidemiological research has shifted a statistical average from not only a representation of good health, but an aspiration of which all individuals and societies ‘should’ strive. The idea of ‘normality’ closes the gap between what “is” and what “ought” to be and so has a moral quality built into it (Hacking 1990).

The terms ‘good’ and ‘bad’ food are significant, for example, in how they suggest individual accountability for food choice on health. According to Coveney, expressions like “you don’t need that’ are reminders of the ethical obligations of modern subjects (2006, 136). There is a moral fortitude in having to ‘overcome’ cravings or dependencies. As Cohen has shown with his work on diabetes, biomedical interactions around food, which stress self-care, appear to offer advice and claim to offer “empowerment” by giving patients the necessary information to take responsibility over their own health. Cohn argues however that this approach transfers not only information but also obligation (1997). Thus ‘to advise’, is to attribute a moral attitude to the state of the body and the self in the world (ibid,197). The science of nutrition is significant then in how it positions the mind as moral subject and the body as the object of moral action.

Yet the obligation of health is not the only moral claim underlying food choice. Of utmost significance to this research inquiry is that a very clear ontological claim is being made; “Eating well depends on cognitive control over the pleasure-seeking body (Mol 2013, 386). This ‘staging of food’ reflects the origins of nutritional science in moralistic discourses of restraint and purity (Turner 1982 in Coveney 1999). In fact, nutritional science has been critiqued for feeding into a moralizing discourse of food as an indulgence (Glasner 2007), and particularly for women, one which requires self-control (Gremillion 2003). To eat ‘good’ food is to be a ‘good’ person, and by good, meaning someone who is will-powered, self-controlled, and self-regulating (Coveney 2006).

Warin found this particularly noticeable even in eating disorder treatment facilities, where discourses around fat, and ‘good and bad’ foods were used by health professionals (2010). The discussion of ‘bad’ foods or ‘bad’ fats in a context where many anorexic patients exhibit the symptom (DSM-4) of a fear of fat is seemingly contradictory. Surprisingly, she found that these concepts of food and fat were taken for granted as universally understood. This may suggest that the ethics of nutrition are naturalized as what is ‘healthy’.

The following assumptions 1) that eating is an efficient means to an end; health, 2) that food is available and distinguishable by its nutrient and chemical properties and 3), that eating is something to be ‘managed’ are built into this approach (Lupton 1996, 114; Warin 2010, Mol 2013). The first two assumptions rely on a scientific epistemology of which food and health are first quantifiable and second, relational, empirically. The third assumption then places the responsibility for health outcomes on the ‘rational’ individual. Once provided information, individuals are encouraged to make ‘informed choices³’ assuming information is knowing and thus will translate into practice.

To not explore these underlying ontological assumptions however, would assume that they are the most ‘natural’ way of ‘knowing’ food, which is how a scientific epistemology sets them up. Mol argues however that we must look at how professional and scientific approaches coordinate contrasting versions of reality in order to understand how they are not unified nor the most ‘real’ (2013). For example, a type of food in disease is being ‘enacted’ in epidemiological research, while a type of food molecule is being enacted in each new nutrient discovery. They are different ways of knowing food; different realities, yet these realities come together in a particular way in nutrition. Mol’s argument in which ontology has become multiple, encourages

³ A recent example; The current City of Ottawa health campaign in public buses pictures a sandwich under a magnifying glass. It reads “Food labelling helps you make informed choices”.

us to ask “about the ways in which contrasting versions of reality come to be *coordinated* in scientific and professional practices” and therefore which types of reality are being enacted and then valued over others (2013). The classification of reality which epidemiological or biochemistry research allows, is a particular ordering of reality which should not be confused with what occurs in practice. As many medical anthropologists have shown, the realities of which a scientific lens captures, are always then enacted within specific culture contexts (for an example see Lock 2001).

Nutrition therefore sets up a particular way of enacting food which assumes that with ‘ideal’ information, corresponding practices of self-control and self-restraint will follow. What is more disturbing is that these same ontological assumptions around eating may be at work in the development of disordered eating in the first place. For example, O’Connor & Van Esterik have argued that modern-day anorexics are largely pursuing aesthetic ideals in which not eating inspires feelings of self-control and self-restraint (2008). These are the same values coded into nutrition as a science. This seems in line with Gremillion’s finding that the same dominant cultural discourses around individualism, self-control, and ideal-fitness, that give rise to the conditions of possibility for anorexia, were in fact recreated in treatment models in the United States (2003).

1.1.4 Nutrition in Eating Disorder Treatment

The context of nutritional science is especially relevant to this study, because it dictates the way food is talked about in health care settings and in eating disorder treatment. Warin’s research in the UK, Canada, and Australia suggests that nutritional science is the “common currency of language about food and nutrition” in treatment centers (Warin 2010, 99). However,

because those with eating disorders already have a preoccupation with food and eating, nutritional information is used in specific ways in eating disorder treatment to try not to foster further preoccupation (Ashley & Crino 2010, 156). This I will explore below.

As one treatment manual explains, those diagnosed with eating disorders need to be "given permission to eat more, to enjoy their food, and to settle for 'good enough' eating and normal weight" (Hart et al, 105, 2006). This is perhaps an opposite use then that associated with much of the nutritional education in society which addresses another problematic category, that of 'obesity'⁴. On the contrary, it is assumed that those with eating disorders attempt to eat 'perfectly' or are overly-concerned, if not obsessed, with food. Those giving nutritional advice are advised to "Convey principles rather than rigid "rules" to avoid reinforcing the patient's compulsive rituals and preoccupation with food (Castro et al., 2004 in Hart et al. 2012). Health practitioners must therefore emphasize to those trying to recover that eating does not have to be perfect, because it is for enjoyment as well as health, thus modifying their own approach.

This suggests that In treatment, the dichotomy that Mol pointed out in which the rational mind is staged as being in tension with the pleasure-seeking body, is therefore minimized. It is rather the 'disordered' and obsessive person, who attempts to eat perfectly, that is the problem. Within conventional treatment, an eating disorder is a matter of 'faculty cognition' (Malson 1998, 128) rather than a logical adherence to an aesthetic or moral regiment, that reflective of nutrition itself, in which those with eating disorders, perhaps, excel. In this sense, by following some of its dictates, or 'ideals' shows this paradigm to already be a part of the problem. within biophysical, epidemiological and biochemical models, the food guide has certain ontological assumptions

⁴ In fact a recent Globe & Mail article highlighted that the use of nutrition programs in schools to curb growing obesity rates has received some opposition from those working on the prevention of eating disorders
<http://www.theglobeandmail.com/life/health-and-fitness/link-to-eating-disorders-raises-concerns-about-school-health-programs/article11857923/>

about the mind's obligation to overpower the body (Mol 2013) making it a particular way of knowing food. The recognition, however, that this discourse problematizes a pleasurable and more ecologically-based relationship to food, has led to the development and growth in popularity of alternative dietary discourses. These alternatives are where I turn next.

1.2 Alternative 'Orders': Training the Mind to Train the Body to Feel

Nutritional science is not a static discipline. In fact research on food and health is a fast-growing field of which a variety of professionals now concern themselves (Coveney 2006). There are consequently important counter-discourses to dietary advice, which have shaped both the field of nutrition as well as public discourse. Rather than look at foods as fuel, or as simply nutrients in the service of 'good or bad' health, new metaphors have emerged which emphasize food as bodily experience, as an ecological relationship, and as pleasure (van der Weele 2005, Coveney 2006, Mol 2013). These alternatives attempt to make relevant that which has been 'bracketed off' by the reductionist approach of classical nutritional science.

For example, Annemarie Mol's work with nutritionists in the Netherlands has explored the emergence of an "Enjoy what you eat" camp (Mol 2013). Van der Weele has also identified a dietary movement which pays more attention to emotions and bodily experience, those formerly disregarded aspects of food (2006). Certain social movements have also influenced these dietary approaches; these include Wholefoods, Slow Food, and a culture of eating as art (van der Weele 2006). Finally, Garrett has argued that in both clinical and popular psychology, certain ideas rooted in Eastern philosophy, and the New Age movement, have strengthened the commitment to bodily experience found in new alternatives to diet and wellness (Garrett 1998). The conjunction of these multiple discourses makes an interesting appearance in eating disorder

treatment, as well as in the way those in recovery speak about and experience food ‘through their bodies’.

1.2.1 Food Movements; Reactions to Industrial Food Practices

One of the first counter-discourses to nutrition arose with the Wholefoods movement and its critique of processed foods. Wholefoods get their names from the claim that non-processed, organically grown foods have more nutrients and were more healthful than industrially manufactured and farmed foods. Beginning in the 1960’s, this movement thus adopted quite orthodox nutritional terms in promoting the wholefood diet. It, for example, used conventional nutritional requirements to argue that modern foods not only lost many nutrients, but also added potentially harmful new ingredients, through technologies of processing and preserving (Coveney 2006).

Thus the concept of ‘natural’ food was born (Coveney 2006). Its legacy continues in ‘natural’ food stores which offer organic and whole foods, including grains and seeds, but also fill the market niche for supplements, vitamins and minerals which are seen to be lacking in the modern food system. Certain products are also sought out as more ‘natural’. In the modern wholefoods movement, there is an ethos of returning to bygone days of whole foods when food and the body were more ‘natural’ and free of modern processes and chemicals. This is especially apparent in wholefood publications which refer to modern chemicals as ‘toxins’ in the body. What is interesting in this ‘counter discourse’ is its development of an ‘Ethics of whole foods’ in which nutritional standards remained the terms. The ethics were shifted towards food quality and food goodness or ‘naturalness’ rather than just nutrients, but the basis for eating, namely in the function of health, remained the same (Coveney 2006, 112).

The benefits of an industrial food system grew enormously in 19th century North America due to both convenience and novelty. Longevity in storage, and standardization, and pre-processing became some of this system's highest values. Fresh produce became the novelty, and food not implicated in industrial processes became 'natural'. In this transformation, food in North America was marketed in order to accommodate the busy lives of consumers, those too busy for 'menial' tasks such as preparation and cleanup (Heldke 1992, 207). The values of an industrial food system thus removes consumers from the temporality of food, the specificity of time and place. In supermarket conditions the consumer can buy anything they want at any season, and in a variety of time-saving packages. A trip into the supermarket aisle exudes the idea that food preparation is not an activity with a value in itself, but a means to an end (209). This is very similar to the functional logic of the equation; food= health. As a result food has become a commodity largely disconnected from the processes of growth and transformation which turn raw materials into meals.

In particular, an industrial food system is reflected in the food guide, which presents food as always available in individual units, regardless of season, regardless of context, freshness, or type of meal, playing into their 'efficacies' in health. Environmental considerations surrounding food choice have been supplanted by the industrial commodification of food. The reduction of food into nutrients facilitates this commodification because manufactures can add what-ever nutrients may be lacking, in synthetic or extracted versions, to a variety of non-nutritious food. In a popular work by Michael Pollan, he argues that we do not as a population eat 'food' anymore, but rather "edible food-like substances" (2008). Industries in fact use the most recent scientific

research to modify their products , creating thousands of new food-like products every year (Coveney 2006)⁵.

Slow Food is a reactionary movement to this type of food system, and it is a movement that has become a global phenomenon. Its symbol, the snail, suggests ways of eating and living which refuse to adapt to the fast-paced, fast food world of modern times. Encouraging people to slow down, enjoy, and get local, it is the opposite of convenience and standardization. Rather, local food, knowledge and traditions are purported to be the corner-stone of eating healthfully as well as ethically. Slow Food offers a particular approach to environmental stewardship in which moving back to local food systems may reduce the environmental harms of modern industrial agriculture and food processing as well as international trade.

This it shares with the Whole Foods movement which Coveney argues was largely informed by an ethic of environmental concern (2006). In the beginning of the wholefoods movement, the overconsumption of western populations was juxtaposed to increasing media coverage of famine in other areas of the world. In this light, industrially farmed and processed food was not only unhealthy, but also inefficient in feeding the world's population. Vegetarianism grew out of this ethic of environmental stewardship as well, with popular works like *Diet for a Big Planet* (Moore-Lappé 1971 in Coveney 2006, 120). An environmental ethics is an important part of many food movements. It is as if, through food choice, people are expressing their environmental values as well. In this sense, the efficiency and morality of food choice are positioned on the individual, much as they are within nutrition, just within a larger environmental context.

⁵ My favourite example being the Vrootman's Oreos with added Omega -3 Fish oil. Yum!

1.2.2 Food Movements; Reclaiming Bodily Experience & Pleasure

There is another important aspect of the Slow Food movement and that is its turn to bodily experience and pleasure. The Slow Food movement argues for the universal right to pleasure (van der Weele 2005, 318). The Slow Food approach, one which started in Italy, but has spread internationally, addresses exactly what the 'Food as Fuel' paradigm excludes; "the cultural and hedonistic aspects of food" (ibid, 322). It rejects the historical association of pleasure with sin and greed and repositions it within a healthy diet. Clearly related to these principles of Slow Food is the recent media excitement around the Mediterranean diet and the "French Paradox" in North America. The popularity of books such as "French Women Don't Get Fat" might attest to this. The messages coming from research on both of these 'cultural diets' is that "enjoyment and pleasure is critical to lifelong good health" (Girard-Eberle 2009, 6). These diets encourage dining with others, eating slowly and in smaller portions, trying new foods, and enjoying deeply the foods you love. It is as if food is an art form to savour.

Van der Weele points out that dietary movements such as that of Slow Food and I would argue, the 'French' or 'Mediterranean diet', focus on a lifestyle in which food becomes an art form (2005). This metaphor suggests that food not be seen as something to be mistrusted or controlled, but rather a source of enjoyment and bodily pleasure. In turn, as an art, it is something precious and difficult that needs to be trained and cultivated. As van der Weele explains, "Seeing something as art inevitably invites us to consider it as a valuable and complex phenomenon that needs not 'my attention' but also cultivation and training" (2006, 323). Through the values of pleasure and sharing, tastes therefore become the central site for cultivating the body in better ways of eating.

In turn, Mol has identified a paradigm shift in nutrition itself which she calls the “Enjoy what you Eat” approach. She argues it is the opposite of a dietary technique which requires control, rather it suggests a body just needs training (2013). This approach assumes that if the body is well-trained and well-cared for, it will eat the correct amounts (ibid, 389). It is premised on the notion that an emphasis on the taste of food will lead to a satisfaction with less. Perhaps, bodies do not inherently over-eat, rather our society, and its fast-paced and low quality of food, creates the conditions for over-eating. This is an entirely different approach than the food guide offers because it suggests the body, rather than be resisted, should be attended to, and in fact *is* the source of knowledge about how to eat. I would argue that larger food movements have left an indelible mark on the field of nutrition itself, so that bodily pleasure and cultivation have become an important part of dietary practices in the past 15-20 years.

1.2.3 Bodily Experience & Treatment

Eating disorder treatment has itself moved away from a purely nutritional approach with the addition of an intuitive eating model (Tylka & Wilcox 2006). Intuitive eating is defined as having a strong connection with, understanding of, and eating in response to internal physiological hunger and satiety cues as well as a low preoccupation with food (Tribole & Resch, 1995). As discussed earlier meal planning is the backbone of nutritional counseling for those with eating disorders, but learning internal bodily cues, the ‘intuitive’, in order to regulate eating, has become its goal.

According to Herrin, a nutritionist, food planning mimics an appetite-based eating pattern and is the most effective method for successful long-term weight management (2003, 67). In fact, meal planning is accompanied by journaling on bodily states, as well as emotions, in order to

help patients learn to identify these sensations within the context of the meal plan (Croll 2010). The meal plan is merely a tool as the amounts of food outlined in the plan "are intended to become internalized and matched with the patient's internal signals of hunger and satiety"(ibid, 135). Those in recovery are hence initially given the 'what to eat', food planning, in order to learn the 'how to eat', intuitively. The body is thus trained in order to 'reveal' its own signals. This process is a form of bodily cultivation done first through the mind in which case the body remains an object of self-regulation.

Garrett has found that those in recovery in Australia readily used terminology coming out of the New Age movement to think/experience their bodies in different ways (1998). These findings are especially interesting because they demonstrate similarities with the intuitive eating model as well as the Food movements outlined above. Garrett demonstrates that New age discourses, influenced by Eastern philosophy as well as popular psychology, have influences in the ways we talk about food and the body. These approaches "contain the idea that the body has its own rhythms, needs, and meanings and that these can be discovered as a means of living a life in greater harmony with 'nature' (159). Techniques and practices such as yoga and mindfulness offer "a ready made language about the sacredness of your body". These techniques thus assume one can come to know, through the body, about food and health.

Along with the development of intuitive eating, these ideas contribute to the language of 'listening to the body' in its 'innate' wisdom. They invoke images of a body which is well-trained and cared for, and in this sense some-how more connected to 'natural' processes. To apply these ideals in treatment, to be recovering, is therefore both an education of proper eating habits as well as an education of bodily awareness. The juxtaposition, however, between meal planning and bodily learning deserves further analysis.

CHAPTER 2 LEARNING THROUGH EXPERIENCE

The current approaches to learning how to eat in recovery involve, first, cognitively organizing the meal plan, and second, sensing the 'natural' body. They are two particular ways of learning to know and relate with food, yet they both suggest there is a 'natural' order to food, or a pre-existing design which those in recovery need to retrieve. Ingold argues that the notion of a pre-existing design underlying all organic life is deeply rooted in modern thought (Ingold & Hallam 2007, 5). This is particularly apparent in modern nutrition in which the mind navigates the 'natural' body to ingest the correct 'objects' of food. What this leaves out however "are the myriad tactical improvisations by which actual living organisms co-opt whatever possibilities their environments may afford to make their ways in the tangle of the world" (ibid). In life all designs come into being through movement, and a focus on this movement, as well as the creativity accompanying it, can attend more to the actual experiences of learning in recovery. The following section will develop this framework by first outlining an approach to the study of recovery, and the significance of the concept of learning. I will then develop a phenomenological approach to learning which situates food and eating within a larger field of relations.

2.1 Recovery from a Phenomenological Perspective in Anthropology

Garrett suggests that recovery research, which relies on experience, provides "far richer understandings of the recovery process" (1998, 65). From these accounts, which have been done by psychologists, social scientists, feminist theorists as well as through auto-biographical and fictional works, it is clear that recovery is a process and not an isolated, measurable event. Most psychologists also accept that recovery is an on-going journey with unclear boundaries. Avis Rumney, a psychologist in the field who also uses her own experience, writes that her first book on anorexia discussed recovery in terms of "cure", but she herself had only been out of treatment

for four years. She had achieved a healthy weight and had acquired “many emotional and social tools” so she labeled herself as “cured”. On the contrary, she explains, “Hindsight is always 20/20. Now I can see that what I possessed at that point was a strong foundation for recovery, but I was in no place to assess what psychological, social or spiritual work lay ahead of me.” (2009, 75). Her own history is however very telling of the literature on eating disorders and the difficulty of distinguishing when someone is “cured” or even on a healthy path to recovery.

Rumney argues that it is debatable whether a condition with psychological roots can ever be “cured”. “Human beings continue to grow psychologically throughout life; “How can a line be drawn between the end of one cycle of growth and another?” (2009, 75). For this reason, she uses the terms ‘recovery’ and ‘in recovery’ “as markers in growth towards wellness and healing” (ibid). In fact, the evaluation of recovery is difficult precisely because each individual has a unique history and future that shape their ability to cope within circumstances both in and out of treatment. As discussed in the introduction, it is often difficult to define the line between ‘normal’ and ‘disordered’ in a society with so many preoccupations around food and body. Although a variety of physiological and psychological, and social assessment criteria exist, Rumney argues that the individual’s subjective assessment of their own recovery is a key consideration given the reality that few people are completely free of internal conflict (2009, 81). Garrett argues that eating disorders are not illnesses of which one contracts and then gets ‘cured’ from. She argues that ‘recovery’, and the subsequent criteria of it, suggest the possibility of perfection and ultimate closure which her participants flat-out rejected (1998, 66-67). To use “recovered” almost suggests one should be perfect or for example, totally accepting of their bodies, their weight and the food they eat. This is rarely the case, as the general population itself does not exhibit such traits.

Garrett's research, a sociological account of recovery from anorexia, suggests the experience is one characterized by ongoing transformations in which recovery is a stage of a journey, rather than a cure from a 'disease' (1998). Garrett challenges the biomedical model by placing eating disorders within an existential realm. She sees what the biomedical establishment labels as 'sick' to be the darker part of a spiritual transformation and recovery to be the source of new found wisdom and awareness. Garrett therefore uses 'recovery' as a term which helps people with eating disorders make sense of this experience in practice, but it is not taken for granted that participants had a prior illness of which they are now cured.

I will draw from her work with the same approach to my participants' understanding of food. It cannot be assumed that those with eating disorders did not 'know' how to eat before, and now must learn. Rather, the learning they experience around food in recovery is part of a journey which did not start with their diagnosis nor did it end in 'recovery'. Much as Garrett argues that eating disorder symptoms are only one piece of the experience, recovery being another chapter, I will argue that learning with food is a lifelong journey. It is through this particular interaction with the biomedical sphere that these experiences are brought together into a coherent path of 'recovered' eating. I believe rather than undermine the significance of 'recovery', this emphasizes that the process of learning after treatment is one which provides unique insights about food and eating.¹ Although the concept of recovery remains problematic, it is a meaningful concept for those who have been diagnosed with eating disorders and best corresponds to the particular area of experience that I wish to explore.

2.2 Recovering Food, Mind & Body

To date, Megan Warin's study of how participants "renegotiate their relations" through food, is one of the few pieces of literature to explore how those with eating disorders experience and talk about food (2010, 107). Warin argues that many authors, especially within discourse-oriented approaches, use metaphors of food to explain its role in the eating disorder. For example, much of the feminist literature on eating disorders situates the refusal of food as a symbolic gesture or a resistance to patriarchy in which social norms are enacted on the body. In a similar vein, psychological explanations minimize the role of food, believing that it is simply the object where psychological distress is expressed. These explanations thus become disassociated from one's actual experiences of food (Warin 2010). This study attempts to address this gap. It uses a phenomenological approach in anthropology in order to better account for experiences of recovery.

Although Garrett's work does not explicitly deal with food, it does explore experiences of the body in recovery (1998). Her work is based on extensive interviews with over fifty participants with a wide degree of ages and experiences of recovery in Australia. There she found that recovery has a common theme: a conscious development of greater openness and more 'moving out' (ibid, 181). She argues that if we deprive ourselves of food, "Our ability to move outward and engage with the world is correspondingly reduced" (ibid,182). The body is therefore a crucial sight for merging with the 'world of things'. In fact, a major theme in Garrett's work on recovery is her participants' emphasis on relearning the body; engaging in dialogue with it and accessing a more authentic self.

Garrett's participants speak about a feeling of "inner connection" in recovery. By bringing back the felt body, participants are according to Garrett, learning to connect the body as itself

with the body as myself. They are thereby 'rediscovering' or 'going back' to a sense of self as part of their own bodies and achieving a 'wholeness' they did not have before. Garrett concludes then that through their bodily practices, framed within a story of an 'authentic/natural' bodily self, they overcome disordered eating and they come to experience "the embodied self as a connected whole" (ibid, 150).

Interestingly enough Garrett does not criticize the perpetuation of a dualistic approach in the way her participants talk about their bodies. Although she attributes much of an eating disorder to an extreme form of body-mind dualism, she argues that the reclamation of the body found in recovery, albeit still dualistic, is useful because it lessens the former extremes of mind/body separation found in the acute phases of an eating disorder. She argues that our language is full of body/self dualisms and it is therefore no surprise that her participants have adopted such terms and as long as they have used them strategically then they do not deserve further analysis (1998).

Furthermore, Garrett argues that agency is always involved in self-transformation but so is the availability of discourses and practices which make agency possible (1998). The concepts of inner body and bodily wisdom are made available within discourses of popular psychology, New Age and Eastern philosophy and in new food movements which foreground taste and pleasure. Garrett argues that if her participants do not speak of this 'inner' body as equally subject to "another more liberating form of cultural construction, it is because recovery does not require this degree of intellectual analysis" (1998, 153).

The bottom line for Garrett is that her participants have recovered, which I do not disagree with, given that recovery is such a robust and fluid concept. In the efforts of looking forward however, I sense this continued dualism may continue to shape how people eat in

isolating ways. While I completely agree with the usefulness of the ‘inner body’, I also question how it positions one’s sense of self as entirely individual and within the boundaries of a single body. At what point does the mind and the world around us fit back into this equation?

This is also the problem with the more recent addition of bodily experience as a dietary technique. It is merely an addition, an added layer of abstraction. Although there are very different ontological assumptions at work, the bodily-focus is simply being added to the cognitive approach outlined earlier. Mol argues that there is a crucial tension found in contemporary nutritional advice; that between controlling techniques and caring techniques (2013). It is unclear, “Is the body naturally greedy or rather nature-culturally capable of self-care?” (ibid, 389). Van der Weele similarly points out, within food metaphors, a gap between the rational mind on the one hand and the irrational (oppressive, wild, dangerous) or non-rational (machine-like) body on the other hand (2006). This has major implications for “real bodies as well as real minds” (ibid, 316) . It seems that the ethics of nutrition, to rationally control the pleasurable body, are in direct conflict with the ethics of cultivation, to train a body with sensory food experiences. Yet, Mol’s work (2012) and my own experience, suggest that dieticians freely mix the two paradigms, which leads me to question how those in recovery work out the kinks.

What is most interesting is that the alternative discourses I have laid out, although they do pose some counter-claims, are in other ways still articulating a mind-body dualism in which the body remains the object of self-regulation by the mind. The mixing of conventional and alternative discourses simply adds a layer of bodily awareness on-top of a largely mental framework and the individual self is still the subject of food choice. From my experience this reliance on cultivating the ‘individual’ is precisely why treatment programs and therapists tend

to neglect the social and ecological contexts of life as equally significant to recovery. A different understanding of learning may help address this gap.

2.3 Learning with Skill, and Environments

The cause of resolving the body/mind distinction is, according to Tim Ingold, poorly served by emphasizing one at the expense of the other. It simply reverses the order, by foregrounding the body, and leaves the dichotomy as strong as ever (2000, 170). A true alternative to Cartesian dualism would be a way of thinking about the body and mind in which body and mind are two ways of describing the same process of action. Instead of the mind telling the body what to do, or the body telling the mind what to do, Ingold proposes a notion of 'skilled practice, that is, "the mobilization of the mind/body within an environment of 'objects' which afford different possibilities for human use" (Sutton 2012, 302). Drawing from an approach to perception rooted in phenomenology and ecological psychology, Ingold articulates this theory of learning as enskillment in his work, Perception and the Environment (2000). In order to better understand how my participants moved beyond the contradictions of 'eating right', I have found Ingold's approach to learning skills most useful.

This approach also draws from phenomenology; a philosophical movement that arose at the turn of the 20th century as a reaction to the rise of the natural sciences and their commitment to truth through rational, empirical thought. Phenomenology challenges the postulation that a 'natural' world exists outside of our experience of it. Edmund Husserl, one of its founders, first articulated this philosophy with a call to study the world before it is given, before it is made 'natural' (Moran 2002). He addresses this pre-given experience as the life-world, "the world in which we are already living and which furnishes the ground for all cognitive performance and all

scientific determination” (Husserl 1975 in Moran 2002, 12). This focus on the life-world, the person in the world, before it is made into objects, rejects the Cartesian assumption that man is first a rational, self-contained subject approaching a given reality.

Heidegger continued this critique by reversing the order. He argues, that man first is a being ‘dwelling in the world’ and the natural scientist view of the world comes after, as the being attempts to separate itself out (Moran 2012). Thus, the project of the natural sciences, in an attempt to ‘represent’ ‘things’, is actually to render them “unintelligible by stripping away the significance they derive from contexts of ordinary use” (2002, 169). The natural scientist “seeks to describe and explain a world which the rest of us are preoccupied with living in” (Ingold 2002,169). Yet this account of the world requires a view that does not exist, because phenomenologists argue that all things are encountered perspectively (Moran 2002, 13).

In fact, from a phenomenological perspective there are multiplicities of appearances of a ‘thing’ that make it grasped as just one ‘thing’. For example, a cup may be perceived for its multiplicities; its depth, height, volume, texture, color, smell, and all of these reflections change as the perceiver moves in relation to the cup. Yet in the end the cup is perceived as one and the same ‘thing’, even though the perception of it is multiple and processual. Perception is therefore key to a phenomenological understanding of reality. According to Husserl, “Perception is not some empty ‘having’ of perceived things, but rather a flowing lived experience of subjective appearances synthetically uniting themselves in a consciousness of the self-same entity existing in this way or that” (1975, 6 in Moran 2002). Just as when someone perceives an object in its multiplicity, they end up with an understanding of these multiplicities as united, phenomenological inquiries aim to understand “how” the object achieves this unity (Moran

2002). It is a process of understanding the world from the starting point that we make the world as we perceive it.

More specifically, the act of perception is always a movement within a body within the world. Maurice Merleau-Ponty added to this discussion the emphasis on the body as the subject of perception (Ingold 2000, 169). He argues that bodily movement carries its own intentionality and it is because of this that action is itself a movement of perception (1964). The body does not simply act as a conduit of the real world and the mind of the person. The body and mind are both in and out, self and world, because they are the same process; “namely the environmentally situated activity of the human-organism-person” (Ingold 2000, 171).

This discussion is entirely appropriate to the experience of learning to eat and here is why. As Garrett has argued, those in recovery must adopt a radically different understanding of their bodies and its relationship to food, which she labels the ‘inner body’. She argues that they learn this by tuning into the ‘felt body’, an experience which they deem to be more natural and authentic than the disordered experience of the body. Yet this ‘inner body’ is still one at odds with the flow of life experience because it situates an authentic self within the body. It becomes merely a container of information in which the mind remains severed from the body, the body has merely grown in significance.

Garrett situates how her participants think about the body as a cultural construction, as something in the mind above and beyond the body and ‘reality’. This seems indeed to be the underlying assumption of even the more embodied nutritional discourses. In the nutritional approach people are taught through information passed from one mind to the next mind. They are then taught to replicate and imitate these cultural processes, which are stored in the mind,

until they become sedimented in the body as 'natural'. From Ingold's perspective this does little to address how human beings actually learn with their bodies in movement.

In fact, the 'natural' body is a prerequisite rejected by phenomenology, as a body of thought, which outlines a way of seeing the world in movement, and for Tim Ingold, within an environment of relations (2000). According to Ingold, information, in itself, is not knowledge, nor do we become any more knowledgeable through its accumulation (2000, 21). Our knowledge consists in the capacity to situate such information and understand its meaning, within the context of a direct perceptual engagement with our environment. It is, "By watching, listening and feeling- by paying attention to what the world has to tell us- that we learn" (Ingold 2013, 1).

The notion of environment used by Ingold is a relative term, it is relative to the being who is part of it (2000). It is significant that Ingold does not use the term environment as simultaneous to the concept of nature. To Ingold, nature assumes there exists a backdrop to human affair which is observable beyond our place in it, a pristine state. In starting with the premise that we are first beings in the world, rather than outside of it, his concept of environment rejects this conventional depiction of nature. Instead environment refers to the world around us as being situated within particular histories and patterns of movement that we, as organisms, are part of by shaping and being shaped by them (2000). Sutton suggests then, that in Ingold's work, the environment is "not objectified as a 'problem' that humans 'adapt' to, as it itself is part of the total field of activity" (Sutton 2012, 302).

Take for example the novice hunter that comes from Ingold's fieldwork. According to Ingold, hunters do not learn to hunt by receiving information, nor by practicing alone (2000). The skills they develop are not passed between human to human in the mind, but rather through a sensory engagement of a "novice with the environment and/or with a skilled practitioner"

(Sutton 2012 303). The novice learns by observing and, "To observe is to actively attend to the movements of others; to imitate is to align that attention to the movement of one's own practical orientation towards the environment" (2000). In this sense learning is a situated-ness of the individual to the actors, both human and non-human, as well as to one's own sense of being.

Perhaps this seems obvious because the hunter is seeking food in a specific environment that we often see as more 'natural' but it should be just as obvious that the person suffering from an eating disorder is seeking food in specific contexts. Although there may be a guide to learning, or a design for making *meals*, "Designs do not magically transmute into the forms they specify. Their fulfillment calls for workmanship" or an ability to be attuned to the "ever-variable contingencies of the situation at hand" (Ingold 2011, 7-8). Those who develop skills in an area are able to use design rules and later innovate and adjust them to the multiple realities 'on the ground'. They develop a precision "that is not to be confused with the accuracy of pre-planned and measured execution", but is an ability to move with the materials in their multiplicity (ibid). Food does not exist available in its nutrient content regardless of the social and sensory spaces in which it is sought or eaten or enacted as 'food'. Nor does it exist only in the self-awareness of the learning individual. These multiple aspects of learning occur in conjunction to one's 'being in the world'.

It perhaps is also important to emphasize that food itself is not simply a passive 'natural' object or an inert form of matter, but part of this field of relations that is 'eating'. The discussion of Mol earlier was used to demonstrate that food is made into a particular type of matter through dietary techniques. But Jane Bennett's repositioning of food as 'vibrant matter' goes a step further (2010). Bennett argues that foods are active as "conative bodies vying alongside and within another complex body" (a person's "own" body)(2010). To Bennett, food is an actant, a

body of productive power, within often non-linear assemblages of other bodies, intentionalities, causes and effects. Food is enacted, acting, and acting upon.

One of my favorite examples given by Bennett is that of potato chips. One might ask whether the individual subject is morally responsible (as they would be in nutrition) for the act of eating an 'unhealthy' food, like chips. Here she argues that it seems "appropriate to regard the hand's actions as only quasi-or semi-intentional, for the chips themselves seem to call forth, or provoke and stoke, the manual labor" (2010, 40). To eat chips is to enter into an assemblage in which the I, in the act of eating is not decisively a matter of personal preference as the chips themselves evoke manual action.

Eating is part of an assemblage of human and non-human elements in which both have some 'agentic capacity' (Bennett 2010, 49). This way of locating food as assemblage challenges the modern divide between organic life and inorganic life, matter and form, which Ingold has also challenged. Bennett argues that the materiality of food and bodies is emergent and in the process of becoming, or decomposing, or digesting. The apple appears as a separate object, until a bite is taken, in which case the line between inside and outside is made blurry. As the apple travels through the body, acting with it, its materiality changes, it becomes part of the body and eventually once again separate. This "swarm of activity" is neglected when we divide the world into inorganic matter and organic life (Bennett 2010, 50).

Another example of why this approach is significant can be found in the work of Michael Pollan (2008). The carrot, made more significant in the past decade by the identification of Beta Carotene, must also have some agency. As Pollan has argued, the science of nutrition may be able to identify the nutrients of that particular food, but it is then limited by the sheer number of combinations possible. In which case, the beta-carotene in that particular carrot may react

differently with the myriad vegetables in the stew in which it was cooked. That fails to even mention which breed of carrot it is, where the carrot was grown, how it was grown, harvested and processed, stored or shipped. Food is multiple and active; this includes its presentation, preparation and reception in a variety of environments and within/outside of a variety of bodies.

To the extent that we recognize the agency of food, we also reorient our own experience of eating (Bennett 2010, 51). If we commit to food as a process or assemblage it is not merely a passive object, nor a final result. Food cannot therefore be separated from the act of eating nor the myriad other forms of agency taking place. In fact, if we observe food as materials then we could possibly come to see food as, “*potential*-for further acts of making, for growth and transformation” (Ingold 2011, 3). In Ingold’s recommendation, to focus on materials, the end product is over-shadowed by these acts of creation, acts which shape the body, its skills and the food itself. Both Bennett and Ingold argue for new ways of seeing relationality and agency between human and non-human life forms and I hope to demonstrate how these are significant to experiences of learning to eat.

CHAPTER 3 PAINTING THE FIELD

Section 3.1 Methodological Musings

The painter paints a world that they are both in and out of, a world in which they are embodied and in which they use this embodiment to paint. Through the example of the painter and his way of "drawing from the world" Merleau-Ponty argues that the painter captures experience and contributes to its ongoing evolution (1964). Those who study the world, attempting for distance and objectivity are the opposite of the painter, and their findings are thus far removed from the phenomena of life, still and static. He argues that if we were to think from the painter's way of being, we would find a way of studying the world that does not give up living in things (1964). I hope that the following methodological approach demonstrates some of this movement of joining in with the lives of those in recovery. I will explore how I recruited and met with my participants, how we came to discuss the research questions, the ways in which I situated myself in the project, and how I drew from our experiences to continue painting 'recovery'.

Section 3.2 Participants

I undertook fieldwork in Ottawa in the spring and summer of 2013 as this is my current hometown. Although most of the study took place in Ottawa, I also made three 4 day trips to Toronto in March, April and June to meet with participants. In studying both cities I hoped to capture a broader range of previous treatment experiences as there are many more treatment options available in Toronto. Since this is a hard to find population and the cultural phenomenon I am looking at is quite specific, I have used a purposive sample. The sample does not offer generalizable conclusions about recovery, but I believe the data does offer an in-depth picture of recovery experiences.

I began the research with participant observation in an online support group, and in touring 3 different support centers in Toronto (I was already familiar with the one in Ottawa). This also helped me identify places to recruit participants. Once I had recruited participants, I conducted one un-structured interview with all of the selected participants in a location of their choosing, usually a local coffee shop. I then conducted a second un-structured interview at a later time in either a café, their home, or a office at the University of Ottawa. In between the two interviews, or after, I conducted more participant observation in a variety of locations relevant to participants where I took field notes. I used an mp3 recorder to record most of the interviews, and later transcribed them and shared these transcripts with participants.

I recruited participants through support centres which offered social services and advocacy for those affected by eating disorders. These centres are often pivotal to the later stages of recovery, after hospitalization or psychological treatment, because they offer support groups, mentoring, art and yoga classes, lectures, volunteer opportunities and advocacy programs. In my own story I maintained connection with Hopewell, the only Ottawa support centre, for over 6 years since attending any programming and I learned that others had done the same.

Hopewell releases a monthly newsletter, in which the recruitment text for this study was posted. This newsletter was in fact the most effective method of recruitment. Other centres in Toronto (there is only one in Ottawa) posted the recruitment text on bulletin boards at their facility, but this was not very effective. I also posted the recruitment text on an online support group of which I am a member and this is where my two Toronto participants were recruited from. Finally, I recruited, opportunistically, through my own University's graduate posting board and this also attracted 3 participants.

In the recruitment text I had three criteria, the first was that (1) they have been diagnosed and treated for an eating disorder and considered themselves recovered (for no more than 5 years) or in an advanced stage of recovery. Also, that (2) they have maintained normalized eating patterns for at least one year and (3) they are comfortable sharing and discussing their eating habits and experiences without fear of remission of eating disorder symptoms. The final criteria were chosen in order to explicitly state the type of involvement required for this study and were meant to reduce possible harm to participants.

Through the recruitment text I sought out participants who were out of treatment and yet still learning to integrate non-eating disorder behaviours into their everyday life. My criteria for participation was that they had been out of treatment at least one year and had maintained 'normalized' eating for a similar period. Normalized in this context refers to the self-regulated eating of meals, in which someone is meeting adequate nutritional standards and maintaining a healthy weight on their own. It also implies that one is not regularly participating in behaviours that undermine the previous criteria such as bingeing, purging, binge-exercising or skipping meals. I also asked that they be no more than 5 years recovered so that these experiences of learning were not too far forgotten.

It was my experience, that in this time period, those with eating disorders are essentially putting 'ordered' eating into practice. As discussed in the introduction, this has been identified elsewhere as the action or maintenance stage of recovery. These stages are useful in pointing out, because a) treatment has a high failure rate and b) many people with eating disorders are forced into treatment by others and do not want to recover or more importantly, do not think it is possible to do so. The first point reflects the importance of studying those more advanced in recovery, so as to better understand the phenomenon of recovery itself. Treatment alone is not a

sufficient indicator of recovery. Nor is the desire to recover. In all honesty, I cannot explain what is the necessary threshold for recovery to occur because I do not think there is an obvious answer. I did however choose to target the stages where participants are putting behaviours aimed at recovery into everyday practice. This provides an entry point into processes of recovery even if it does not answer why people recover outright.

Fourteen women in total responded to the study call. No one was rejected, except for two that were too far away to meet in person and two who decided not to participate. I had a total of 10 participants. All of the participants' names were changed to pseudonyms in order to protect their anonymity. Although I did not reject anyone who wished to participate, there were two participants who were still struggling with recovery in a way that made me question if we would be discussing a topic too sensitive. However, accepting that recovery is self-defined and that they themselves found they fit the profile and found interest, I included them. In total I met face to face with 10 women; 8 from Ottawa and 2 from Toronto. All of my participants self-identified as women. All of them were white and all of them had received or were currently enrolled in some form of post-secondary education.

Although other studies have demonstrated the prevalence of eating disorders in Latina and African American women in the United States (Thompson 1992, 1994), as well as amongst men (Strother et al. 2012) the recruitment methods I used were unable to reach those populations. Hepworth's research on health care workers in the 1990's might offer some insight into the difficulty of reaching these groups. Her work showed that health care practitioners were aware of men who may have had eating disorders, but that men were more likely diagnosed with other mental health disorders (1999). It is likely that those same men would not be as comfortable accessing services geared towards women. In fact, while volunteering at the eating

disorder support centre in Ottawa, current support materials were being re-written to be more inclusive of men with eating disorders. At the time, many materials used only the feminine pronoun assuming that only women had eating disorders.

Assumptions about what type of people have eating disorders have a long history dating back to the creation of the diagnostic category itself. Anorexia Nervosa gets its name from the late 19th century genre of hysteria diagnoses, those diseases related to the uterus and particularly female adolescence (Malson 1998). The illness's resurgence in the 1980's continued to be understood by psychologists as a disease of the "young, rich, and beautiful" as mentioned in the introduction (Bruch 1978, xix). It was then argued by second wave feminists that anorexia was a metaphor for the changing gender norms of the late twentieth century (See Orbach 1986, Chernin's 1986). Given the creation of the diagnostic category itself always involves a "making up" of people (Hacking 2007, 55), it is perhaps no surprise that my participants were all white women of the middle or upper class. In addition, all but two of them had experienced their eating disorder sometime from age 12-25. According to advocacy campaigns and recent research, this does not represent the spectrum of those with eating disorders, but it may reflect those who access services and are comfortable identifying with the diagnosis and therefore with the study criteria.

All of my interview participants had received post-secondary education. Five were attending or had attended graduate school and three were completing undergraduate degrees. Two worked in health care, two worked in research areas, and one who has worked in research and teaching was currently unemployed. The education and professional achievement levels of this group, many higher than mine, contributed significantly to their ability to articulate their ideas and opinions. They were often very familiar with the research process and although not

intimately familiar with anthropological methods, many expressed interest and enthusiasm in the design of an ethnographic study. They were often interested in the project academically as well as personally. This made them a highly reflective and articulate population to study/learn with.

Section 3.3 Conversations

Participants made it clear that they wanted to share their stories, stories they had spent many years dissecting and building in treatment and recovery. I would argue that most participants saw the interview and interaction with someone else who had recovered as a way to learn from and share similar experiences. In fact, most subjects expressed a desire to share their history of an eating disorder with others, but were unsure of how best to do so. Two had already spoken publically about their struggle and two of them, both who worked in nursing, were very cautious about sharing, although they desired to do so. In total, participants shared a common desire to connect with others who had gone through an eating disorder, whether in person, or through the study results, and the research project offered up that opportunity. I also willingly shared my own story and I believe these interactions wove our experiences together in a way that allowed us to learn from each other. In that sense it allowed the story of my participants, as well as myself, to continue.

Participants first contacted me through email and we then arranged a convenient time to meet for coffee. This was ongoing from March to August 2013. I suggested, and all of my participants agreed, to first meet for coffee to get to know each other. In the email I suggested that we could discuss their history with an eating disorder if it felt comfortable. To begin with, I wanted to share the inspiration and intentions of the project in person. It felt necessary in order to demonstrate that I saw myself as collaborating with them to uncover more about an

experience of recovery and food that I also shared. At each coffee date I explained my own history and why this project was important to me. I also got to know who the participants were and I believe this helped ease the anxiety which some of them showed in sharing such a personal story. For some, we chatted away the first hour and had to schedule another coffee date for them to really go into details about their history. For others, they had the time and were willing to jump right in to revealing some of the most intimate details of their lives.

This first interview consequently consisted of asking participants to tell their story. For many this did not require any prompting. Participants were well aware of their 'story'. It was a narrative they had all worked and reworked many times in treatment and through self-reflection. It usually began with the diagnosis or the reasons why they started eating in a disordered way. It continued to how things got out of hand, or why they got worse or better, and chronicled their experience with treatment. According to Garro & Mattingly, narratives are not stores about illness, but about life being disrupted by illness. Narratives therefore reveal the experiences of change and disruption caused by an illness, in this case an eating disorder, through a biographical account (2000, 72).

In this interview I had originally intended to focus on recovery. However, after meeting my first participant, I sensed the need to let that person speak about their eating disorder. It was as if revealing the entire story unburdened participants and the researcher from 'beating around the bush'. It is a story many are afraid to tell and that most only share with those closest to them, if they can even do that. I felt I needed to know that history in order to allow us to talk freely about the experience of recovery and so I let people tell it as they saw it. I then allowed them to ask me any more questions if they wanted to know more about my story than I had given in the beginning. After this step, I noticed a visible reduction in the hesitation participants felt. I myself

felt more at ease once 'my story' was shared and I could feel that same tension decline in others. Collecting this form of narrative not only eased the tension around the subject area, but actually provided crucial context for the second interview. It was important to know what treatments the participant had gone through as well as some of the stages of their recovery. Had I only focused on recovery I might not have gotten such a comprehensive picture of where participants were at and how far they had come.

The next formal meeting with my participants I conducted unstructured in-depth interviews in which we discussed food in recovery explicitly. The lack of structure allowed participants to navigate the conversation where they felt was most important and also to where they were comfortable. In hind-sight it also made the diversity of participants more apparent. Some were still in recovery, only a year out of treatment, and for others, many years had passed. Not everyone was hospitalized and some had sought alternative treatments. Recovery experiences were therefore very different and not often in the same chronological order or trajectory. By having the interview un-structured I believe I was better able to capture the most important and relevant parts of their experiences with food.

There are certain materials that I also worked with in interviews. These include the food journals participants made in treatment, if they had them and were willing to share them. I also brought a copy of the food guide if that was a part of their treatment. Some participants brought in journal entries or literary pieces they had written. Two participants showed me books and articles they had kept about food. Some shared recipes and healthy cooking ideas. I also inquired about any other nutritional information or diets of which the participants used or related to. I saw these materials as useful points of reference for discussing the early stages of relearning how to eat. They also aided me in discussing the ways participants managed to maintain 'normalized'

eating patterns on their own. These materialities also formed tangible evidence of how we, as those recovered/ing, continue to partake in recovery by learning and sharing new ideas and ways of being with food.

Section 3.4 Practice/Participant Observation

My project explores the encounter with nutrition against the backdrop of “involved activity” (Ingold 2001, 168) with food. Hence, I attempted to foreground the sensual and moving experiences of food in order to see how food is “being done” (Mol 2002, 31), how it is created in practice, by those in recovery. In the food guide a map is offered for turning nutrients into meals and as the body is made malleable to training, food remains static. I alternatively view food as materials rather than “prêt a manger” nutrients. In seeing food as materials I have also encouraged others to see food as potential. Although I was also interested in the symbolic meanings and physiological experiences of food, by emphasizing its materiality I believe I was able to study this phenomenon in a more transformative way. In truth, I found this way of looking at food much lighter, because it was more fluid, more temporary, and more creative.

According to Ingold, by focusing on materials, the ethnographer is better able to appreciate what it feels like to make, as well as what can be made. In particular, we can see how materials take form and how learning and creativity occur in their transformation (Ingold 2011). For example, when walking through an Ottawa market, I discussed with a participant how we encounter food. We talked about its movement through the hands of migrant workers to the farmer to the retailers which then repackage it as “market goods” and sell it at our local, not so local, market. We discussed what meals could be created and how difficult it is to not overthink

this meal creation, but just to go on an impulse and choose the eggplant. We negotiate techniques to make a curry, we try to move forward and not look back.

This is what participant observation looked like for me, not as data collection, yet as a way of *knowing from the inside* (Ingold 2013, 5). We continued to meet for coffee, or went for walks throughout the summer. In July in Ottawa we picked strawberries at a local farm and serviceberries at a tree in front of my house. We shared delicious snacks, such as black-bean brownies, at their home or went out for dinner. At these meetings I focused on the most noticeable impressions I had. In general, I tried to focus on the non-verbal aspects of every encounter, especially the sensory components. In fact, I had expected to engage a more sensorial appreciation in my fieldwork. Beyond just sharing meals, I had hoped to engage in daily activities such as cooking, shopping, and preparing food, but in fact, talking was the most frequent (most comfortable) activity I did with my participants. Hence, we shared a lot of coffee. In fact, eating with my participants seemed the most awkward and foreboding activity. This proved in itself to be a revealing observation.

Participant observation is an important avenue for exploring the embodied experiences of recovery as eating, or attempted eating, with my participants has shown. As Warin has found, experiences are not conveyed only through words, they were simultaneously embodied and performed (2010). Participants contorted their faces or bodies at certain subjects, or they held their bodies in certain ways when facing a situation. I both took note of these 'embodied aesthetics' as Warin did, in order to ask questions about why certain moments elicited that response, or how the body felt to be in at that moment (ibid, 14). I also discussed with participants their past experiences of embodied reactions and sensory events. According to Jackson, it is a mixture of language and experiences rather than a separation of the two which

phenomenological methods aim for (1196, 42 in Warin 2010 14). This approach, to both study embodied experience as well as to try to access it in conversation and narrative, influenced how I conducted participant observation as well as interviews.

The combination of participant observation and interviews addresses a need to deeper explore everyday phenomenon in recovery. The ability to meet with participants multiple times, in the multiple contexts which form the 'everyday', allows for a type of interaction not possible without the ethnographic methods of anthropology. Everyday objects, decisions, places, sentiments and relations reveal a world of depth that is experience-near and detail-rich. This combined with interview, which gives the participant the chance to reveal their own analysis of the experience, is key to understanding recovery as it is lived.

Section 3.5 Further Strategies

There are a variety of other tools that I have used to enrich this ethnographic study. As discussed earlier, I used my own experiences both as a learning tool as well as a conversation technique and most importantly, as an entry point into the subject. I also used my own experience to volunteer at the eating disorder support center in Ottawa for the past year as a mentor for two women in recovery. Meeting bi-monthly with these two strong and engaging individuals actually created a space for me to better understand my own story. They drew me back into the life of an eating disorder. Although our histories were different, we constantly were able to share understandings that I have never shared with anyone else. They also brought me back to the difficulty of recovery. As we continued to work at pulling ourselves farther away from this disorder I was constantly reminded of how utterly life changing and terrifying it is to

recover. Although their voices are not rendered explicitly in this study, they have inevitably shaped my understandings of recovery in very profound ways.

For one year I have also been following and participating on an online support group started by a very inspiring young woman in recovery in southern Ontario. The groups' numbers have steadily risen since then as word of mouth spread across Canada through treatment programs, other support groups, and in my case through friendship with someone else struggling. In my time on this group I have responded to questions, given encouragements and shared some of my own joys and struggles which only those with this experience would understand.

In September of 2012 I started keeping my own log of posts related to food in order to better understand how those in recovery talk about food online. I discovered some interesting patterns. As it would be difficult to collect consent within the large group, which is indeed private, as well as to make sure the research was not harming anyone, I decided to create a sub-group specifically for the purposes of this study. Accordingly, I created a Facebook Focus group which allowed 5 people who were located out of Toronto and Ottawa to participate in the study. It allowed me to recreate discussions found on the support group with those who identified with the recruitment criteria as well as to open up questions about the group itself, thus adding to the experiences rendered in this account. Although this smaller group lacked the dynamism of its parent group likely because it generated way less content, it did contribute interesting discussions to the research.

3.5.1 A Note on Reflexivity

In contact with all of my participants I responded to their experiences and opinions with my own. But, I was worried about letting my own story shape what I focused on in theirs. This is

partly why I made my own experiences explicit in the project, in order to be able to differentiate them. As a recovered person, I can and do imagine what 'recovery' feels like, while also having many of my own questions about how it is accomplished. I engaged with my participants not only as someone who is studying their process, but as someone who is processing it themselves. It would therefore be negligent to not include my voice in this study. Anthropology in general has made this shift towards including reflexivity, but it is especially important when the topic is so close to my heart, and body, as recovery is. My research questions are therefore posed, not just to be answered, or explored theoretically, but to create the space for both participants and myself to continue to negotiate recovery. I have used reflexivity as an inspiration, a curiosity, a way of relating, and a way of being towards the world with the actors in this study. In this way those with eating disorders are not merely research objects. Instead, this research is about experiencing change and growth in lives, including my own, that were once characterized by an eating disorder.

CHAPTER 4 UNMAKING & REMAKING ORDERS

One of the most emergent themes in this study is the body. To all of my participants, recovery meant a new appreciation, or a new cultivation, of the body, as if the body had become a new source of wisdom. Phrases such as to ‘get out of one’s head’ and to ‘listen to one’s body’ were so common, I myself took them for granted. As these conversations continued however it became clear to me that many of my participants were still unsure of whether they could trust their bodies. Furthermore, positioning one’s body as the ultimate authority on food sometimes left one eating in ways that seemed strange or different from the people around them. Our conversations therefore explored what these concepts really meant and how they fit into everyday practices of eating as a bodily experience.

We also discussed frequently how recovery required new ways of thinking. These were needed to keep the body in line with the goals of recovery. From a nutritional perspective, patients in treatment for an eating disorder had to learn how to think about what constituted a ‘healthy’ meal, but also not to be *too* ‘healthy’ and rigid in their thinking. They had to learn to enjoy food for more than its function, for the pleasure of it, but those pleasurable foods were the most difficult to eat, and in our society, labeled the most ‘unhealthy’. So I had participants asking themselves why they made the choices they did and why they still had to justify the choices they didn’t make. These sort of contradictions made eating a continuous challenge in which recovery seemed opaque, ungraspable.

Section 4.1 The Disorder

The different stories of how my participants first developed an eating disorder were surprisingly diverse. Miranda, for example, developed allergies at a young age. Food started to make her feel sick, this was also possibly anxiety as it was the same time that she moved to a new city. She started eating ‘right’ and just got more and more perfectionist and over-achieving and

critical until she was diagnosed in grade 6 with anorexia. She explains, “I didn’t understand how people could settle for 90%, there’s still 10% left” a principle which she applied to eating.

Amanda can remember the summer, “it started like a game”, an experiment to see whether she could get away with it. There were two bathrooms in the house and she was a night owl so she started making her own schedule around food and purging. She hated herself and body and felt out of control with food; binging and purging was her answer. Joane had always had a weird relationship with food, for instance even as a kid, she just didn’t understand how people could control themselves. When entering university she was unhappy and stopped eating but did not see herself as having a real problem; she didn’t have any psychological issues or traumatic experiences. It was only upon being forced into treatment that she realized how much self-hatred came up around food. Others revealed deeply painful and traumatic experiences which inspired them to turn inward and “take it out” on their bodies.

Whether it was related to shame, control, or dissatisfaction, my participants explained that in recovery they were trying to overcome a distance from their bodies which they had developed. As Garrett has shown, many people with eating disorders feel as if their body was something external to them (1998). Those with eating disorders often force their bodies to do uncomfortable, even painful things, such as purging or cutting, which were practiced by many of my participants. Both Erin and Krista would exercise to the point of exhaustion and then keep going to the point of developing painful and lasting injuries. Charlotte used to set goals for herself and would fulfill them no matter the toll on her body or health. So for example, she may garden for hours without rest or water. Even though she was exhausted she kept going because she had planned she would. She felt as if her mind controlled her body. It was also common to experience the body as something that only other people looked at or judged and many felt they were less

noticeable when eating less. As Warin has demonstrated in her research on anorexia, the body becomes the site of one's interaction with the world, including a way of refuting that interaction (2010).

O'Connor & Van Esterik argue that the biomedical perspective on eating disorders positions them as a mental illness; the mind's war on the body (2008) and this is reflected in many accounts. This was how Garrett's participants described it; they mainly 'live in their heads' ; mind overruled body (Garrett 1998). As Elory explained, the focus on food and her body allowed her to appear 'normal' on the outside, it kept the "screwed up and chaotic" parts of herself on the inside. And this is how most of my participants relayed the eating disorder experience. Participants referred to negative self talk, obsessive thinking, and calculative and controlling thoughts, as 'mental' activities which separated them from the world around them.

They intellectualized or 'over-thought' simple actions, most notably eating, which had been totally transplanted from an every-day, mundane activity, to the biggest decision of the day. Food consumed their thinking. Until eventually, most of my participants could not function in everyday activities. Some could not focus on school, others fell apart during free time. They could not enjoy social settings or celebrations because, as Erin explains, "We were trapped in our own minds". It is for this reason, or by outside influence, that my participants sought, or were forced into, a diagnosis, and treatment for an eating disorder.

Section 4.2 Finding 'Order'; Treatment & Meal Planning

Eating disorders are largely diagnosed at the first line of medical treatment; family doctors. When I was 15 or 16, I remember going with my mother to my doctor and being diagnosed with bulimia nervosa. Once a patient receives an eating disorder diagnosis they are either referred to a psychologist, a psychiatrist or to a treatment team (Yager & Powers 2007). I

was referred to a psychiatrist, but others may be referred right to an eating disorder treatment program or team, at either a hospital or private/semi-private institution, where they must undergo an assessment and then wait for an admission. This is often based on where the patient is located, the availability of an eating disorder-specific institution, the state of their physical health, as well as economic resources (Yager & Powers 2007). The availability of resources and insurance coverage is a serious consideration for most patients, especially those in the United States (Gremillion 2003) but also in Canada where semi-private institutions are seen to offer more progressive care than public hospital programs.

When referred to a treatment centre, some patients are checked into in-patient, or residential facilities, and some, usually when their health is less medically compromised, are admitted into out-patient where they attend day-long treatment programs. They then return home on evenings and weekends. Both in-patient and out-patient typically include psychiatric care, general medical care, nutritional counselling, individual, group and /or family-based education and counselling and/or psychotherapy through a network of health care professionals (Yager & Powers 2007, 47-48). A treatment team may include dietitians, therapists with different professional focus in family, group or individual psychotherapy, cognitive behavioral therapy as well as mindfulness-based practice, and art and music therapists (ibid).

When it comes to food, dietitians are a key part of eating disorder treatment teams. The role of the dietitian is to teach patients and families about "normal nutrition" and perform nutritional assessments (Hart et al, 105, 2006). If a dietitian is not available, the general practitioner or psychiatrist will take this role (ibid). All but one of my participants had been instructed on nutritional information. The rest had a variety of types of interactions with dietitians or nutritionists, either through groups, individual sessions, meal-planning at an

institution, or other treatment plans.

In fact, regardless of treatment type, Fariburn et al., argue that the most effective behavioral intervention in eating disorder treatment is the introduction of a food plan (2001, 377). To make a food plan one plans their three meals and snacks into specific portions of food for each meal. There are three main meals a day and these should be set at regular times, at least every 4 hours. Based on daily recommended values (such as in the Canadian Food Guide), so many servings of each food group are organized by the patient into the three meal/ snacks model. In some hospitals this is referred to as the exchange system because patients are allowed to make their own menus choosing from a variety of foods in each food group which are referred to as 'exchanges'. Heather explains that the exchange system, "Is pretty much like the food guide because there's different groups- starches, fat, dairy, protein, fruit and vegetables. Just our meals would be divided into exchanges not food groups." In Heather's treatment program, patients would have an hour at the beginning of the week to mark their own menus for the week based on exchanges and then approve it with the dietician.

For those not in a group setting, or after they have left treatment, self-monitoring is often used with a meal plan for the patient to compare how their eating actually corresponds to the intended structure (Croll 2010, 135). Monitoring can be paired with details of the food eaten, time and place, as well as emotions and thoughts on the meal. Some self-monitoring charts also include a hunger/satiety scale for the patient to match with meals (Croll 2010).

From a treatment perspective, this planning is necessary to disrupt symptoms and is enforced quite harshly in the acute phase of the eating disorder when symptoms are most severe (Croll 2010). According to Croll, "Nutritional Rehabilitation" has three stages;

- 1) symptom interruption with a highly structured eating plan
- 2) Teaching a more intuitive, mindful way of eating

3) helping the patient master self-regulated eating in line with the body's cues of hunger and satiety (2010, 131)

It has been shown that perceptions of hunger, satiety, and appetite are deeply impacted by ED behaviors therefore a major aspect of nutritional rehabilitation is "understanding, recognizing and reconnecting with intricate internal signals related to food intake" (ibid, 136). Patients need to relearn how to feel hungry or full for example. Then, as patients get comfortable with the structured eating plan, they are encouraged to introduce flexibility and try new foods. The goal is that they will learn to eat based on the cues of hunger and satiety that return with regularized eating. Once these signals are restored, the patient is encouraged to let go of the structure as they strengthen their ability to be mindful of these cues as well as the emotions and psychological factors associated with eating (2010).

From this perspective, meal planning continues long after formal treatment. According to one guide, after 6 months of sustaining new behaviors such as following a meal-plan, those in recovery are said to be in the 'maintenance stage' (Brotzky, 2009). This means they must continue to sustain these new behaviors while giving special attention to preventing a relapse of old behaviors such as skipping meals, binging or purging. The maintenance stage involves identifying triggers that could cause those former behaviors as well as solidifying new ways of thinking and living. This is where patients work to integrate the meal plan as a part of their everyday life. At this stage of an eating disorder, according to the categorization, those in recovery have put into action a variety of new behaviors which challenge the symptomatic behaviors of their eating disorder (Brotzky, 2009).

I originally began meal planning with my last psychologist in 2009. Perhaps it was used earlier in treatment from 2003 to 2009, but I do not remember much about that treatment- other than it didn't work. In 2009, I found the food guide extremely useful however. I had had an eating

disorder for eight years and I just did not believe I deserved to eat a full meal. I had no conception of how much I should eat because I always assumed I was over-eating. Yet, there was something authoritative about the food guide. As Croll points out, meal planning often gives patients a sort of "permission to eat" (2010, 133). When my psychologist gave it to me, she convinced me that 'this' was 'normal' eating because this was what a body needed to function properly. Heather, and Elory both explained it as coming to know what a body needs.

To me, this guide meant I was no longer in charge of food, but rather had to follow what was prescribed. I had to pre-plan, or record everything I ate. Heather explained, "The biggest thing the exchange system taught me was reassurance, because you know you are really hung up on specific numbers but with exchange systems you don't know what the number is and you know everything varies, some is over, some is less and just seeing that it works out and it doesn't make a difference is a huge *huge* thing. It takes the obsession away". These systems of organizing food into groups or exchanges therefore take away the authority of choice in eating.

This sort of treatment is not immediately successful at taking the obsession away however. Both Heather and I had previously undergone treatment with little to no success. In fact when Miranda was first diagnosed, it did not change her way of living at all. She explains the first time, "I ate my way out; you just do what you are told, you follow rules and then you just go right back to it after treatment." Miranda didn't care about the psychological stuff, she did not think anything was wrong with her eating. She just wanted to go back to school. In my story, I was willing to institute meal planning, only after an extensive and meandering treatment history. According to the conventionally accepted "stages of recovery" which are often used in eating disorder treatment, I would have been in the action stage (which precedes the maintenance stage). I had accepted the course of treatment laid out. I was ready to implement this strategy, I

trusted the treatment, and “I was willing to face fears in order for changes to occur” (Brotzky 2009). In fact, most of my participants spoke of how the process of meal planning and eating regularly is deeply uncomfortable and scary, something I will explore further below.

4.2.1 Defining ‘Healthy’; The Benefits of an Order

In my case, although I was making meal-planning part of my life, my plans were usually pretty scribbled. I started on the designated sheet, but it was cumbersome and I ran out of copies so I wrote them anywhere I could. I usually had to show them to my psychologist after every two weeks so I often re-copied what I could find into my notebook. I did roughly follow the recommendations however, even if I did not always record them. For one, this way of eating helped me see that I had been under-feeding myself for years. In fact dieticians recognize that cravings and binges are often caused precisely by the act of under-eating (Croll 2010). I also learned that eating these amounts of food would not cause me to gain weight. I could occasionally eat ‘junk food’ and surprisingly, after a year of eating according to the guide, I was almost the same weight I was when I was 16 and first got diagnosed. This was a shocking realization considering I spent 8 years feeling constantly like I was gaining and losing weight, depending on the meal, when I likely never strayed more than 10lbs from the same measurement.

Those with eating disorders are well aware of what is ‘healthy’ in terms of good or bad foods, diet and non-diet products, disease-preventing and disease-causing foods. In O’Connor & Van Esterik’s study on anorexia in the US, three quarters of their interviewees (16 of 22) grew up valuing healthy eating and living (2008). All of my participants were also taught healthy eating at home and some at school. It seemed like most of their families had family meals with ample vegetables and grains and the ‘values’ of healthy eating were present. They knew which products

were linked to good health outcomes and which products were not. In fact, most of my participants developed the first signs of their eating disorder in adolescence. Some became more and more structured, making 'healthy' eating practices the regiment of their day. Others used the few hours between school and dinner to hide 'unhealthy' foods that they knew their parents or peers would not approve of. Either way, 'healthy' was a prominent concept in the narrative of their illness as it was something we were all still defining.

Elory for example lived off of one 'healthy' meal a day, before she started treatment. She ate half of a pita, lots of salad, grated carrot, light salad dressing, and two slices of non-fat cheese, but that was all she ate in one 24 hour period. With such a 'light' meal, she was consequently under-nourished. Before working through the food guide, Heather was also not eating enough of most foods. As Heather explained, "the food guide helped because I learned that I need all of those different things." In fact, many of my participants were accustomed to eating only a select few foods that were considered "healthy" and were forced to change these habits in treatment. The purpose of the food guide, and nutritional counseling, in eating disorder treatment, is to inspire cognitive shifts to eating a wide array of foods, eating without fears of the effects of foods, and getting adequate amounts of food (Croll 2010).

From what I discussed with participants, it seemed like the food guide therefore created a much needed line between healthy and 'too healthy'. Nutritional interventions in treatment reposition healthy as more than just eating 'good' foods and eliminating 'bad' ones. Rather nutrition is about getting enough food and a well-balanced distribution of foods. 'Healthy' for those with eating disorders often involved a strict adherence to the 'right' choices, which can ultimately lead to malnourishment and also to bingeing. In effect, those giving nutritional advice to eating disorder patients are meant to encourage the food guide as a "plan", but discourage taking this

plan too far, to not try to eat *too* perfectly. Taking the guide to the extreme is recognized as maintaining the eating disorder rather than moving away from it. For example, one treatment manual explains that patients should be encouraged to learn likes/dislikes but not allowed to justify other diets which are seen as too restrictive (Croll 2010). Continuing on diets, other than that imposed by nutritional science, is actively discouraged in treatment. In the Ottawa General Hospital Eating Disorder Treatment Program participants were not allowed to be vegetarian unless they had a religious justification. In Warin's research, the religious justification was sometimes not even seen as a valid reason for eating restrictions in treatment (2010). It is only the 'healthy', scientifically-established guidelines of nutritional science which are officially accepted.

My participants revealed a number of dietary practices which complicate the notion of one cohesive 'healthy' diet. Diets are a particular technique to shape eating practices, bodies and sometimes society or the environment more generally. Yet, as shown in the theoretical section, there are a variety of approaches out there. Diets meant to help people lose weight are different than those meant to be disease-preventing. Diets seen to be more sustainable for the environment are different than those meant to be more ethical towards animals. What is interesting is that a variety of these diets played into the way my participants narrated and shaped their eating practices.

Early on, it was common to many of us that we would use certain diets to justify under-eating or highly restrictive eating. Heather explained, "I remember the first time after outpatient I decided, 'I don't need bread any more' and it was just like another mind-game". You see, Heather justified not eating bread because of the health defects of eating too many simple carbohydrates. From the position of recovery, she now sees that this was just a way to eat less,

but a strategic way, that made more sense in a society abounding with health trends. I often wonder whether the idea of going 'gluten-free' was appealing to me not because gluten was not nutritious but because it would restrict me from eating all of my favorite 'bad' foods. It was hard to tell when so many of my friends, those without disordered eating, were going gluten-free.

Interestingly enough, all but two of the 11 participants (and myself), were vegetarian at some point during the time when we were seeking treatment. Although we may agree with this diet now, and some of us continue to be vegetarian, how and why we did it in the past was perhaps unduly influenced by the desire for perfect eating. Joane recognized that the moral undertones of 'eating right' very much influenced disordered eating behaviors and in order to recover, "You had to stop using food as a 'test' of how 'good' you were". These 'mind games' can lead to under-eating or binge/purge cycles whereas the meal plan sets one up on a regimented, but physically nourishing, way of eating. Because it is positioned as the correct, i.e. "natural", way to eat, it is like the 'no-diet' diet to recovery.

Meal planning in treatment is ergo a way of training the mind to feed the body adequately. This first requires you to actually counteract the cues you are getting to stop eating. As Elory explains, "When you are coming in you're really out of control and you don't listen to your body, but then it [the food guide] is very patronizing, its telling you to not listen to your body and just consume this amount of food". Regardless of how bloated or full you feel, you have to eat the required amounts. As Krista and Miranda can attest, this process is deeply uncomfortable. Even after more than a year in, Krista still feels stuffed after a 'normal' food guide-sanctioned breakfast. Nutritional science does not offer space for these embodied experiences of re-learning how to eat. Most of my participants' experiences in hospital settings revealed long and difficult meal times in which no one could leave until their plate was clean. The agony of eating, disgust

and bodily discomfort were palpable in these stories where at first patients simply have to eat what is planned.

As Julie explained, sometimes at snack time she would have to put all of her energy into eating a single granola bar because everything in her body was telling her not to. But she also explained that it got easier, slowly but surely, because the stomach starts to adjust to such scheduled eating. For those of my participants who had been eating this way for many years, feelings of hunger and fullness re-adjust to this style of eating and it becomes hard to stop eating this way. From the first month to the first year, this guide offers a format for how much food a person needs and patients are taught to force their bodies to adopt this regiment. People in recovery, rather than just feel hunger and fullness, had to *learn* to feel them.

Section 4.3 Ordered Eating, Disordered World

Sometimes hunger and fullness did not feel right, as if it was abnormal. Heather explained, “I still sort of feel like an anomaly, like I’m too hungry for my own good sometimes. I counter that anxiety with logic and evidence, that I’ve been doing ok [following plan] and I haven’t been hungry all the time”. She still did not know if her ‘hunger’ was normal though. A few of us, in fact, were frequently ‘hungry’, much more so than others around us. So although our eating became ‘ordered’ it did not necessarily fit well into the society around us.

For example, the insistence on regularity in meal-planning is difficult. I remember thinking, “Nobody eats every 4 hours, well, excluding me. Were all my friends starving themselves without realizing it?” I also had trouble locating meal times. They do not really exist on a University campus. With the Food Guide I was taught to eat three regularly timed meals a day, but meal times are not built into the class schedule, there is no official lunch or dinner time, classes run right through the day and night. So it was quite difficult to eat lunch at the same time

everyday. Joane also had this experience at her work waitressing. There were no breaks, no meal times and she had to fight to have snacks. Julie remembers being the only one in high school not eating snacks in between classes in the hallway; “But I had chemistry and I couldn’t eat in the lab, so I had to go for a walk between classes to eat my granola bar. When she (the teacher) said I couldn’t eat in class I panicked and then eventually we figured it out that I would just be a minute or two late so I could go eat.” It was something she had to do.

Then there is the difficulty of meeting all the food groups when you are not always in control of the meals you eat. If I ate dinner at someone’s house or at a conference, I would often be lacking one group or eating too much of another. Unless I made every meal myself and brought it with me wherever I went, something that some people in recovery do, I had to adjust to what others were eating or what was being served. Charlotte usually prepares a snack before or after she goes to eat at a friends’ house, because she finds they often serve very few carbs and she is still hungry. Especially in the period right after treatment, most of my participants brought their own food places, including restaurants, in order to follow the plan . This can be humiliating and sometimes discourage eating ‘regularly’. When Julie was 16, she was the only girl at her new job who brought a bag lunch, everyone else went out for lunch. She felt like a target was on her lunch bag, “like this was my eating disorder bag”.

I also started to experience dissidence in how other people close to me ate. My partner at the time started the ‘Paleo-diet’ and would make us meals with no grains. Grains are the basic staple of Canada’s food guide and eating them is still the only way I feel full. About an hour after eating a meal they prepared, I would need to grab a snack to satisfy my hunger. They could go for hours without eating again. Holidays were also befuddling. Where on the food guide can you over-eat on occasions like Thanksgiving feasts? Birthday dinners? As Krista asked, if treats are ok,

than why are they not on the food guide? These sort of questions resonated with my participants as they tried to introduce the 'order' of nutrition into their lives.

Having said that, some of my participants did change the way their families or those around them ate in order to make them more 'ordered'. So for example, Julie and her mother, for the first few months after treatment, would sit down every Sunday night and go through what they would eat everyday for the week ahead. She found that "It took the stress away. And my mom thought it was super fun!" Eugenie continues to plan meals with her family so that they all eat 'healthier'. Although her family will still eat some 'junk food' they mostly follow the rules Eugenie has set up around eating. This is itself interesting because it implies that the person who had a 'disorder' teaches those without how to eat. I myself was not very successful at this. When I tried to change how my mother ate, especially in asking her to reduce the frequency of desserts or the size of meals, she flat out rejected. The role of those in recovery to teach is a theme which will be picked up in the following chapter. For now it is suffice to say, that it is fairly early on when participants realize the 'order' of eating is not necessarily so in practice. Personally, these experiences let me to ask whether I could trust the Food guide and that is not a question I was happy with after having justified my recovery on the premise that I was maintaining a 'normal' and 'healthy' diet. Perhaps this is one reason why other approaches to eating are so appealing.

Section 4.4 Finding Order in the Body

All of my participants, especially Krista, expressed some doubt about the quantity of food suggested in the food guide. Elory argued that it was a rough guide, tailored to an entire population, and therefore not the ultimate authority on how much and what to eat for individuals. What seemed more important to participants was an ability to learn what the body wanted and needed. This 'listening' and 'mindfulness' reflects an important alternative in popular discourses

around food and 'life-style' eating. So in this way, they addresses a particular subjectivity about the body as 'trainable'. This is notably, the second goal of nutritional therapy; after establishing a normalized eating plan and a certain weight, to develop a more intuitive, mindful way of eating (Croll 2010). This sort of work starts to happen after instrumentalizing the food guide for a certain period of time and then continues past treatment.

It is recognized in eating disorder treatment models that particular ways of thinking need to be challenged in order to recover, but it is also recognized, that the body is the site of these practices. Eating practices shift how the body is itself experienced. It is understood for example that those in a starvation state are not able to make healthy decisions; which is why weight restoration is the first goal of treatment for anorexia (Croll 2010). It is also recognized that those with eating disorders have highly irregular eating patterns and that these have had consequences on their bodily processes; so there is a need to re-train the body – and then listen to it again. The body is therefore attended to through dietary techniques which help those in recovery reconnect with their "body's natural signals" (ibid, 131).

My participants explained that an overemphasis on the mental, or over-thinking, was a continuing challenge to overcome in eating. At first in recovery it was very difficult to stop the lines of thinking which led to eating disorder behavior. When facing stress, anxiousness, or sadness, they found themselves compulsively thinking about what/how they ate. Food was, and for some of us continues to be, the site for dealing with emotions. Erin for example can often tell now when she is hungry for something that she won't get in food, something about her relationship for example, she knows not to look for that in food. Amanda has learned to identify that tendency and now she knows "if I start to feel like that again I just need to get out of my own head. Go for a run or something". For Amanda, getting out of her head is a way of stopping the

movement of thoughts which cause unwanted behaviors. It is furthermore accomplished by getting 'into' her body.

Joane emphasized that recovery requires a basic awareness of what is a meal; grains, protein and a variety of micro and macro nutrients, but the real choices of what to eat should start to come more naturally as you learn what feels good; "The rest I just see how it feels". One participant explained it as intuition, the ability to understand something without conscious reasoning. Julie described it as, "A lost art form- paying attention to how you feel". Participants often positioned the body as having an innate wisdom to it. For example, it often came up that cravings may be a sign that your body needs a particular type of food or is feeling a particular emotion. One participant craves fruit when she has not had any for a while. Another can tell when she needs something crunchy in her diet. A third goes for certain vegetables when she needs those micro-vitamins. Joane put it quite clearly; "My body is smarter than me; it will tell me what it wants If I let it". The interesting thing about this quote is the ending, where it's clear that one can only 'hear' the body when one listens or 'lets it' speak. The 'me' is the mind, whereas the body is almost someone else, a someone else which must be reintegrated into how 'I' think. These sentiments often evoked a body separate from oneself, as if it feels and has needs of its own.

Charlotte explains this skill as a form of "active listening" ; "Its being aware of what your body and your mind and your emotions and everything are telling you and than not just being aware of them, but then following through on what they are telling you". As Garrett suggests, those in recovery may have a sense of inner dialogue as they begin to see the inseparability of the body as itself from the body as myself (1998). As she explains, the shift from outer to inner allowed her participants to escape the constraints of a merely outer body or the objectified body which was largely directed by the mind (ibid,150). In this example Charlotte is indeed referring

to a newfound awareness which is less disembodied, but it still positions the you as separate from the body, mind and emotions, a slip of the tongue which may be more telling than Garrett leads us to believe. I believe the goal of what Charlotte labels “active listening” is a form of training one’s self to actually overcome dualistic thinking by situating one’s self as a ‘being in the world’ rather than outside of it. It is often not expressed in such ways though. Even Charlotte herself later explains that she still does not trust her body to know proper amounts of foods.

4.4.1 Knowing, Control, & Uncertainty

There is crucial tension discussed by my participants between trusting the body/self and the mind/self; essentially questioning which one was more authentic. As Garrett’s research has also shown, in recovery, people are taught to focus inward and re-conceptualize the needs of the body as just as important, or more so, than the needs of the body they present to others. They therefore become more attuned to the ‘felt’ body which seems to emanate from within (1998). Reindl in 2001 published a phenomenological study of recovery from bulimia. Through in-depth interviews Reindl concludes with a similar theme; that recovery is the process of coming to experience a sense of self, but this self only exists in the act of sensing (2001). To this author, a process of learning to sense one’s self is to learn “to attune to one’s subjective, physical, psychic, and social self-experience.” It is not to find ‘the self’, as an entity or a construction, but rather the experience of a sense of self in the activity of sensing. Reindl argues that sensing is “referring inward to consult and know and trust one’s subjective experience”, including emotions and perceptions of the body and the world (ibid, 12). To Reindl, referring inward is the most important act of recovery.

There is however an authenticity at stake in discourses of the ‘inner’ body. Take for

example the case of hunger. When Garrett's participants talked about learning 'hunger', there is a "sense that the biological body is directly 'known' and accepted once more in recovery" (1998, 153) as if something was lost and found again. It supposes that those with eating disorders deny hunger, and in recovery, they recognize and respond to this physiological message. The felt body is re-instated as a legitimate source of knowledge about food, and this seems to be hugely important to people's recovery. According to treatment this newfound source of knowledge is however only accessible once their patients have re-instated regular or 'normalized' eating. It is through embodying the correct diet that it is inscribed in the body. Through forms of cultivation they begin to access certain rhythms, needs, and meanings, as if they belonged to the body 'naturally'. The body is privileged as a site of an authentic and natural state, a notion which is problematic from an anthropological perspective (Garrett 1998, 147). Especially since the body is discredited completely at first to treat the mind, which is then responsible to teach the body's its own authenticity.

This shows how significant our discussions around 'normal' hunger were. In the early stages of recovery, most participants did not feel hungry regularly, or at all. However, for those of us years into this pattern of eating, it was as if we were always hungry. Yet, we felt once again as abnormal because we had to eat every few hours and it sometimes felt like no one ate that much. Elory and I could recall study sessions where hours would pass in the evening and no one seemed to even consider dinner. Someone else brought up the annoyance of going on a car-trip and no one wanting to stop for a meal. It is these times where normal is put into question for those in recovery. Many of us could recall the immense time thinking or 'inner dialoguing' of what to do in these situations, what was 'healthy'; to be like everyone else, or to trust what we had learned. In fact I think this uncertainty might play a role in why some of us have made 'healthy eating and

living' a key focus in our lives whether as nurses, or mentors, or teachers. We are sort of dedicated to figuring it out.

The difficulty of being too controlled in one's eating was a major source of concern for most of the participants. All of them, but one, thought it was important to be able to eat all foods and not 'ban' any. Even Charlotte who had been since diagnosed with food allergies, allowed herself to sometimes eat foods that were 'unhealthy', meaning they may trigger a sensitivity, because she emphasized a need to be compassionate and realistic about the situations where she might find herself. 'It happens". Eugenie was the only exception in that she outright does not eat junk foods with sugar or chocolate, because she worries it will bring back cravings for these foods. The rest of my participants, on the other hand, were worried that any form of constraint on food choice could be a "slippery slope" to more restriction. This reflects the approach most used in treatment in later stages, where the strict diet is lessened in order to try a variety of foods, including those which scare you. Patients in treatment are encouraged to both learn what is 'healthy' but also except that no foods are completely off-limits because pleasure is important too. The line between the two is not necessarily clear and was a source of confusion for many of my participants.

4.5 Mind-Body Dichotomies in Practice

How much control is too much though remains a question. When was it alright to eat 'junk food' and when was someone being too 'healthy'; and according to which model or according to which body? In one sense Elory knew that 'healthy' food like nuts, beans and salmon were 'good for you' as in they were linked to good 'health outcomes'. They were 'healthy' fats according to the most recent research. But to Elory, they were perhaps too good for her and she worried that she was still being fat-averse (fear of fat being a symptom of anorexia). Elory believed that is was

helpful to eat what feels good, i.e. healthy food, and that eating a lot of high-sugar foods can make one feel 'gross', she also questioned whether that feeling was more so in her head than actually in her body. "I don't think its just in my head when you are really hungry and you have a chocolate bar and you feel hot right away and you know the body processes it right away, and then you're tired. And its not just in my head, but then I think maybe it is, because everything else has been". According to her diagnosis everything else has been in her head, in which case she turns to the body. I think here she questioned whether the ethics of nutrition; the moral 'goodness' of eating healthy, is too implicated in her taste preferences.

I find Elory's thought processes very insightful for two reasons. First of all, it points to the conflict of mind-body authenticity. Secondly, it reveals why a dualistic understanding of recovering the 'felt' body does indeed have consequences for people. As I discussed earlier, participants, including myself, felt that recovery required a re-learning of the body, a 'tuning in'. This implies that when in the acute stage of the disorder, the body did not influence one's experience. Rather, disordered eating was all 'in the head'. As Warin has shown however, anorexia *is* in fact experienced as an embodied way of relating to the world, and although it may reject certain bodily expressions, others are amplified (2010). For example, one's sense of the fat in a food may be greatly exaggerated and experienced as 'polluting' and 'defiling; responses that are embodied in disgust (ibid, 107). Krista and Miranda, respectively, referred to how much an eating disorder used to "make sense" and "feel normal" for them. O'Connor & Van Esterik's analysis of the eating disorder as a body with mind experience also highlights that although health professionals use the term mental illness, these illnesses are not just in the mind (2008). If mental illness is also embodied than a "tuning in" to the body is not guaranteed to bring about a new experience.

Yet Elory's struggle makes clear that she 'knows' what are healthy foods and how they feel. She does not problematize the assumption that foods labeled healthy always make the body feel good. This is in fact the opposite ontological assumption of the nutritional model identified by Mol, that the body inherently tends towards 'unhealthy' foods (2011). Elory argues the opposite, healthy foods, i.e. food objects correlated with reduced risk of disease and nutrient components, inherently 'feel' good. And 'bad' foods, like a chocolate bar, cause the body to loose energy. Furthermore, loosing energy means feeling "gross". But it is unclear whether Elory believes these bad feelings exist to 'tell' the mind not to eat that food or whether she identifies that feeling within a cultural framework in which the mind has been trained to understand energy conversion and the moral consequences of a chocolate bar in an empty gut.

Elory turns to the body as an authentic source of knowledge, but also questions whether her own thoughts on the purity and function of 'chocolate bars' may be affecting her bodily perception. I believe she is questioning how the body learns these reactions. She is also questioning when the enjoyment of the chocolate bar would over-rule the physiological 'use' of it. And this is where her reflections point to the mind with body as an act of perception; one where a certain amount of doubt flows from the eye and mind in movement. And yet, no natural 'real' experience exists to trust.

Here is another example. As Amanda explains in her yoga practice, she made "a mental switch, from hating what your body can't do, to enjoying what it can." Yoga then became immensely helpful to her. She began to appreciate what she could do and felt her body changing as she practiced more. I would say it's not just a mental switch then, its rather the bodily transformation works with the way you think about yourself and what you can do; it is a matching of mind and body. Because those with eating disorders are so prone to negative

thinking, it does require us to re-orient our thoughts. This is the contribution of psychological therapy, but these thoughts occur with bodily experience. One does not change without the other, nor are they necessarily hierarchical. It is mind-with-body activity that inspires continuous transformation.

Yet I also got the sense that Elory and Amanda almost feel 'tricked' by the mind.. or the body... tricked by some aspect of this experience because it did not make clear what is the right choice. And I wonder how many of us are tricked by the notion that there is a correct choice. Elory feel's her own credibility in food choice is undermined forever because she has had an eating disorder. This I believe is generally experienced by my participants although it was not always explicit. It came up though when we talked about having children, and our fears of passing on an unhealthy relationship to food. It came up when we felt uncomfortable challenging how our friends ate, or when we had to eat dessert with our families just so they didn't have any suspicions. In fact, I really looked forward to enjoying meals with my participants, to using our senses and joyfully sharing tastes. Even so, when my participants and I did attempt to share food during my field work, I felt as if a fear of judgment seemed to hang in the air. What food choices we would make seemed to carry weight in each other's presence. I wondered whether we were critiquing each other or critiquing ourselves. I wondered whether we worried that other people might think we were still 'disordered'. I think we still worry that we are.

Garrett points out that many people with eating disorders take the 'agnostic position'; they are uncertain of whether anyone ever really recovers but they are interested in trying to define what recovery is (1998, 67). Part of this uncertainty is rooted in the debates about the etiology of eating disorders, albeit psychological, genetic, cultural, and whether one can 'recover', be 'cured' or simply 'manage' it . Yet I also think most of my participants, most of whom did not feel

comfortable saying they were recovered, felt that recovery must mean some sort of perfection or finality. Yet, in its most obvious sense recovery suggests that people recover 'normal' eating habits and ways of thinking about food. To continue playing with words; they go from 'disordered' to 'ordered'. As I have illustrated in this analysis though 'normal' or 'ordered' is much more difficult to grasp than one might expect.

In fact Garrett argues that many of her participants were dismissive of 'normality' which the clinical criteria presuppose (1998, 67). I would say this was the same in the case of food. My participants were critical of contemporary food discourses from food industries to health 'trends', and unsure of when to trust nutritional science itself. At the same time, being 'normal' was an attractive ideal, a sort of abstract notion of that which is different from how they used to eat (ibid). My research points to a more profound discomfort with 'normal' however. Rather than just a different way of eating then before, especially since many of my participants didn't feel like they ever had a normal or 'ordered' relationship 'before', those in recovery seemed to still be searching for some sort of order that, in a phenomenological perspective, simply does not exist.

I believe those who have recovered have learned a wealth of information about food, both cognitive and experiential, but they struggle with which should get more weight. And, ultimately the proper way to eat remains a topic of interest, if not a recurring obsession, for my participants; a fact I find troubling. Implementing dietary advice into their lives still deeply shapes how they go about the day to day and whether bodily or cognitive, this 'order' remains elusive. In the following chapter I will further demonstrate how these piece-meal stages of learning the order, through mind then body, do not actually correspond to how 'order's are always being made and remade in life.

CHAPTER 5 LOOKING FORWARD

Lupton has argued that, “the sharing of food is a vital part of kinship and friend-ship networks in all societies” (1996, 52). Yet, how does one position the place of sharing food in the recovery journey? If first a patient is taught to map their food into specific portions at specific times, and then to ‘turn inward’ to the bodily signals shaped in this process, this informs how and when they eat. Unless the families and friends of those using the model adapt to this schedule, one which is not entirely common, than the person trying to recover must learn to eat alone. Or force others to adopt what they fiercely defend as normal. This sets recovery up as an individual journey. Which is itself interesting because as Warin’s research has demonstrated, eating disorders are rooted in contestations of relationality (2010). Warin’s research showed that in fact anorexics purposefully challenged the taken-for-granted rules of commensality, as anorexic behavior was a practice of often refuting relations by food refusal. My participants admitted hiding food, eating or purging secretly, and refusing meals; practices that isolated them from friends and family. This suggests that recovery requires a reorientation of relationality not a guide to further isolation.

Furthermore, in nutrition, there may be a guide to learning, or a design for making meals, but a grouping of nutrient categories does not make an edible, nor an enjoyable, meal. The model, although colour-coded and image-based, does little to encompass the sensory experience of cooking and eating, nor can individual bodily signals account for the sensory experience of sharing food. This is why another way of looking at how we learn to eat is so useful in an analysis of recovery. If first of all, food is inherently social, and secondly, the social and relational is inherently part of learning, then how can we explain learning to eat without accounting for them? I think we cannot and this is precisely why Ingold’s work on learning and skill is necessary to guide an analysis of how those in recovery learn to move forward with food.

In recovery, I have found that one must learn to improvise and adjust the rules of eating to the multiple realities 'on the ground' where people and things are always changing. And this is exactly what I've found in my field-work. Participants have learned to move with food rather than to control it. They have played with the sensual components of food, especially in cooking and sharing meals. They have cultivated new skills in situating themselves in certain environments and, most importantly, they have turned to multiple forms of relationality in order to situate eating and choices around food. In this way the contradictions underlying the style in which they were taught are rendered less important as are the relationships which contextualize how, what and when they eat. It is these relationships and experiences which allow those in recovery to move forward by letting go of 'ordered' eating.

Section 5.1 Foods Just Don't Taste the Same

In the field of nutritional as a science, food preferences, tastes, and habits, to which I would add engagements, "are secondary to food's biological mission to compose the body" (Lupton 1997, 7). This reduction of food lingers in nutritional therapy, as it is still arguably the 'natural' base on which people build bodily awareness. People are thus taught to eat with their minds. As an alternative, I look at eating as a set of skills which involve body and mind, as well as a set of relations with other people and with foods that are vibrant. This is particularly relevant to the sensory engagements of eating which do not happen only within the inner body/self but rather in relations and processes with foods.

The Facebook group I have been following leaves no doubt that learning food can be a very sensory experience. Members share instantly uploaded photos of melting ice cream or lasagnas. They give restaurant recommendations and share details of the new foods they have tried or the old foods they have revisited. Those who comment on these posts often reply with their own

recent success, as in, I just ate pudding for the first time in years and “I didn’t die!” They joke, they animate, and they recreate experiences of eating, all online.

Facebook posts are often celebrator, proclaiming pleasure and satisfaction at tasting a particular food, which was formerly shunned or feared. One poster really exemplifies an experience when she wrote, “mmm...the moment when you order a haloumi melt bagel because you don’t care how fattening it may be but it looks so goddam good and it tasted amazing too!”. She in fact draws the readers in to the experience *of* eating. As Sheila Reindl has argued in her work on bulimia, recovery requires a reconnection with sense experience as the act of sensing is how one develops a sense of self in practice (2001). This forum demonstrates however that sensing does not end at the subjective experience, it is continued, elaborated and transformed through sharing sensory experiences.

One of the most common bodily changes experienced by my participants during recovery was in fact their sense of taste. As Elory explains,

“I think I’m still realizing sometimes, actually realizing there are some things I don’t like and some things I really do like, whereas so often before I didn’t even register like tastes, it didn’t matter if I was binging. Once you sort of realize certain things, it’s harder to go back. I can’t convince myself that eating a bunch of crackers is something I actually enjoy, it doesn’t work anymore.”

Her experience of taste actually changed, perhaps by simply dwelling, in the experience, with food. This was explained by others as an ‘opening up’ to new foods in new places. Likewise they sought more experiences in order to do so. Elory defined ‘Recovery’ as “Having more experiences and textures in your story”. She sees eating disorders as an “exquisite adaptation” to a particular environment, and in recovery, “you have to radically re-situate yourself” in new environments. Taste is an interesting sense to explore the practices of resituating yourself.

It is important to reiterate here that ‘tastes’ do not exist waiting for the person in recovery to finally notice them, rather they exist in the act of noticing them. Taste is a situated activity.

Using a phenomenological perspective, the senses are not only organs which provide sense data to the mind to process as the Cartesian model suggests (and the nutritional model it seems), rather the senses are first located in a body engaging with the world. A clear example of this engagement occurs in the phenomenon of drinking a fine wine (Hennion 2007). The actor does not just see and taste the wine, tasting its chemical properties and processing those taste and sight data cognitively, rather the actor first attunes their sensibilities to the wine, engaging with it and evoking the wine to reveal its more subtle flavors (2007). What Hennion's example further illustrates is that the senses are cultivated, utilized and experienced in different ways. Someone, not accustomed to wine drinking, could taste a wine as they eat their meal and note nothing of it, save its acidity on the tongue. Or in Hennion's example, someone could stop their meal, roll the wine on their tongue and invite it to express itself while also expressing and verifying these tastes with other wine-drinkers in the room. In this sense, taste is an activity, not an organ, nor something that can be accessed as if separate from mind (2007).

Tastes therefore do not exist outside of the act of tasting. One example of the activity of taste really stuck with me. Krista, in treatment told a story about group therapy.

"In the hospital after you eat, we had check out, and you had to say something about your meal. I said 'Oh, I liked my peanut butter' and they all paused and someone said 'but you didn't eat any peanut butter. Look at your plate, you did not eat any peanut butter'. And I guess I would just think I did and I would pretend whatever I was eating tasted like peanut butter."

Krista told this story as if at the time she really believed she was eating peanut butter and was surprised when told she was not. I therefore argue that she could not possibly be pretending subconsciously. Perhaps she actually experienced the taste of peanut butter, perhaps she did not taste anything. In a hospital setting where the same foods are regularly repeated and where eating is always an ordeal monitored by nurses, tastes can take different forms.

In fact, Krista was one of two participants who did not seem to like food very much.

Although she was trying to “teach herself” to taste what she eats, this assumes that tastes are available if only one could sense them correctly. She also explained at one point that she did not really like eating, and only eats because she has to maintain her weight goal. I found this discouraging as Krista was the newest out of treatment in my study, and possibly had the most recovery work still to do. As we chatted in a café, I tried to really describe my love of the breakfast wrap I was holding and compared it to other foods I loved. It worried me the way she apathetically glanced at her Starbucks scone. She admitted that she sees things as calories, minimum requirements. I alternatively tried to share all of the foods I loved, to talk sensually about the snack I was having, because the experience of food to me is something to share and enjoy. But she was not necessarily in agreement. That is, until we discussed some of the activities she does with friends.

In the past few months Krista had tried new foods with friends, foods like oysters, lobster, and chicken wings. When referring to the experiences when she was learning to eat these new things with others, Krista emphatically shared whether she liked or disliked them. It seemed like in these occasions she had tasted foods in a way that alone and or in treatment she could not. When she had gone out for oysters for example, her friends helped her learn how to eat these new delicacies and they all laughed at her first attempts. I could tell that she liked the feeling of being open to new things, the excitement of sharing something. In the past she recalls always being the friend who could not eat what everyone else was eating. She repeated this sentiment when describing her love of the taste of cheese, a food which she had rejected since childhood. She remembered quite vividly that for most of her life she felt like an outcast at typical meals like pizza and pasta; “everything has cheese!”. These foods she now loves because she loves cheese. She can go out with friends and not have to order a special meal, something weird like cheese-

less pizza. She is proud that she likes this food, it makes her 'normal' and able to share and feel part of a group.

I would argue than that Hennion's example of wine drinking as a social activity is not only for erudite practices, but rather a fundamental part of our experience of taste. As an activity, taste is a matter of perception which phenomenologically is processual and multiple. The mind with body shape experience, itself always situated in relations with human and non-human beings. The tastes are not out there waiting to be accessed, but rather evolving in our continued practice. This is perhaps why both Elory and Joane explained that you just need to keep building a repertoire of experiences in order to recover. The more you do, the harder it is to go back, and feel like the person you once did. Foods just don't taste the same.

Section 5.2 Skilled Practice

In the above example, tastes are embodied but also active. They are not passively received but rather engaged with in what Bennett refers to as a 'swarm of activity' that is the body (2010, 101). Sutton argues that in order to understand taste; how it is embodied, cultivated, transmitted, and deployed in daily practice; Ingold's phenomenological approach to skill is most applicable in that it attends to everyday practices by drawing out the "emergent qualities of action". Sutton expands on Ingold's work to the realm of cooking and food production in order to grasp the skilled practices to be found there (2012). I will use Ingold's notion of skill (2000), with Sutton's contribution, an analysis of food making practices (2012), to frame the multiple activities around the production and consumption of food which I found in my fieldwork. I will discuss the difference between modern food practices and skilled practices, as well as how those interacting with food learn these skills as both novices in an environment and from their interactions with other more skilled practitioners.

To Ingold, skills are not simply techniques of the body, as posited by Marcel Mauss, for this implies that the individual body as a biophysical entity becomes a mechanical object in which movement is inscribed onto the body (1934 in 2000, 352). Ingold argues rather that skill is not a property of the individual, but of a “total field of relations constituted by the organism-person, indissolubly body and mind, in a richly structured environment” (2000, 353). Skilled practice is a condition of the practitioner’s embeddedness in an environment. Consequently, it follows that the practitioner does not apply a mechanical force to objects but engages in processes of care, dexterity, and judgment as these objects afford different possibilities for use (Pye 1968, 22 in *ibid*). The practitioner does so by practicing and observing, getting the ‘feel’ of things and by coordinating his attention and movement to the movement of others with their own bodily movement (Ingold 2000, 353).

5.2.1. Modern Food Practices

Ingold argues that much of modern technology subverts qualities of skilled practice to a rational paradigm of plans and mental operations (Ingold 2001). It removes the practitioner from the skilled use of a tool and its social context by turning them into a mere operator. Yet this does not imply the end of skill, because in fact new skills are constantly developing with new technologies in which people creatively incorporate them into their own everyday practices. This is a very important distinction as much of the modern discourse around the transmission of knowledge about food preparation laments the loss of traditional knowledge and practices, a point which Sutton argues is overly simplistic (2012). He argues that the way in which cooking blurs the line between production and consumption makes it an ideal candidate for a theory of skilled practice even with the integration of new technologies with food.

In fact, my participants and I had many interesting discussions about the modern food system. Many criticized the availability of food vendors everywhere and how so often the food available was pre-processed, packaged and ready for consumption. It was labeled as 'healthy', often by adding supplementary nutrients not generally in it, but they questioned whether processed food could be 'healthy', especially when eating it all the time. There was a general awareness that this food was removed from the larger processes that transform seeds and fruits into edible meals. As Heldke argues, our current food system readily devalues the process of food as not having any value in itself, it is simply a means to an end, the food product (1992, 209). Food is plastic wrapped, dehydrated, pre-cooked or pre-cut, the consumer reads the list of ingredients, nutritional labels and the colourful descriptions, and senses only the outward appearance. This brief moment of interaction, the 'staging' of food, and then its digestion as an object of 'health', has become that which largely influences food choice.

Perhaps this is why so many of my participants looked for new ways to contextualize food, to draw it away from the act of consumption, often seen as an act of moral or bodily restraint, to the larger field of relations which actually create 'food'. Modern food practices may in fact dis-embed these relations and the value of food production, but my participants were very critical of these processes. In fact practices such as gardening, shopping at farmer's markets, picking fruit, cooking from scratch, sharing and savoring meals, feeding others, and learning new recipes, were all a part of their recovery stories. Similar to the food movements discussed in the first chapter, they were trying to change interactions and understandings with food.

Erin states simply, but enthusiastically "Now, I cook, I garden, I grow things that are nutritious and beautiful". Erin, who struck me as a more subdued, clear-cut type of person, referred to these "coping mechanisms" so enthusiastically I had to smile. In recovery, she

exclaimed that her behaviors have become more hands-on and appreciative. She was working with food in new ways all the time through these activities and her excitement was reverberating. It was one of many examples where I felt like food had become more 'vibrant' for my participants and myself.

In fact four of my participants were genuinely interested in gardening. Erin had in particular incorporated gardening into her life as a way to further develop her relationship to food. She believes that the food one grows themselves tastes very different from something from a supermarket; it's a taste you remember. In fact Bennett argues that although all foods are alive, perhaps some foods are less 'vital' (2010). She asks whether such products like processed cheeses, and sterile-filtered wine, are "rendered more passive, less vital, and more predictable than their unpasteurized, unfiltered counterparts?" (ibid, 47). As Erin explained, even just local products can be so much more flavorful than those at a grocery store, and the relationships you can build with the farmers at the market also shapes the eating experience because you start to learn about the product and its life. Erin's realization of this has really changed how she values food. In general, those who gardened seemed to appreciate the value of food as an active and living thing.

5.2.2 Doing food

Foods have their own agencies, they are not passively waiting for us to consume them. As Pollan's work in *The Botany of Desire* shows, they are interacting with us, tempting us to spread their seeds (2001). Through practices such as gardening and shopping at farmer's markets, the act of eating can be re-contextualized within a much bigger process than the simple act of consuming or not consuming. A particular food is part of an assemblage of ecological

relationships including the people who desired it, grew it, picked it, processed it, shipped it, sold it and bought it. It then transforms as you make it and transforms you as you eat it. All of these relations becomes more apparent the more you engage with food. The choice, to eat or not eat is rendered too simplistic in these practices. It is replaced by a more vibrant connection with food.

Food-making was an activity of great importance to my participants. Not only did all of my participants feel it was significant to recovery, but it revealed a lot about their processes of 'learning' food. Take for example, the act of trying a new recipe. Amanda explained that whereas a meal plan is very strict, "A recipe you taste it as you're going along and you just sort of play with it." Amanda felt like someone in recovery could learn creative ways to interact with food by preparing it themselves. Food-making involves the body more so into the process of food, not just the act of consumption. As Heldke argues, food-making activities challenge a sharp subject/object divide, one that usually separates "head work and hand work" (1992, 217-218). In cooking, she argues there is not total separateness from the ingredients, nor can one have complete control over them. This is because the mind cannot read ingredients like a meter, rather, "The knowing involved in making a cake is 'contained' not simply 'in my head' but in my hands, my wrists, my eyes and nose as well. It is a knowing things literally with the body" (ibid). As Amanda explains, "You play with it (a recipe) to suit your own tastes, thereby involving yourself in the food." It is a practice of knowing in movement.

Recipes are not merely a manual in which all necessary information is transmitted to act on, because the conversion of this information into bodily behavior is generally not such a simple matter. The recipe speaks to skills that are already acquired, from melting, to stirring, to handling different substances, to knowing where to find the right ingredients and tools within the layout of a kitchen (Ingold 2001, 10) All of my participants liked to try new recipes perhaps to broaden the

skills they could bring to the kitchen and to the table, and these formed new ways to rekindle relations with food. Amanda argues that in order to not continue to obsess about food, a recipe is much better because you are focused not just on the end product but “the process of making something that is going to be tasty and healthy” . The recipe provides the model, but it is through improvisational skills that a recipe becomes a success and also becomes part of you in the process.

Amanda firmly believes that cooking has helped her adopt a better way of relating to food and I would argue this might be because cooking and preparing food also emphasizes enjoyment in both process and product. The enjoyment of food or eating for purely hedonistic reasons is something those with eating disorders deeply struggle with (Ashley & Crino 2010) and as Amanda herself argues, “ I don’t think its enough just to teach someone how to eat, you’ve got to enjoy food and I think that’s why cooking seems like a big deal, because if you enjoy cooking how do you not like food?” Although, it might not be that simple.

Heather explained that she always liked cooking, even when she was engaging in anorexic practices, but it was then more about having control, always making food her way. It was always “boring”, mostly vegetables, no oil or salt. Now, she recalls, “Sometimes I’ll be cooking dinner and I think back, why would I even go through the trouble of cooking if that was the end result? I like making things and I love when it turns out and tastes good and when I can find something both my boyfriend and I like, he’s super picky” . This approach to cooking, an openness to experience and taste, and a turn in emphasis from product to process was therefore a pivotal turn from eating disorder to recovery.

In fact many participants in Warin’s ethnography of those actively struggling with anorexia, would still cook and bake food but without consuming any of the product (2010). Warin

describes the antiseptic, sanitized smell of most of her participants' homes. Even after making food they would clean incessantly. She only recalls one site where aromas were present; that of fresh biscuits baking. The participant who lived there explained that only now that she was "recovering" could she enjoy baking and these aromas. This example illustrates the transformations in sensorial engagement which are made meaningful in recovery, but it also shows that cooking alone will not bring about a new relationship with food. Cooking can be transformative because it is a practice which introduces creativity and openness to food in process, and, it is more importantly, a practice which is largely social.

Heather still struggles with eating alone. In fact, in our conversations, it seemed like her boyfriend had played an important part in helping her be at ease eating meals together. As seen in the quote above, part of her enjoyment with cooking was located in her ability to share the meal (an accomplishment given his pickiness). Amanda also emphasized that she mostly enjoyed cooking when her partner was there to share it with, and mostly cooked simple meals when she was alone. Charlotte and I had an interesting conversation about how scary eating alone can be, she described it as a sort of "empty space". She often therefore plays with her rabbit or watches TV. It may be that cooking as a sensory and commensal activity, emphasizes the process of food as it turns into something more than itself, something to be savored, and something to be shared. Both the sensorial and the social play an important role then in having better experiences of food-making and also of feeding. I would argue then that to reduce the end product of cooking into food groups, or exchanges, or even just to the satisfaction of hunger, is to brush off all the activity involved in food as it is practiced.

5.2.3 Learning with others

The sociality of food practices is something which treatment programs seems to be paying more and more attention to. Some treatment programs do try to incorporate the socio-cultural context of food practices by incorporating food experiences other than just eating the set meal plan. Some programs, for example, have shopping and cooking groups where patients work with a dietician to buy ingredients, prepare the meal, and dine together (Ashley & Crino 2010). This is seen as a form of collaborative and experiential learning which situates food in a social and practical context (Ibid). Shopping at grocery stores, reading nutritional labels in healthy ways, cooking meals together, and serving one's-self adequate portion sizes with the appropriate kitchen tool, are all part of this 'rehabilitation' into 'normalized' eating. About 3/4 of my participants had done these practices in treatment.

Although some treatment programs have now implemented cooking sessions as part of therapy, cooking with a group of other individuals diagnosed with eating disorders was both helpful and unhelpful for those of my participants who had that experience in treatment. Elory found that in treatment the cooking sessions she had were quite uncomfortable because you had a group of different personalities and everyone was struggling with different areas. She tried just to keep quiet and not get too involved. But depending on the group dynamic, cooking together may be more useful. Julie explained how her group in treatment was amazingly tight-knit and they helped each other through meals. She especially recalls the Christmas cookies they had made one time in treatment. She found the baking part was really fun, until they realized they had to eat the cookies. So they sat down and on the count of three this group of girls pushed each other to eat two cookies each. Together they took one bite at a time. This surely points to a solidarity in treatment, a feeling of shared suffering but also hope. Whether cooking with a group

of people, all with eating disorders, would help someone reposition their relations to food, however, I think is questionable.

If eating and preparing food is relational, then relations with others who do not have eating disorders seems more beneficial. As I have discussed earlier, a large part of learning skill, from an Ingoldian perspective, is with a skilled practitioner. It is this relationship between novice and experienced that the novice attunes their bodily movement to the movement of others and the world around them. From the other side, teaching is consequently not just a showing of things, but a revealing in which the novice must touch, feel, sense and situate themselves into that space in order become comfortable in it. Although Sutton points out that a lack of cooking apprenticeship, where an experienced elder teaches a junior, seems to characterize modern, or even post-modern society, there are new forms of apprenticeship at work, such as the ubiquitous cooking shows (2012, 355). Most of my participants for example discussed their use of internet recipes, which are often accompanied by pictures, reviews, detailed comments, and links to other blogs or cooking sites. As discussed earlier, Facebook exchanges about food, especially recipe ideas for fast but filling meals, types of snacks easy to eat on the go, ways to enjoy foods that are more difficult, were common. In fact, cooking groups, outside of the family are also a growing phenomenon.

Cooking with a group outside of therapy can be quite an interesting experience and it is one Elory and I both found useful. Elory had gone on a group sustainability bike tour where they stopped at local farms and made their own meals. This group revealed to Elory that it's alright to not eat perfectly; it's alright to mess up. Sometimes a meal did not turn out that great and it was in that moment, where her grouped shrugged it off, that she realized she did not have to take it so

seriously either. She learned from those around her, and because they had perhaps a less obsessive or fixated relationship to food, this was helpful.

I encountered a very similar lesson in volunteering in a group which makes a free meal once a week on campus. At first, I found it incredibly difficult to not lose my temper with people who seemed to not care about the quality and timeliness of food we produced. They were willing to work slowly and try totally unknown experiments, whereas I wanted the meal to be perfect. Eventually I realized that I was trying to control every aspect of the meal rather than letting it evolve collectively. Whatever was made, my colleagues showed me, would be good because it would be shared.

I would say that both Elory and I learned to move with food and people by following their movements and trying to feel their sentiments. And in this setting we both experienced something transformative to how we think and feel about food. I was shocked when Julie told me that in high school after treatment she actually used her relationships as a conscious strategy for recovery. In fact, she willingly made a new group of friends to eat lunch with because her old friends did not really eat lunch or if they did it was always diet foods or half-meals. It was surprising because I believe at such an early period after treatment it is very difficult to convince oneself that eating how we were taught is 'normal' and what we really want. I am sure that many young girls in that situation, including myself, would reject the food guide and skip lunch like the teenage girls around them. It's much easier to justify eating disorder behaviors that other people see as normal. But this is exactly the opposite of what she did. Instead, Julie found a new group of lunch friends who ate an actual meal and although it was sometimes difficult to eat everything she had in her lunch, the group supported her when she needed to eat silently. Perhaps they also helped her, just by eating themselves, feel more comfortable about that amount of food. This

might suggest better forms of therapy, especially in social support settings. Rather than recreate cooking within the hospital setting, why not involve those in recovery in external food environments, with other types of people, and other types of engagements.

This theme of eating with others kept reappearing in my interviews amongst those who seemed to be the happiest with food and it surprised me because it was so different than my own experience. When I was trying to implement the food guide, I was an undergraduate student trying to fit in meal plans and snacks into a schedule which had no regularity. Most young students are newly free from the structure of meal times in high school and with their families, and I honestly felt like the only person on campus who had to eat every few hours and one of the few who ate three complete meals a day. It was slowly through the recognition that people around me could eat whenever they wanted and not think about it that convinced me I could be like that too someday. I accepted that eating in such a regimented way would be temporary and started to mimic the ease of those around me. Even if I still know how many carbs I've had today, I pretend like it doesn't matter.

However, Heather, Amanda, and Erin all alluded to how much easier it became to eat three meals a day when living with someone else who did. Amanda, who I discussed earlier, finally had to 'give up' her eating disorder behaviors when she moved in with her partner. It is at that time that she started cooking all her meals from scratch, because her partner had an allergy in which he could not eat most pre-made or processed food. Together they made most meals from raw ingredients, an experience which, as I discussed earlier, she found very meaningful for her recovery.

Yet to go from eating disorder to highly structured eating , to then letting go of structured eating, is extremely difficult. In fact two of my participants were still in that stage, and did not feel safe going off of the plan at all. Heather had also been very reluctant,

“I was afraid if I didn’t follow the rules, I would fall out of control, and mess up, but then I started spending more time with my boyfriend and I actually moved in with him and it got more relaxed. He eats when he’s hungry and when he feels like eating. I tried to give myself the comfort I needed, knowing I had enough of the food groups, but I definitely calmed down about getting the exact right time and learned to go with the flow more. “

At first Heather was shocked that her boyfriend would just eat whenever he was hungry, he didn’t have to think about it or make sure his hunger fit with a schedule. She didn’t think she would ever be able to eat that way, but when I interviewed her the second time she said, “Strangely enough I’ve been maintaining for a year without really keeping track.” Could this story point to the sort of imitation and alignment of movement of which Ingold speaks when explaining the process of learning. I believe so, because the ease of which Heather is speaking, I do not think can be consciously decided upon. Rather, it is a process of feeling comfortable by mimicking the behaviors, the bodily expressions, as well as the patterns of thought of others with your own movements and intentions. The body moves with mind to a point where eating continues ‘without keeping track’.

It is also significant that most of my participants emphasized the necessity of eating what others were eating in order to experience what was ‘normal’, as if trying to be comfortable enough to just ‘do’ rather than calculate or plan. I alluded to this in the case of Joane and her lunch friends. Heather also emphasized how much more normal hunger became through her boyfriend. She also got accustomed to eating lunch at work when she went regularly with co-workers. Slowly Krista was also learning to enjoy foods by trying them in groups. Foods take on a different significance in the presence of others who do not have disordered eating.

In my own experience, one of my best memories with food, and the one probably most significant to my recovery, occurred at a dinner with my friend Elena. It was one of those light bulb moments that a few of my participants also had in their recovery story. Elena enjoyed food so much and cared so little about all of the things I worried about, that I decided I should try it, try enjoying it, try imagining myself eating food the way she does. One night at dinner, I tried it and I walked home that night actually feeling like a different person. By mimicking others eating food, by mimicking others enjoying foods that were 'bad' for them, I firmly believe one can start to feel what that is like.

In fact only one of my participants refused to eat what others ate, she still did not eat certain 'unhealthy' foods, and she consequently had changed the way her family ate. For her, the switch to healthy eating was easier to do when those around her followed and I believe a lot of my participants would agree. For example, Heather explained herself as a "Food Pusher" something I can certainly relate to. She elaborated,

"Even now I'll phone my boyfriend, 'are you hungry, do you want lunch?'. I can't have lunch alone. My mother would help with that, she would eat with me. I think it's a comparison thing, I don't ever want to feel like I'm eating way more than anyone else. It's still a thing, I can get over it a lot more easily now. I survive and I still eat lunch, but it's comforting to have someone else there."

Being able to eat with others is an important avenue of regaining 'regularity', a feeling of fitting in with what is going on around us. It means also that we may encourage others to eat more frequently. In fact, the value of eating regularly, i.e. every 3-4 hours, is a value not shared by many Canadians, as anyone who has done treatment can attest to. Sometimes when people are not eating like us, we therefore encourage them to, and as long as the exchange happens in both directions, I believe it is a helpful practice in recovery.

Section 5.3 Situating Food & Recovery

5.3.1 Analytical & Social Critiques

Some participants critiqued the way people around them talked about food. For example, Joanne took it seriously when people talked about diets or degraded their bodies or fat in front of her. In particular she used a mixture of theoretical perspectives, from philosophy to feminism, to develop a critique of our current food system and discourses which inspire fat-shaming. In fact, all of my participants were critical of diet discourses and the diet industry in general. Eugenie was working as a fitness coach to try and bring a more positive approach to diet in the fitness world. Also, all of my participants were aware of current problems in our food system, such as heavy pesticide use, environmental degradation, the abundance of cheap filler foods and the poor quality and lower price of processed foods compared to more healthful, less-processed foods. In this sense I believe they were contextualizing the encounter with food through more analytical techniques as well.

Recognizing that certain foods can be contextualized within larger discourses also made it easier for some of my participants to partake in 'unhealthy' foods or deal with diet mentalities. As Joanne pointed out, "It's so social, like there are so many social cues telling us how we should eat, and how we should feel after eating (in front of us on our café table is a sign for guilt-free brownies). She points to it and asks, "Why should we be guilty in the first place?" These messages not only underlie nutritional science, they proliferate in media and advertising, especially those geared towards women (Coveney 2006). As Joane points out, companies are playing with our emotions to sell products especially towards women who don't feel 'skinny' enough or 'beautiful' enough. We discussed how chocolate cakes are labeled decadent, snack packs are labeled 'thin', a certain 'skinny' wine is marketed for its reduced calories.

We also discussed how companies mobilize nutritional research to create “new” products by merely adding whatever compound has recently been linked to a particular health outcome. The aforementioned brownies were, for example, high in Omega 3, and perhaps this is what made them ‘guilt-free’. Joane explained that there are so many health benefits of food, as well as a diversity of items out there. “Companies even use new packaging, from 100 calorie servings, to low sodium, its so easy for marketing...They can always sell something new too, say its good for your skin, hair, nails, it has antioxidants or fiber. I just go with what I feel like in the moment.” In this case if she wanted a brownie she would eat a brownie, or share one. These are the environments in which we, the recovering(ed) learn to eat. In which case learning within an environment does not exclude the analytical and abstract. As the above example shows, Joane uses both bodily cues as well as situational engagements and a more analytical approach to know food.

In fact, our current society is saturated with food choice as well as dietary advice which means we still need to think about food choices, even if we perhaps prefer a more bodily way of knowing. I think perhaps we have developed useful ways of moving with food. When discussing buying food out or making your own food, a trait I did not expect to share with my participants, for example, was thriftiness. Most of them found buying food out a waste of money and often were quite frugal shoppers. Maybe this relates to our need to have control over things, but it often was helpful in reducing the stress of choosing foods.

Given the thousands of minutely different products available at the grocery store, how do you make simple choices like what cereal to buy? I mean the cereal aisle is a perfect example which came up in two of my interviews. It is literally debilitating to make a cereal choice, when weighing all of the different health labels and serving sizes, the sugar content and the different

flavors. Krista used to spend 30 minutes in the cereal aisle and then always end up buying the same box of All-bran. She always wanted to try the new types, but they were never “good” , i.e. healthy enough. Now she buys whatever is on sale. With this technique, she tries new cereals, learns which ones she likes more and alternates. Heather also buys whatever is on sale to help her from “getting too caught up in all the food possibilities”. This is still how I make choices at the grocery store and it was funny to find I was not alone. Sometimes going with the flow means learning new criteria to situate one’s choices. In a hectic, information-overload super-market, economizing is a good way to adapt to this abundance of information, especially when a certain moral weight accompanies each ‘right’ choice.

5.3.2 Recovery: Disordering the ‘Order’

The recovery experience reveals how current dietary advice is not only pervasive, but fragmentary and often contradictory. On the one hand nutritional science has a history of presenting a regiment of eating in which eating requires thinking rather than pleasure. In fact, one of its major messages is that pleasure must be overcome by rational thought. More recently however, alternative approaches in dietary advice have rejected the notion that the pleasurable body must be controlled. Rather these approaches have coalesced around the notion of cultivating the body and its tastes; a deskilling followed by reskilling. Both of these paradigms are used by health practitioners (Mol 2013) and are encountered by those in recovery like a maze of options (Garrett 1998).

These approaches continuously assert a correct way of eating, but it is an order that is untenable. This is perhaps why those in recovery continue to question themselves – are we experts or continuing to “over-think” things? At one point I questioned whether our expertise

was in fact inhibiting a more profound recovery. I think this research demonstrates though that if we contextualize recovered eating, in practice, as a form of learning within an environment; then there is no perfect design- and this is what I'm pointing too. My participants were learning about their bodies but also about 'being' in and with the world around them. Their experiences were informed by reflection and engagement within a larger socio-cultural context; that of disorder and order around food, but also a practical engagement with the ecological context of food.

In refining both an experiential and an analytical understanding of food, I found my participants *were* becoming experts in food. But experts in a much different way than those of nutritional science. This is because they were dedicated to an understanding of food that radically challenged and yet was still deeply rooted in the eating disorder experience. As Kraaz argues, those with eating disorders have developed a wealth of insights about the world while learning to navigate and interact with it in a healthy way (2006). He argues that we disrupt the order, because "We can act as positive evidence for changing the way our culture relates to food' (ibid, 98). As long as we see recovery as a returning to 'normal', a learning of the 'right way', than we miss what the experience of order and disorder teaches you about food. Recovery is perhaps best served by learning this context, developing a critique and developing new skills. In such a way those who had eating disorders can ultimately stop searching for order. They do in fact disorder the order because they reveal so profoundly that order doesn't exist for anyone.

Erin explained recovery as a period of vulnerability and growth and I think my participants have also demonstrated it is a freedom for movement, transformation and improvisation. This is why I have proposed a way of seeing learning in practice. In this way learning to eat in recovery is not a lifelong burden, nor is it a 'cure' to a disease. Learning is rather a development of skill

that is sharpened through experience in different contexts. Rather than the journey of an inward looking individual mind/body against the maze of food products and bodily orders out there, recovery is an emergent and vibrant journey. It is a process of fine-tuning the ability to innovate, be creative, and always situated within an environment as well as part of making this environment as you go. Most importantly, it is an experience which offers an immense amount of insight and these insights are of enormous value to a society which itself struggles with eating.

CONCLUSION

In interviews, Facebook postings, in sharing meals and in cooking and engaging with food with my participants, we explored together how far the design of food goes, and what skills are needed to know food beyond the model. Those in recovery are learning to eat in an everyday life governed by unpredictability and choice. It is the ability to move with food, to eat in a sporadic and yet comfortable way, to bring food back into the flow of everyday life, that is eating well. If we continue to seek an 'authentic' bodily or nutritional way of eating than we separate ourselves out of this flow, but what I have shown is that the end product, the satisfaction of hunger, or the digestion of nutrients, depending on which framework you use, is actually over-shadowed by acts of creation and improvisation, in which we situate ourselves in an environment and flow forward. With this research I *am* trying to move forward as well. I am proposing that we can go beyond mind/body and body/mind and accept that eating requires the movement of both and that neither exists outside a relation with the world around us. In which case, we always have more to learn.

Heather jokes about being a "food pusher". Actually a lot of us are, or at least we think about it. When we are out with friends, studying in the library, or hanging out at home, we notice when we have eaten and we notice when you haven't. Sometimes, we share what we know. For example, we explain that eating regularly does help regulate your blood sugar; it helps you focus. This is helpful for us, maybe it would be helpful for you. Most of us also know that completely restricting foods from your diet just gives them a power that they wouldn't otherwise have. In fact, food doesn't have any inherent power over you. It is a powerful force to be engaged with, but its nefarious place in our society is more reflective of a particularly socio-religious context than its 'nature'.

Furthermore, eating regularly and not restricting are practices which reduce the urge for bingeing or for self-punishment. In fact, you don't need to punish yourself for eating badly, you don't need to gloat for eating 'well'; foods are not good or bad because of their 'healthiness'. Food is so much more than that, and so is health. Eating a diversity of foods, sharing foods, giving time to the experience of food and appreciating that sometimes you just need to eat to keep going, are all part of living. The deeper you live with food, the deeper you live life and the more you can learn. We do have these things to teach, and not just to others with eating disorders.

In the effort of looking forward, we also have a lot to learn. Those in this study in particular agree we have a lot to learn from each other. As Elory pointed out, its amazing how other peoples' weird activities can make you see how weird your own are. For me, this study, as well as my work mentoring, only underline that what we think is normal is never static. In talking with so many people with or who once had eating disorders, including all those I have met in other, completely un-related aspects of my life, I am amazed by the different histories, stories, justifications, relationships, beliefs, and understandings of eating disorders and recovery out there. It makes me feel like the only thing we have in common is a diagnosis. And believe me, if there are that many ways to be different and then labeled 'disordered', I am not convinced a single diagnosis could describe all of our experiences. Needless to say, a single approach to recovery is impossible.

But I do argue that we need to look at the world of experiences which brought us into the needle-point of an eating disorder diagnosis and the world of experiences which brought us out. Although it may be the most difficult and impacting part of our lives, it was only one moment in which we needed help in a system that needed to classify us in order to help us. As Elory explains, "When you struggled with something your whole life, its entangled into every part of your life

and its difficult to untangle”, but I believe the work of untangling is a process of connecting with the world around us in new ways. This is where we learn to eat, regardless if we have been learning our whole lives, it is a pivotal time to grow and to eat well.

We need to look outward then. We need to learn from our friends who never question what they eat. We need to learn from those we judge as fat or lazy even though we know we shouldn't. We need to learn from those who seem happy with food and its place in their lives. We need to learn from those who don't. We need to engage with these people as much as we do with others. We also need to learn from the discussions going on across our country about healthy eating. What I am most struck by is that you, my participants, deserve to be a part of this conversation. I believe this research shows that you are a pivotal part of how we all move towards better, happier and healthier relationships with food. Your experiences are a part of this world and your recovery brings you an immense wealth of knowledge and understanding that I am so glad you shared with me, and that I hope you will share with others.

APPENDIX

Pages 2 and 3 of Health Canada's "Eating Well with Canada's Food Guide"

Diagram A

Recommended Number of Food Guide Servings per Day									
	Children			Teens		Adults			
Age in Years	2-3	4-8	9-13	14-18		19-50		51+	
Sex	Girls and Boys			Females	Males	Females	Males	Females	Males
Vegetables and Fruit	4	5	6	7	8	7-8	8-10	7	7
Grain Products	3	4	6	6	7	6-7	8	6	7
Milk and Alternatives	2	2	3-4	3-4	3-4	2	2	3	3
Meat and Alternatives	1	1	1-2	2	3	2	3	2	3








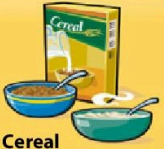













The chart above shows how many Food Guide Servings you need from each of the four food groups every day.

Having the amount and type of food recommended and following the tips in *Canada's Food Guide* will help:

- Meet your needs for vitamins, minerals and other nutrients.
- Reduce your risk of obesity, type 2 diabetes, heart disease, certain types of cancer and osteoporosis.
- Contribute to your overall health and vitality.

Diagram B

What is One Food Guide Serving?
Look at the examples below.

 <p>Fresh, frozen or canned vegetables 125 mL (½ cup)</p>		 <p>Leafy vegetables Cooked: 125 mL (½ cup) Raw: 250 mL (1 cup)</p>		 <p>Fresh, frozen or canned fruits 1 fruit or 125 mL (½ cup)</p>		 <p>100% Juice 125 mL (½ cup)</p>					
 <p>Bread 1 slice (35g)</p>		 <p>Bagel ½ bagel (45 g)</p>		 <p>Flat breads ½ pita or ½ tortilla (35 g)</p>		 <p>Cooked rice, bulgur or quinoa 125 mL (½ cup)</p>		 <p>Cereal Cold: 30 g Hot: 175 mL (¾ cup)</p>		 <p>Cooked pasta or couscous 125 mL (½ cup)</p>	
 <p>Milk or powdered milk (reconstituted) 250 mL (1 cup)</p>		 <p>Canned milk (evaporated) 125 mL (½ cup)</p>		 <p>Fortified soy beverage 250 mL (1 cup)</p>		 <p>Yogurt 175 g (¾ cup)</p>		 <p>Kefir 175 g (¾ cup)</p>		 <p>Cheese 50 g (1 ½ oz.)</p>	
 <p>Cooked fish, shellfish, poultry, lean meat 75 g (2 ½ oz.)/125 mL (½ cup)</p>		 <p>Cooked legumes 175 mL (¾ cup)</p>		 <p>Tofu 150 g or 175 mL (¾ cup)</p>		 <p>Eggs 2 eggs</p>		 <p>Peanut or nut butters 30 mL (2 Tbsp)</p>		 <p>Shelled nuts and seeds 60 mL (¼ cup)</p>	

Oils and Fats

- Include a small amount – 30 to 45 mL (2 to 3 Tbsp) – of unsaturated fat each day. This includes oil used for cooking, salad dressings, margarine and mayonnaise.
- Use vegetable oils such as canola, olive and soybean.
- Choose soft margarines that are low in saturated and trans fats.
- Limit butter, hard margarine, lard and shortening.

Source: Health Canada

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