

**SEEKING THE BODY ELECTRIC: THE ROLE OF EMBODIED AFFECTIVE  
EXPERIENCE IN THE PROCESS OF RECOVERY FROM ANOREXIA NERVOSA**

by

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**ABSTRACT**

Anorexia nervosa (AN) is presently defined by restriction of energy intake, low body weight, fear of gaining weight, and disturbances in body image (American Psychological Association, 2013). Absent from the current framework of AN is the acknowledgement of embodied and lived experience. Alternatively, the Developmental Theory of Embodiment (DTE), founded on Merleau-Ponty's conceptualization of embodiment, proposed that AN develops from complex interactions between the embodied female self and the sociocultural context in which it is situated (Piran & Teall, 2012). Extending from the framework of the DTE, the purpose of the study was to explore the role of embodied and affective experience in women with AN through the process of recovery using body-centered poetic discourse as a method of inquiry. Six women diagnosed with AN reflected on three time points of their recovery journey: at the worst of the eating disorder, in recovery, and towards unified body-self. Thematic analysis of poetic discourse resulted in the identification of eleven embodiment and three affective themes. Moreover, three body-self patterns emerged from the AN recovery process: bifurcated, recovered, and unified body-self. With recovery from AN, poetic discourse displayed a pattern of shifting from negative embodied experience, characterized by experiencing the body as bad, disconnected, and restricting to positive embodied experience, characterized by experiencing the body as valuable, connected, and freeing. The change in the affective experience was intertwined with that in the embodied experience, likewise shifting from negative or absent to positive. In summary, body-centered poetic discourse illustrated recovery from AN as parallel to the restoration of embodied lived experience. The clinical and societal implications of these findings are discussed in terms of reforming conceptualization

and prevention of AN from a framework emphasizing the role of the body and the importance of freedom and agency in restoration of the female embodied lived experience.

Keywords: Anorexia nervosa, embodied experience, embodiment, affective experience, women, embodied methodology, poetic discourse.

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**CHATER ONE: INTRODUCTION**

Womanhood, and all that is a woman, and the man that  
comes from woman,  
The womb, the teats, nipples, breast-milk, tears, laughter,  
weeping, love-looks, love-perturbations and risings,  
The voice, articulation, language, whispering, shouting  
aloud,  
Food, drink, pulse, digestion, sweat, sleep, walking,  
swimming,  
Poise on the hips, leaping, reclining, embracing, arm-curving  
and tightening,  
The continual changes of the flex of the mouth, and around  
the eyes,  
The skin, the sunburnt shade, freckles, hair,  
The curious sympathy one feels when feeling with the hand  
the naked meat of the body,  
The circling rivers the breath, the breathing it in and out,  
The beauty of the waist, and thence of the hips, and thence  
downward toward the knees,  
The thin red jellies within you or within me, the bones and  
the marrows in the bones,  
The exquisite realization of health;  
O I say these are not the parts and poems of the body only,  
but of the soul,  
O I say now these are the soul!

Walt Whitman, *I Sing the Body Electric*, lines 152-167

These words penned by Whitman (2004) evoke a sense of sacred, artful connection between the body and the self, eliciting admiration for the intricate subject-object dance of human existence. Yet, speaking of the complex embodied feminine experience in modern Westernized society, Sáenz-Herrero and Díez-Alegría (2015) noted that: “women are fragments, pieces, and incompleteness; thus, with this lack we find the origin of distress and associated psychopathology” (p. 136). Starkly contrasting Whitman’s words, the experiences of many women with anorexia nervosa (AN) are living proof of this fragmentation and disembodied existence, and of the loss of the sacred connection between body and self.

Anorexia nervosa has garnered clinical and popular fascination alike since first emerging in medical records over a century ago (Gull, 1874; Lasègue, 1873), arguably due to both its emaciating physical effects, and to its alarming severity that defies the usual intrinsic human drive toward survival. Whereas diagnostic criteria for AN have been somewhat altered over time, AN is presently defined by: (a) restriction of energy intake leading to a significantly low body weight on the basis of age, sex, development, and physical health; (b) intense fear of gaining weight or becoming fat, or continued behaviour interfering with weight gain despite significantly low body weight, and (c) disturbances in the way in which one’s body weight or shape is experienced, excessive influence of body weight or shape on self-evaluation, or continued failure to recognize the seriousness of current low body weight (American Psychological Association, 2013). The nosological distinction between subtypes of AN is organized into restricting and binge-eating/purging types, categorized by the presence or lack thereof episodic binge eating and purging behaviours (i.e., self-induced vomiting, misuse of laxatives, diuretics, etc.) over the course of three months or longer (American Psychiatric Association, 2013). Additionally, the clinical severity of AN is determined by body mass index

(BMI) values, with the minimum criterion for clinical diagnosis being equal to or less than 17 kg/m<sup>2</sup> (American Psychiatric Association, 2013).

The health implications of AN are particularly detrimental, especially given that, typically, the onset of the disorder is during the critical maturation phase of adolescence when malnutrition has a significant impact on the endocrine system, bone mass, metabolic rate, and reproductive functions in women (American Psychiatric Association, 2013). In addition, the high chronicity of AN, the high rate of relapse, and the prevalence of comorbid disorders such as depression, anxiety, bipolar disorder, and substance abuse, mark AN as a very complex clinical disorder that is typically exceptionally difficult to treat effectively (American Psychiatric Association, 2013; Carter, Blackmore, Sutandar-Pinnock & Woodside, 2004). Although recovery from AN after a single episode is possible for some people, other individuals display patterns of weight gain followed by relapse or sustained illness over the course of many years (Carter et al., 2004). The mortality rate for AN surpasses that of any other mental disorder, with as many as 10% of individuals with AN dying as a result of medical complications associated with the disorder or from suicide (American Psychological Association, 2013; Canadian Mental Health Association, 2015). Notably, AN is far more common in females with clinical populations generally reflecting a 10:1 female-to-male ratio (American Psychiatric Association, 2013).

In sum, the physiological and psychological effects of AN are both alarming and devastating. Echoing what is observed physically throughout the course of the illness, the focus of the current definition and categorization of AN emphasize external body aspects such as weight, shape and BMI, body image, as well as food and eating behaviours as central in defining AN. There is no mentioning of the role of subjective emotional or embodied

experience in the way AN is currently conceptualized and diagnosed in the DSM-5, and then treated in the mainstream medicalized model of clinical practice

In contrast with this focus on eating and body shape in defining AN, there is a growing acknowledgement that affective aspects, particularly emotional awareness and distress tolerance, are key features of AN (Fox, 2009; Kyriacou, Easter & Tchanturia, 2009; Oldershaw, Hambrook, Stahl, Tchanturia, Treasure & Schmidt, 2011; Racine & Wildes, 2013). Linked to these research findings, the role of the body in affective experience is also emphasized in recent literature on AN, suggesting that the body may function as a ‘concretized metaphor’ for affective experience (Miller, 1991; Skårderud, 2007a; Underwood, 2013). Manifesting in a glaringly physical way, AN reflects Whitman’s (2004) illustration of the tangible and the abstract tightly interwoven: food, flesh, cognitions, and affect. As the role of the body is markedly central to AN, and so fundamentally connected to the affective processes underlying AN, it makes sense to explore AN development and recovery process through the emotional experience and embodiment lenses (Miller, 1991; Skårderud, 2007a; Winkielman, Niedenthal, Wielgosz, Eelen, & Kavanagh, 2015). Instead of the traditional external focus on body characteristics, shape, and image, which potentially perpetuates a Cartesian disembodied perspective, there is a need for conceptually reframing AN as a disturbance in embodiment and emotional awareness (Lester, 1997; Skårderud, 2007a; Skårderud, 2007b), and the recovery from AN as a process of restoring the integrity of the embodied affective experience

Given the overwhelming prevalence of AN among women, there is much room for investigating women’s experiences of their bodies as pertaining to the development of and recovery from AN through feminist lenses. For instance, aspects of Western consumer culture promote Cartesian ideals for women defining what is feminine in terms of physical body as



exemplified by the beauty industry and mass media, through pornography, and, increasingly within health and fitness culture. From make-up styles to “waist trainers” and plastic surgery procedures, the female body is constantly objectified, augmented, and alienated, creating a chasm in the feminine embodied experience, a rift between the female self and the female body. Underwood (2013) suggested that “efforts to lessen the impact of problematic eating should be directed at changing the broader culture of the body, the body-self relationships that are fostered, in addition to treating the pathologised individual who meets certain criteria” (p. 387).

Illustrating this shift in understanding AN from a feminist body-centered perspective, this study sought to understand women’s experiences with AN in terms of embodied and affective experience. Using body-centered poetic discourse, this research project addressed the question of what are women’s embodied affective experiences during the process of recovery from AN.

## CHAPTER TWO: LITERATURE REVIEW

Drawing together concepts of affective processes, theories of embodiment, and feminist critiques, this chapter will review literature in light of this study's purpose of exploring the role of embodied and affective experience of women throughout recovery from AN. This chapter begins by outlining trends in how AN has been conceptualized, new trends in conceptualizing AN in terms of embodied affective experience, exploration of theories of embodiment, and views of AN from feminist perspectives.

### **Trends in Conceptualizing Anorexia Nervosa**

Historically, eating disorders have been understood in terms of obsession with food and body weight and shape. Specifically in cases of AN, a great deal of attention has been given to the misconception that the pursuit of thinness is what fundamentally fuels the intense restriction of dietary intake observed in persons living with AN. This section of this chapter will outline the main historical trends shaping our understanding of AN, providing a foundation for the aims of this research by highlighting a void in acknowledgment of the role of embodied affective experience.

**Psychoanalytic understanding.** AN was first conceptualized as a disorder of psychological origin by Freudian psychoanalytic theory during the first half of the 20th century (Caparrotta & Ghaffari, 2006). With feeding being closely linked to sexuality in psychoanalytic theory (Caparrotta & Ghaffari, 2006; Freud, 1895), particularly emphasizing the oral stage of psychosexual development, AN was thought to develop from melancholia, ego dysfunctions, and suppression of sexuality (Freud, 1895). Expanding upon Freud's stance, Abraham (1920) further developed the psychoanalytic perspective on AN as related to woman's sexuality, and proposed that the disorder was linked to a fear of oral impregnation.

From this understanding, food restriction witnessed in persons with AN reflect an unconscious fear of becoming pregnant through the mouth (Abraham, 1920). Although the emphasis on suppressed sexuality and oral impregnation was rather primitive, formulated from a mere few extreme cases, this early psychoanalytic perspective generated a departure from a strictly physiological conceptualization of AN by emphasizing the psychological nature of the disorder and the symbolic function of the symptoms of disordered eating.

Interpersonal focus. Beginning in the 1970s, Bruch (1973, 1982) made a departure from the traditional Freudian conceptualization and focused on the intra- and interpersonal dimensions of AN etiology. Out of her extensive psychotherapeutic work with AN clients, Bruch has explored the themes of self, identity, and control in persons living with AN. Bruch's remark that: "Food lends itself readily to [misuse in the context of eating disorders] because eating, from birth on, is always closely intermingled with interpersonal and emotional experiences, and its physiological and psychological aspects cannot be strictly differentiated" (1973, p. 3), brings to the forefront the notion of food as symbolic representation of the self and affect, and the interwoven nature of mind and body as deeply embedded in AN. Moreover, Bruch (1973) noted that individuals with AN expressed a lack of identification with their own bodies, feeling extraneous from one's own body.

Additionally, Bruch's suggestion that a deep longing for control is central to AN development remains steadfast, being revisited by present day approaches to AN. The observation that many women living with AN play out their desire for control through their own bodies, as their bodies are often the only area of their lives in which they can exert control, not only continues to inform current day research and treatment but also is reflected in feminist approaches to AN (Lester, 1997; Malson, 1999; Skårderud, 2007a).

**Cognitive-behavioural focus.** In the 1980s and 1990s, cognitive-behavioural approaches to understanding and treating AN proliferated, emphasizing that body image disturbances, and cognitive distortions regarding food, eating, body shape and weight are core aspects of the disorder (Lipsman, Woodside & Lozano, 2014; Thompson, 1990). At large, such frameworks continue to dominate how AN is presently understood in research and clinical practice where the foci of assessment and interventions are fat phobia and distorted body image (Lipsman et al., 2014). As maladaptive attitudes and behaviours concerning food, eating, and body weight and shape are features of AN (American Psychiatric Association, 2013), cognitive behavioural therapy (CBT) is arguably a logical AN treatment option. However, empirical evidence displays that CBT is only modestly effective (Galsworthy-Francis & Allan, 2014), with less than half of individuals treated exhibiting minimal to no AN symptoms following the conclusion of treatment (Kass et al., 2013). Moreover, the current DSM-5 diagnostic criteria reflects such focus on cognitions about food, body weight, and body image disturbance, maintaining fat phobia as a key feature of AN. However, such perspectives arguably fail to acknowledge the vital function of affective experience and the symbolic role of food and body. This shift towards body image disturbances and eating behaviours in and of themselves leaves little room for critical examination of the subjective feminine experience within the context of Western cultural norms and expectations. Lastly, cognitive-behavioural approaches to AN tend to perpetuate an outside perspective (i.e., preoccupation with food and the external body shape and weight) rather than exploring an internal perspective of embodied and affective experiences.

**Family-based focus.** Due to the low efficacy rates of individual therapies, family-based treatment alternatives such as the Maudsley Model of Treatment for Adults with

Anorexia Nervosa (MANTRA) have garnered increasing attention (Kass et al., 2013). Family-based treatments such as MANTRA address maintaining factors including perfectionism, cognitive distortions, avoidance of strong emotion, and rigid or otherwise problematic family relationships (Hay, 2013; Kass et al., 2013). Although dropout rates are consistently low, and outcomes in terms of weight gain and AN symptom reduction are modest yet significant, (Hay, 2013; Kass et al., 2013; Schmidt et al., 2012), MANTRA has some obvious short comings. In addition to its less than impressive efficacy, it is recognized as requiring further development and evaluation (Hay, 2013; Schmidt et al., 2012). Moreover, family-based treatments such as MANTRA require the willingness and presence of parents, siblings, or spouses in order for the identified patient to receive treatment. This creates a particularly problematic barrier, limiting practicality and accessibility for many women requiring treatment for AN.

**Emotion-focused approaches.** Given the emotional deficits associated with AN (Fox, 2009; Kyriacou et al., 2009; Racine & Wildes, 2013), recent treatment has begun to target affective processes (Dolhanty & Greenberg, 2007; Dolhanty & Greenberg, 2009). Emotion-focused therapy (EFT) is founded on the principle that emotion is fundamentally adaptive, providing complex information that can serve as a dynamic guide for behaviour (Goldman & Greenberg, 2015). Likewise, emotion holds the potential for great dysfunction through a lack of emotional awareness, maladaptive emotional responses, emotional dysregulation, or problems in personal narrative/existential meaning (Greenberg, 2010). EFT aims to enable the individual to become aware of and engage with more adaptive emotional processes, express and regulate emotions, and learn to utilize adaptive emotions to transform maladaptive affective cycles (Goldman & Greenberg, 2015). In cases of AN, EFT seeks to explore and

process underlying maladaptive emotions such as fear or shame, which are thought to fuel dysfunctional eating behaviours (Dolhanty & Greenberg, 2007; Dolhanty & Greenberg, 2009). EFT also often focuses on the harsh internal critical voice, typically referred to as the ‘eating disorder voice’ or ‘anorexic voice,’ working to uncover and process maladaptive emotional cycles provoking self-criticism (Dolhanty & Greenberg, 2007; Dolhanty & Greenberg, 2009). Dolhanty and Greenberg (2009) report positive outcomes including healthy weight maintenance, increase in emotional awareness, and decrease in depression in a detailed case of EFT for AN. Additionally, EFT holds potential for enhancing family-based modes of treatment for AN (Robinson, Dolhanty, & Greenberg, 2015). However, empirical study and support for EFT for AN, at present, is greatly limited.

**Conclusion.** Overall, the current treatment options for AN are limited and reported recovery rates are devastatingly low, with only 46.9% of cases reaching full recovery (Steinhausen, 2002). Moreover, rates of chronicity and relapse ranging from 20.8% (Steinhausen, 2002) to 35% (Carter et al., 2004) have been reported. Such staggering rates reflect the elusiveness of recovery from AN, suggesting that current understanding of AN may be insufficient. In addition, mainstream conceptualizations of AN focus predominantly on distorted cognitions, body image, and eating behaviour, yet place little focus on the individual’s *experience* of their body.

#### New Trends in Conceptualizing AN

Given the narrow focus of the current understanding of AN and the recent research evidence of the role of embodied experience in AN, an alternative conceptualization shifting the focus from thoughts and beliefs about food, body shape and weight, and body image to embodied affective experience would complement well the mainstream approaches. Further,

such a shift in conceptualization will provide the necessary impetus for future research into alternative research and clinical approaches to AN.

This alternative understanding emphasizing the central role of embodied experience in AN beseeches exploration of how the body is experienced, situated within the Western sociocultural context. Detachment from the role of the body in human experience is particularly salient in Western consumer culture, where the body is increasingly linked to aesthetics, appearance, and self-expression (Underwood, 2013) as opposed to an honoured and integrated component of one's self. For example, a research study conducted by Underwood (2013) suggested that even in healthy participants there is a marked tendency to project one's feelings on the body, to attribute one's feelings to one's body, and to make efforts to change the body in order to change feelings about the self. Thus, as Underwood (2013) noted, "The interconnection between body and self meant that eating and other behaviours were always matters of the self as well as the body" (p. 382). Such observed connection between the self and the body suggests that a focus on embodied experience lends itself naturally to the exploration of restriction and control over food and the body in persons suffering from AN.

Recent studies have indicated that emotional deficits represent a key feature of AN (Fox, 2009; Kyriacou et al., 2009; Racine & Wildes, 2013). Several research studies have indicated that individuals meeting the DSM-5 diagnostic criteria for AN often display difficulties recognizing, understanding, expressing, tolerating, and regulating their own emotions (Fox, 2009; Kyriacou et al., 2009; Racine & Wildes, 2013). Specifically, Racine and Wildes' (2013) longitudinal study investigated emotional regulation in a sample of 192 individuals diagnosed with AN, and found that, whereas impulse control difficulties were linked to bingeing and purging behaviours, emotional awareness predicted the severity of eating

related cognitions, suggesting that varying emotional deficits are reflected through different features of disordered eating.

A meta-analysis study of the relevant research literature found further support for the relationship between emotional deficits and AN (Oldershaw et al., 2011). Of the 37 experimental studies reviewed, 13 examined the recognition of emotions in others, and the results of these studies indicated an overall impairment in facial emotion recognition in AN cases. Namely, individuals with AN display difficulty in accurately identifying the emotions of others based on viewing facial expressions. In addition, AN was associated with the lack of ability to link emotions to bodily sensations. Moreover, individuals diagnosed with AN exhibited difficulties retrieving and describing past emotions. In sum, the results of this study have highlighted the central role that emotional experience plays in disordered eating, with impairments in emotional awareness and recognition being associated with AN. Moreover, while the connection between emotional deficits and AN is supported, there is an evident lack of consistent, unifying models in this area of research and treatment. Additionally, of the 37 studies identified and reviewed, not a single one employed an embodied perspective as a lens for investigation of emotional impairments and AN.

Further exemplifying the severity of emotional awareness deficits, a series of research studies have suggested that individuals with AN tend to display high levels of alexithymia, or an extreme impairment of the ability to identify and describe emotions (Beadle, Paradiso, Salerno & McCormick, 2013; Rommel et al., 2013). Beadle et al. (2013) examined alexithymia, cognitive empathy (i.e., the ability to understand others' mental states), and emotional self-regulation in a sample of 26 women diagnosed with AN, and in an age-matched control sample of 16 women who did not meet criteria for AN diagnosis. Assessments were



carried out longitudinally, both during periods of starvation and at weight restoration. Study findings indicated that, in comparison to healthy controls, women with AN had more severe alexithymia and displayed more intense personal distress, defined as a domain of empathy measuring vicarious negative affect in response to others' suffering. Furthermore, alexithymia and personal distress associated with AN were consistently higher than that of healthy controls even following weight restoration. Such results suggest that emotional factors such as the capacity to experience and identify one's emotions and the increased sensitivity to interpersonal distress/suffering may represent core vulnerability/predisposing characteristics of AN.

In summary, existing literature has illustrated the connection between emotional deficits and AN, particularly identifying difficulties in emotional awareness, understanding, and regulation (Fox, 2009; Kyriacou et al., 2009; Racine & Wildes, 2013). Although such emotional deficits have garnered attention and empirical support, the DSM-5 diagnostic criteria have yet to include such deficits as a core feature of AN. Moreover, despite the role of the body in emotional experience, as outlined in the following text, emotional deficits in cases of AN have yet to be examined from an embodiment lens.

### **The Experience of Embodiment in Anorexia Nervosa**

**Philosophical foundation of embodied perspectives.** Pioneered by the works of key philosophers and scholars including Husserl, Heidegger, Sartre, and Merleau-Ponty, as a theory of mind or of consciousness, embodiment perspectives address the role of the body in shaping the mind by recognizing that the reciprocal relationship between the self and its surroundings is mediated through the body (Winkielman et al., 2015). When examining embodied perspectives in relation to AN, perhaps the most salient links are drawn through returning to the

philosophical roots of the embodiment theories. Fundamentally, Heidegger (1949) rejected the Cartesian notion of self-body dualism, and conceptualized embodiment as intrinsic to Dasein (being-in-the-world), with the subjective self (mind) and object self (body) mutually comprising and shaping one another. In other words, the body is not only representative of the self, but rather the body constitutes the self as *somebody* in the world, and, reciprocally, the self constitutes the body as an agent in the world. Merleau-Ponty (2012) embraced Heidegger's departure from Cartesian self-body dualism, and further developed the phenomenological understanding of embodiment. For Merleau-Ponty (2012), humans experience the world always as embodied beings, perceiving and interacting with the world to the degree to which our bodies enable or constrain us.

It is useful to note how language enables or constrains the way embodied lived experience is communicated and understood. The German language makes the distinction between *Körper*, referring to the body as an object or objective reality, and *Leib*, referring to the body as a lived or experienced reality (Husserl, 1998). This nuanced distinction parallels that of Sartre's (1943) "body being for oneself" and "body being for another." Sartre's analysis of lived corporeality makes the distinction between the lived body and the physical body, or body-subject and body-object. The concept of body-subject refers to the body experienced from within, one's own direct experience of their body in the first-person perspective. Contrastingly, the concept of body-object refers to the body thematically observed from outside, from the third-person perspective. Similarly, Merleau-Ponty's (2012) notion of *corps propre*, referring to the "body who I am and who is I," is different from the notion of *corps objectif*, or the observed body.

Contemporary scholars, Sáenz-Herrero and Díez-Alegría (2015) have noted that, like English, the Spanish language does not distinguish as fluidly between the concepts of subject and object body, yet Spanish literature has called the objective body “extra-body” and the subjective body “intra-body.” Sáenz-Herrero and Díez-Alegría (2015) describe intra-body as void of colour, shape, or form, but is instead comprised of feelings of movement, perceptions of physiological changes, and experiences of sensations such as pleasure or pain. This constitutes the interoceptive experience of the body. Therefore, the intra-body is understood as the body lived from within rather than the body seen from within. It is subjectively experiential.

The distinction between the subjective body and the objective body made throughout the literature on embodiment illustrates that dimensions of corporeality are characterized by having an implicit acquaintance with one’s own body from the first-person perspective, while also experiencing it as a physical, objective body (Sartre, 1943). Merleau-Ponty (2012) further elaborates on these facets of corporeality, distinguishing between body-for-self and body-for-other. Here, body-for-self (*corps propre*) aligns with Husserl’s concept of *Leib*, maintaining a first person, subjective perspective of one’s own body, whereas body-for-other reflects Husserl’s concept of *Körper*, a third person, objective perspective of one’s body. The body-for-self is known from within, deeply experiential and intimate, while the body-for-other is a thing of flesh, defined by shape, weight, form, etc. Yet to be embodied is to experience one’s physical body as both subjective and objective, “for we exist in both ways *simultaneously*... I am never a mere thing and never a bare consciousness” (Merleau-Ponty, 2012, p. 480).

**Contemporary contributions to theories of embodiment.** From an embodiment perspective on a general level, it is proposed that information processing is directly molded by

the body, and that the body's interactions with its surrounding world, and the recollection of previous experiences or information, whether sensory or affective, is at least partially reproduced, reenacted, or reexperienced (Barsalou, 1999; Clark, 1999; Wilson, 2002). Such reenactment is referred to as *embodied simulation*, and is seen as crucial to reasoning, using emotional concepts, and interpreting language (Winkielman et al., 2015). From such a perspective, processing of information about sights, sounds, and other sensory stimuli, as well as other kinds of information such as abstract social, emotional, or moral concepts is influenced, informed, connected to, and even may rely on perceptual, proprioceptive, and somatosensory resources (Niedenthal, 2007; Niedenthal, Barsalou, Winkielman, Krauth-Gruber, & Ric, 2005; Winkielman, Niedenthal, & Oberman, 2008). Within the realm of embodied emotional cognition research, two primary areas of focus have emerged: 1) somatosensory-motor elements of emotional experience as contributing to higher order emotional processing; and 2) emotional metaphors (e.g. distance or temperature to describe emotional closeness or engagement) as requiring the capacity for sensing heat or understanding distance (Winkielman et al., 2015).

A more recent focus of embodiment literature has explored the circumstances under which affective information is simulated and what particular features are simulated through the process of reflecting on abstract mental states (Chen & Bargh, 1999; Neumann & Strack, 2000). Many mental states have defined internal components (e.g., anger feels hot) while also involving visible external features (e.g., facial reddening with anger), illustrating the role of the body in affective experience (Oostervijk, Winkielman, Pecher, Zeelenberg, Rotteveel & Fischer, 2012). Additionally, research has shown that maintaining an internal or external perspective (i.e., focus within the body or focus on external surroundings) impacts one's

understanding of abstract mental states, whether cognitive or emotional in nature (Oostervijk et al., 2012). Such findings have potential implications for emotional awareness and processing, particularly in cases where individuals disengage from negative or overwhelming affect.

There is a consistent tension between objective, or cognitive/neurological science, and subjective, or phenomenological experience that characterizes embodiment literature. However, narrowing the theoretical frame of reference, from a neuro-phenomenological perspective of embodiment, it is argued that consciousness extends beyond introspection, of internal physiological awareness and perception, incorporating reflexive capacities enabling a suspension between objective and subjective realities (Varela, 1996). Specifically, a neuro-phenomenological view of embodiment suggests that phenomenological experience and their counterparts in cognitive/neurological science relate to each other through reciprocal constraints (Varela, 1996). Consciousness is then “not some private, internal event having, in the end, an existence of the same kind as the external, non-conscious world” (Varela, 1996, p. 339). Embodied human experience is undoubtedly a personal event, yet it is not private; it extends beyond biological processes as individual embodied consciousness is “inextricably linked to those of others and the phenomenal world in an empathic mesh” (Varela, 1996, p. 340). Matters of embodied lived experience are thus situated at the intersection of fleshy physiology and subjective phenomena transcending biological processes.

**The role of the body in emotional experience.** As previously noted, the body plays an integral role in affective processes, being particularly central to emotional awareness (Winkielman et al., 2015). Emotional awareness and regulation are tied to bodily interoceptive processes, alluding to the need for incorporation of embodied perspectives in further

exploration of the relationship between affective experience and AN symptoms. William James' (1884, 1994) proposition of emotion as the result of interoceptive recognition of states of the viscera illustrates the interconnectedness of the physiological processes and emotional experience, fueling the understanding that "mentally represented bodily state is an integral part of emotional experience and an integral component of emotional processing." (Winkielman et al., 2015, p. 157). Neo-Jamesian theories of emotion focus on neurological activity as it corresponds with affective experience (Spackman & Miller, 2008). Exemplifying such a framework, Damasio's (1994, 1999) somatic marker theory proposes that somatic states "mark" possible options by associating them with positive or negative feelings (e.g., is there the potential for harm in this setting?). These markers serve as guides, prompting "gut" reactions often in conjunction with a thought that aids in the analysis or decision-making. Somatic marker information is believed to occur in the ventromedial area of the prefrontal cortex. Sensory information travels to the limbic system, which in turn activates other areas of the brain producing corresponding reactions throughout the body. It is then this pattern of activation in response to a particular stimulus that is compared to existing memories of similar states, producing association models of stimuli-sensation-affect. Through such neo-Jamesian theories of emotion, the body is recognized as being integral not only to the stimuli-response processes involving neurological activation, but also to the experience of emotion itself. It is through the body that emotion takes on greater intensity (e.g., a deeper sense of pleasure), and quality (e.g., warmth as a result of increased blood flow to the skin's surface), or pain (e.g., discomfort as a result of increased heart rate, gastrointestinal upset, etc.).

Furthering neo-Jamesian thought, echoing the centrality of the body in affective experience, Mazis (1993) focused on the word emotion itself, which implies movement.

Expanding on this notion, in order for there to be movement, there must be something that is moving, something that takes physical form or is embodied in order to exist in space.

Therefore, Mazis (1993) contended that the term emotion denotes embodiment, requiring a vehicle, a body, through which existence in space is made possible. As Spackman and Miller (2008) observed, “The embodiment of the emoter is, then, essential to the emotion itself; it is not a secondary aspect of the subject’s appraisal of his environment” (p. 369). Although literature consistently supports the relationship between emotional experience and embodiment, the connection between emotional features of AN and AN symptoms has yet to be investigated in terms of embodied experience.

**Embodied affective experience in anorexia nervosa.** Pioneering empirical study of embodied experience in AN, Stanghellini et al. (2012) hypothesized that individuals with disordered eating display disturbances in the way they experience their bodies. Drawing from embodiment philosophy and from the distinction between subjective body-for-self and objective body-for-other, Stanghellini et al. (2012) investigated the experience of corporeality in eating disorders and concluded that “persons with [eating disorders] experience their own body first and foremost as an object being looked at by another, rather than cenesthetically or from a first-person perspective” (p. 148). Findings suggested abnormalities in experience of one’s own body, with the body akin to an object being looked at by another. Additionally, findings display patterns regarding personal identity, namely that of defining one’s self primarily in terms of the way one is looked at by others and through one’s ability to control one’s shape and weight.

Additionally, as previously discussed, a wide range of emotional deficits have been identified as strongly related to AN, with research displaying that individuals diagnosed with

AN often exhibit difficulties recognizing, understanding, expressing, tolerating, and regulating their own emotions (Fox, 2009; Kyriacou et al., 2009; Racine & Wildes, 2013). When viewed alongside research findings depicting that differing affective experiences, such as emotional awareness or impulse control, are associated with differing disordered eating features (Racine & Wildes, 2013), the notion of the body as a ‘concretized metaphor’ for affective experience (Skårderud, 2007a) emerges yet again. In AN, various facets of affective experience appear to be played out in physical form, through eating and body-focused behaviours.

Such findings are both intriguing and compelling; however, the diversity in eating disorder subtypes among research participants is potentially limiting. As it is increasingly understood that core etiological features differ from one subtype to the next (Oldershaw et al., 2011), the experience of one’s body may very well also differ between AN, bulimia nervosa, and binge eating disorder. Thus, investigating the embodied affective experience specifically in AN is of importance. Moreover, the experience of one’s body as related to the process of recovery from AN represents a valuable direction for exploration. With existing research findings suggesting body-for-other as the primary perspective associated with the eating disorder presentation (Stanghellini et al., 2012), investigating how experience of one’s body may shift with recovery holds valuable implications for the way AN is conceptualized and approached.

**The Developmental Theory of Embodiment.** Exploring embodiment as it relates to eating disorder etiology, Piran and Teall (2012) proposed a Developmental Theory of Embodiment. Piran and Teall (2012) adopt the definition of embodiment as referring to the “experience of engagement of the body with the world” (Allan, 2005, p. 177), contrasting with



body image, which consists of the perceptual component referring to “the awareness or knowledge about the shape, size or form of the body” or the attitudinal component referring to “the view of the body as being pleasing or displeasing (Dionne, 2002, p. 13). As implied by its name, the Developmental Theory of Embodiment emphasizes the role transition from childhood to adolescence (Piran & Teall, 2012). Particularly from a sociological perspective, this transition period in female development is noted to be especially poignant, as the adolescent girl’s body suddenly attracts newfound attention solely due to her body’s aesthetic appeal (Sáenz-Herrero & Díez-Alegría, 2015). This framework serves as a bridge between sociology and psychology, between the body, as approached by critical social theory, and embodied experience of individual development (Piran & Teall, 2012). The Developmental Theory of Embodiment is at its essence a theoretical framework that focuses on changes in embodied experience. Furthermore, it proposes that the varying embodied journeys in diverse, complex social situations account for why certain individuals develop disordered eating while others do not (Piran & Teall, 2012).

Such an embodiment perspective differs from the construct of body image in areas of its breadth, inner focus, and dialectical relationship with social/cultural context (Piran & Teall, 2012). Regarding breadth, embodiment extends to encompass a range of experiences, both positive, including self-care, attunement with one’s body, and joy (Piran, Carter, Thompson, & Pajouhadeh, 2002), and negative, including alexithymia (Taylor, Bagby & Parker, 1991). For Piran and Teall (2012), disembodied experience then extends beyond dissatisfaction with one’s body, including a lack of awareness of one’s emotions and internal physiological states. Secondly, such an embodiment stance also reflects an inside-out perspective, rooted in sensory perception and awareness, starkly contrasting with the construct of body image, which involves

evaluation of one's body from an external perspective or gaze (Piran & Teall, 2012).

Thirdly, Piran and Teall (2012) articulate that embodiment recognizes and reflects the complex, interactive relationship between the embodied self and culture in which the self is situated.

With such observations in mind, highlighting the recent growth of research investigating the "self" in pre- and post-pubertal girls, Piran and Teall (2012) express a need for research examining the developing experience of the body, and the integration of the body with the self. This call has spurred research on the Experience of Embodiment (EE) as a construct, investigating how women across the lifespan inhabit their bodies (Piran, 2016). This research program conducted an extensive qualitative investigation of lived experiences of embodiment of girls and women, through 171 interviews with 69 girls and women (Piran, 2016). From a constructivist grounded theory approach, data analysis yielded five dimensions of EE, with each dimension representing a continuum: (a) body connection and comfort vs. disrupted connection and discomfort; (b) agency and functionality vs. restricted agency and restraint; (c) experience and expression of desire vs. disrupted connection to desire; (d) attuned self-care vs. disrupted attunement, self-harm, and neglect; and (e) inhabiting the body as a subjective site vs. inhabiting the body as an objectified site (Piran, 2016). Research illuminated girls' and women's embodied experience across a range of ages, as well as shifts in embodied experience across the female lifespan. This research affirms adolescence as a "crisis of embodiment," whereby there is a disruption in body-self connection and comfort, agency, desire, self-attunement, and objectification (Piran, 2016, p. 54). Moreover, this research of female embodied experience, displaying shifts in EE across the lifespan associated with interactions

between the embodied self and social location aspects, further supports the Developmental Theory of Embodiment (Piran et al., 2002; Piran & Teall, 2012).

A tripartite Adverse Social Experiences model has also been used to investigate the development of eating disorders as at the intersection of self, body, and culture. In particular, this model focused on violations of body ownership and exposure to prejudicial treatment as related to negative embodied experience (Piran & Thompson, 2008). From this research, violations of body ownership, such as childhood and adult sexual and physical abuse, as well as exposure to prejudicial treatment, including exposure to weightism and sexism, were shown to be associated with eating disorder development (Piran & Thompson, 2008). At large, such findings further support the connection between disrupted embodied experience and eating disorder development.

In summary, existing literature supports AN as being located at the intersection of body, self, and sociocultural context (Piran, 2016; Piran et al., 2002; Piran & Teall, 2012; Piran & Thompson, 2008). Emerging from such literature, it is evident that a developmental embodied perspective represents a valid and valuable approach to AN research, particularly as an alternative to the concept of body image. As body image is a uni-faceted construct, at its core reflecting self-body dualism, seeking to explore the developing experience of the body and the integration of self and body is greatly needed particularly as related to AN development and treatment.

### **Feminist Perspectives on Embodiment in Anorexia Nervosa**

Feminist critiques of conceptual frameworks for approaching AN have gained attention particularly as exploration of societal factors in eating disorder etiology become increasingly prevalent. Katzman and Lee (1996) give voice to this trend, having proposed movement away

from models of eating disorders emphasizing “fear of fatness” and body image distortion as driving forces behind food refusal. In lieu of such models, there is a push towards focusing on the notion of women caught straddling two or more worlds (e.g., cultural, gender, movement from childhood to adolescence, expectations of womanhood) as giving rise to disordered eating. Such an approach parallels Steiger’s stance (1995), positing that “an overreliance on weight preoccupation as an etiological variable in anorexia nervosa risks being unduly ethnocentric and misses the universal power of food refusal as an attempt to free oneself from the control of others” (p. 389). Elaborating on themes of oppression and freedom, Steiger (1995) proposed that the recognition of eating disorders as a predominantly female phenomenon potentially reflects a universal difference for males and females in how self-definition and self-control are established, as opposed to simply a disorder resulting from the internalization of the media messages. In Steiger’s (1995) words, eating disorders are “[disorders] that may be linked more to power imbalances than gender” (p. 68). Such a stance reflects Fredrickson and Roberts’ (1997) Objectification Theory, which proposes that women learn to appraise their body from an outsider’s gaze. This dominant, typically male gaze leads to women being treated as objectified bodies that exist for the use and pleasure of others (Fredrickson & Roberts, 1997). Women thus learn to monitor their appearance, with the awareness of this evaluative gaze, so as to appear acceptable (Fredrickson & Roberts, 1997). Therefore, it is out of learned strategy for attaining social power, rather than vanity, that women focus on appearance and strict body control (Fredrickson & Roberts, 1997). Both Steiger’s work and the Objectification Theory deepen critique of media image internalization as it relates to AN and the female body. Media-presented ‘standards’ of what is desirable, as

well as dominant Western cultural messages at large become the heavyweights in a power differential.

Further building on matters of embodiment and disordered eating from a feminist standpoint, Malson and Swann (1999) propose that eating disorders should not be approached as individual pathologies but rather as culturally and politically situated forms of embodiment. It is argued that culturally-seated inequalities of ethnicity, ability or disability, sexual orientation, and gender are inscribed upon bodies, which are ‘articulated’ through body management practices. Therefore, it is the dominant cultural and political environment that contribute to harmful ways of augmenting one’s body. Such ‘body management’ techniques are noted as increasingly varied within Western culture:

For, in addition to self-starvation, ‘dieting’ and bingeing and purging, there are many other self-harming practices, such as cutting and a wild variety of increasingly diverse and prevalent body management techniques, such as body-building, cosmetic surgery, tattooing and piercing. (Malson & Swann, 1999, p. 399)

Along with such diversity, body management has become an omnipresent part of contemporary Western consumer culture, whereby the body is “constituted as plastic rather than as a natural given” (Malson & Swann, 1999, p. 401). Although Malson and Swann forgo delving into classic embodiment philosophy, here the concept of the ‘plastic’ body of Western culture again conjures up the Merleau-Pontian notion of the body-for-other. Equally worth noting, as consistent with the majority of literature examining eating disorders from a social-critique lens, Malson and Swann’s analysis focuses on cultural and political influence on embodiment by way of the construct of body image; however, such approaches fundamentally

adhere to a Cartesian self-body separation. Body image, as defined by Schilder (1964), a founding figure in body image concept, refers to “the picture of our own body which we form in our mind, that is to say, the way in which the body appears to ourselves” (p. 11). By definition, body image makes a distinct separation between the self and the body, one’s *body* appearing to *oneself*, which stands in stark contrast with the embodied notion that “I am my body” (Merleau-Ponty, 2012, p. 151). Consequently, employing body image, albeit often unintentionally departs from an embodied perspective rather than shifting to focus on body-self relationship.

Speaking to the distinction between subjective body-for-self and objective body-for other, Sáenz-Herrero and Díez-Alegría (2015) posit that traditional femininity fosters an identity centered on the woman as someone who is perceived, who is viewed and evaluated by others. Inherent to such an identity then is appearance. Moreover, adolescence plays an awakening role in this identity for females, where the adolescent girl discovers sexuality through her developing body suddenly gleaming the attention of others simply on account of her body’s aesthetic appeal. Sáenz-Herrero and Díez-Alegría (2015) observed that:

From the corporeal experience, women’s bodies are markedly represented by instrumentalization, dissociation, and tension. The body is an instrument, the object for performing a variety of functions of a social, reproductive, and productive nature. Maternity and corporal reality would be constitutive elements of an identity that on many occasions is dissociated with a sexuality and sensuality in tense coexistence. (p. 115)

For women, embodied experience is formed in relation to those around her: she is the wife, the mother, the caretaker. Extending from this perspective, the female body exists

primarily for others. Taken in conjunction with increasing commentary on the objectification of the female body within Western consumer culture (Fredrickson & Roberts, 1997), feminist literature on embodiment as overviewed in the preceding text solicits empirical investigation of women's experiences of their bodies, particularly in relation to eating disorder etiology and recovery. Women are situated in a cultural and political context that fosters a woman-for-other and woman's body-for-other way of being. Moreover, whether due to prejudice, straddling breadwinner and homemaker roles, experience of trauma, feeling at odds with one's developing pubertal body, or having one's voice stifled, the female experience is often wrought with control usurped. Such experience arguably leads to disembodiment, a chasm between the self and the body.

### **Rationale for the Study**

Although Bruch's pioneering work posited that AN symptoms extended far beyond mere physicality and into symbolic function tied to self and body (1962, 1973, 1982), the dominant conceptualization of AN is still largely focused on food, eating, and body weight and shape (Lipsman et al., 2014; Thompson, 1990). Taking into account the growing support for emotional deficits in AN (Fox, 2009; Kyriacou et al., 2009; Racine & Wildes, 2013) while acknowledging the role that the body plays in emotional experience (Winkielman et al., 2015), a complementary research focus on the role of the embodied affective experience in AN could bring important understanding and insights. Departing from Cartesian self-body dualism, a phenomenological understanding of embodiment as proposed by (Heidegger, 1949; Husserl, 1998; Merleau-Ponty, 2012; Sartre, 1943) maintains that human experience is embodied experience. Human embodied experience is also characterized by a subjective facet, of experiencing one's body subjectively from the inside outward, and an objective facet,

experiencing one's body from the outside looking in (Merleau-Ponty, 2012). Being particularly salient to matters of embodiment and AN etiology, research has displayed disruptions in embodied experience as surfacing alongside eating disorders (Lester, 1997; Stanghellini et al., 2012). Moreover, perspectives including feminist critiques (Katzman & Lee, 1996; Sáenz-Herrero & Díez-Alegría, 2015; Steiger, 1995) and the Developmental Theory of Embodiment (Piran & Teall, 2012) illustrate AN as situated at the intersection of body, self, and sociocultural environment, highlighting how embodied experience may be impacted and shifted across time. With such literature as a foundation, exploring the embodied affective experience throughout recovery from AN is framed as a valuable and necessary endeavour,

### **Purpose and Research Question**

In an effort to address the current limitations in the mainstream conceptualizations and research focus of AN, this study sought to employ a holistic way of understanding AN by employing an embodied research method. The purpose of this study was to explore the embodied and affective experience of women with AN through the process of recovery, using sentence stems generating body-centered poetic discourse as a method of inquiry. In light of this study's aim, the research question was: what are women's embodied affective experiences during the process of recovery from AN?



### CHAPTER THREE: METHOD

#### Paradigmatic Foundation and Research Design

Both paradigmatically and methodologically, research concerning itself with women's experiences often finds itself caught in a place of tension, aiming to investigate female experience within a predominantly masculine scientific tradition. At its very core, this study takes a critical, alternative approach to existing ways of understanding, investigating, and treating AN, aligning itself with a transformative feminist paradigm. Given that human embodied experience is an inherently subjective, complex phenomenon, employing quantitative measurement of concepts such as introspection or attitude towards one's own body would fail to encompass the full breadth and depth of participants' embodied experience. Furthermore, traditional quantitative scientific methods arguably are guided by masculine values, methods, and language, contributing to a narrow or limited glimpse of subjective human experience, particularly with regard to investigation of areas characterized by feminine values including interdependence, intimacy, and nurturance (Devault, 1990; Gilligan, 1982). Such scientific traditions are not inherently problematic, and may find strength through unbiased objectivity, yet they may result in overlooking the subjective nuances of lived experience that may become actualized through the researcher-participant interaction. Feminist scholars face the challenge of finding ways of working within a predominantly masculine disciplinary tradition, aiming to transform such a tradition through critiquing and shifting while also maintaining the rigour required to stand up alongside traditional ways of knowing (Devault, 1990).

**Transformative lens.** The most central tenant of the transformative paradigm is the issue of power and how the researcher is to be cognizant of and work to combat such dynamics

at each stage of the research process (Mertens, 2007, 2015). As an extension of dissatisfaction with research conducted out of other paradigms, a transformative approach first and foremost seeks to equally and justly represent marginalized populations or cases within research with the primary aim of betterment and change (Mertens, 2007, 2015). With this in mind, it is essential that any form of power imbalance, inequality, or oppression be contested throughout each stage of research. In congruence with the core of this research study aiming to challenge the predominant ways of investigating, understanding, and treating AN, it is necessary that the research process itself maintains an openness to critique, respect for the lived experiences of the participants, and reflexive development. Greater involvement of the research participants within this particular study is purposefully pursued first via qualitative data taking the form sentence stems generating poetic discourse, allowing for participants to give voice to their own experiences. Participant involvement is then furthered by a second set of interviews, allowing for participants to provide explanations, commentaries, and reflexive edits of poetic discourse as opposed to sole interpretation of the data being left to the researcher.

**Feminist lens.** Advocates of a feminist approach to psychological research such as Gilligan (1982) contend that each individual's experience is valuable and unique, and that there is a need for exploration and understanding of phenomena utilizing different ways of knowing; a perspective that lends itself well to qualitative research methods. Principles of critical self-reflection and reflexivity are integral to a feminist approach to research (Mertens, 2015), emphasizing the importance of interaction between the researcher and participants, stressing that the researcher thoughtfully engages with and allows for the research to be shaped by voices emerging throughout data collection and the research process as a whole. Moreover,

with the majority of cases of AN occurring in females (American Psychological Association, 2013), questioning and investigating why women are impacted by AN at higher rates within Western and Westernized societies is imperative for enhancing understanding of AN etiology. To a large extent, dominant perspectives attribute such patterns to internalization of media standards and poor body image (Thompson, 1990; Williams, Thomsen & McCoy, 2003); however, recognition of the symbolic role that the body plays particularly in AN (Skårderud, 2007a), in addition to cultural trends towards Cartesian dualism and the disembodied experience of women (Lester, 1997; Malson, 1999), prompts further exploration of women's experiences through a feminist-guided, phenomenological perspective. Such a perspective represents both a relevant and compelling approach to AN, appropriately honouring the sacredness of human lived corporeality while challenging the traditional object-body emphasis on body image in eating disorder research.

**Integration of transformative and feminist perspectives.** Feminist research also hinges on the assumption that the meaning of knowledge is determined through societal and cultural lenses (Mertens, 2015). Dynamics between the knower (i.e., the researcher) and the would-be-known (i.e., the participant) should incorporate interaction, integrating the concept of reflexivity while also being anchored in the understanding of how power may influence this relationship (Mertens, 2015). Involvement of the participants in this research study therefore extends from recognizing participants' personal experiences as cultivating a sense of each woman being the expert of their own lived experience. Moreover, at the heart of this research study, each women's experience with AN, emotions, and body was approached in a manner that seeks to honour what has often been overlooked or devalued by empirical quantitative research: quintessential feminine characteristics such as emotionality, relationality,

vulnerability, and creativity, among others. In this way, this research aimed to serve as a vehicle of empowerment, not only through its outcomes, but also through generating a sense of value and sacredness of the knowledge gained and shared through each woman's experiences and insight.

Researcher position. Due to the nature of qualitative research and the importance of the self of the researcher as a tool for inquiry and analysis, this section seeks to provide an illustration of myself, as the principal investigator, in relation to the research topic.<sup>1</sup> As a starting point, two women whom are very dear to me have suffered with AN. Each of their journeys with AN has looked very differently, yet both have equally highlighted the underlying current of discouragement that plagues dominant views of the AN recovery trajectory. This discouragement has fed my own growing desire for advocacy, reformation, and hope as I develop my personal approach to research and psychotherapy. I resonate deeply with the sentiment and aims of transformative and feminist paradigms, longing to see change flowing out of inadequacy, and recognize within myself discontent with how the mainstream medical community often overlooks the self among the flesh and bones. Yet I find myself situated at a point of tension, between the undeniable physiological component of AN and perspectives emphasizing the self within the body within the sociocultural environment. I have witnessed the glaring reality of the need to intervene and sustain the physical body amidst self-starvation, while also experiencing intense discomfort while observing forced refeeding measures. It was not until I began to delve into this project that I fully realized the origin of this discomfort. As a woman in Western society, I have experienced the actions of others communicating to me

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<sup>1</sup> Language in this portion of the text deliberately employs a first-person point of view so as to reflect the researcher's voice and the personal nature of this section.

that I am not the only person who has jurisdiction over my body. Whether subtle (e.g., comments on the appropriateness of my clothing) or more overt (e.g., sexual harassment), I can connect with the violation of another person imposing a certain unwanted attitude or action upon my body-self. It is this part of me that also can connect with the distress experienced by women, like the ones voicing their experiences in this study, who have their bodies measured and prodded and refed for the sake of AN treatment.

The women in my life who have fought the tireless battle with AN have also taught me about resiliency and hope. In the face of dismal rates of recovery and relapse, these women have chosen the turbulent path of finding a way to live with and within their bodies, for better or for worse. Through this choice I have seen transformation. I have witnessed weight restoration and symptom reduction, yes. But I have also witnessed something deeper and more profound, a change in the way the self relates to the body. It is at this point of tension, discomfort, and hope that I approached this research: tension between physical realities and subjective lived experience; discomfort with the propensity to undermine or overlook the self within the body within the sociocultural context; and hope that change may be found in and through encountering and relating as embodied selves in the world.

**Participant recruitment.** Six adult women previously diagnosed with AN were recruited through purposive sampling, utilizing psychotherapeutic clinics in the community in addition to social media networks. After gaining the approval of the overseeing research ethics board and each facility to participate in recruitment, posters were distributed to the clinics and over social media (Appendix A). Women who were interested in participating in the study were instructed to contact the research team via email. Following their expressed interest, potential participants were then invited to complete the phone-screening interview. If eligible

for inclusion in the study, an in-person interview was arranged between the participant and researcher. Women considered ineligible for study participation were thanked for their time and interest, given a list of resources, and received an offer to be placed on a contact list for future research participation opportunities through the MA Counselling Psychology program at Trinity Western University.

**Inclusion criteria.** As mental illness, and particularly AN is very personal in nature, during initial screening it was made explicit that participation in this research study involved open expression of one's experience with AN. However, precautions safeguarding each experience shared (i.e., meeting in a familiar/safe location for each interview, inviting reflexive participation of each women during data collection and interpretation, utilizing creative and metaphorical mediums for self expression) were taken. Additionally, due to the high demands that this study placed on the capacity to reflect on embodied emotional experience, it was necessary that the women included in this research study were currently at a state where they were able to effectively comment on and dialogue about their affective and embodied experience. Given the severe physical consequences of AN, it was necessary to take into account not only the impact of extreme malnutrition and low body weight on neurological functioning, but more importantly the best interest of the women involved in this research. For this reason, the mandatory inclusion criteria were: female, aged 19 years and older, and living independently, thus not currently requiring medical intervention or inpatient treatment. Additional inclusion criteria were: participants must have been diagnosed with AN as per DSM IV or 5 criteria, either in the past or currently; and identify English as their first language.

**Exclusion criteria.** Potential participants were screened over the phone using a brief semi-structured interview for suicidality, psychosis, current substance abuse, and active

dissociation, in addition to above mentioned inclusion criteria, using a brief semi-structure interview (Appendix B). Participants who were acutely suicidal or unable to take part in the study due to other severe mental health concerns were referred to appropriate support mental health resources (Appendix C).

### **Data Collection**

**Procedure.** Following initial phone screens, if a good fit between each woman and the study was determined, a first interview was arranged between the participant and the researcher. This meeting, as well as the second interview, took place at the Fraser River Counselling Services facility on the Trinity Western University campus or at another privatized counselling office located off of the university campus. During the first one-hour interview with each participant, the researcher discussed consent information (Appendix D), collected demographics information (Appendix E), and guided the participant to complete the sentence stem activity, as outlined in a following section. Each interview was video recorded to facilitate transcription of dialogue and poetic discourse.

Following the first interview, a second interview with each woman was arranged, one to two weeks following the first. This interview was also video recorded. During this interview, women were presented with the transcribed body-self poems and were invited to comment on, clarify, or make changes to the poems so as to ensure that the poems accurately captured their lived experience. This reflexive approach to data collection and interpretation mirrors the transformative feminist paradigm at the heart of the study.

**Use of pseudonyms.** At the conclusion of the first interview, each woman was invited to choose a pseudonym that was used to identify all corresponding data. Reflecting the relational nature of this research, it was important that each participant and the corresponding data that

they provided were identified by a pseudonym that safeguarded participants' anonymity and confidentiality, yet maintained the quality of being personal. As opposed to using numbers to identify participants, each woman choose a pseudonym that she felt reflected an important aspect of herself or her AN recovery story.

**Participants.** Participants selected for this study were six adult women, between the ages of 21 and 28 years. All participants were Caucasian, and identified as having formal education ranging from some university or college to post graduate education. All participants reported previously having met diagnostic criteria for AN. Participants reported a range of five years to twelve years since initial AN diagnosis. Five of the participants reported diagnosis of AN, restricting type, and one of the participants reported past diagnosis of comorbid AN and BN. Of the six participants, two reported continuing to limit food intake on a regular basis for weight maintenance purposes at the time of the study. When asked to rate current stage of recovery from AN on a Likert scale of one to ten (one = beginning of recovery, ten = complete recovery), all six participants identified themselves as being at a six or greater. Each woman reported a treatment history of a combination of multiple service providers, ranging from private counselling to residential treatment for AN. Five had received hospital inpatient or outpatient treatment, two had received government counselling services, five had received privatized counselling services, and one had received residential treatment. Cumulative duration of treatment for AN ranged from just over two years to 12 years. Four of the participants reported past diagnosis of comorbid major depressive disorder, two reported past diagnosis of comorbid obsessive compulsive disorder, and one reported past diagnosis of comorbid generalized anxiety disorder. Four of the participants reported currently taking



medication of antidepressant classification due to ongoing AN, depressive, or anxiety symptoms.

**Method of inquiry.** Body centered poetic discourse was chosen as the method of inquiry for this study. As discussed in the previous sections of this text, embodied experience was the central phenomenon being investigated through qualitative methodology as a means of seeking to more fully understand corporeal experience while also embracing alternative ways of knowing. Specifically, embodied experience for the purpose of this study refers to the complex, personal experience of one's own body in the world. Due to embracing a Sartrean and Merleau-Pontian perspective of embodiment, which encompasses both body-for-other and body-for-self viewpoints, experience of the body as pertaining to this study was purposefully left as a fluid and expansive concept, allowing room for individual interpretation by each participant. As a means of exploring themes of embodied experience in AN, the form of data collected and utilized by this study was body centered poetic discourse. Sentence stems were used as an anchoring strategy to elicit body centered poetic discourse. The use of sentence stems emerged from balancing the aim of inviting metaphorical reflection with the desire to provide a certain level of structure for reflection. Although such a method has not been utilized in investigation of the lived experience of AN to date, poetic discourse has been identified as a robust embodied method of qualitative inquiry (Chadwick, 2016). Further supporting this method, prompts such as cue cards have been heralded as a useful medium for facilitating embodied qualitative research in existing literature (Sutton, 2011).

Providing additional support for this method of inquiry, previous research investigating embodied and emotional experience has utilized poetry (Bracegirdle, 2012) and thematic analysis of metaphorical discourse (Peltola & Saresma, 2014) as a means of exploring such

subjective complexities. Thematic analysis of metaphorical expression, whether through interview dialogue or written mediums such as prose or poetry represents a method congruent with a feminist paradigm, embraces an embodied perspective and suits the study of AN for numerous reasons. As Peltola and Saresma (2014) illustrated through investigation of embodied and affective experience in response to music, metaphorical language gives way to expression of subjective, experiential phenomena representing a natural medium for rich description of lived experience. Metaphor permeates the nature of both human affective and embodied experience (Crumley & Reid, 2009; Skårderud, 2007a; Woodman, 1980), also lending itself well to transformative research pursuing alternative ways of knowing. Furthermore, thematic analysis of metaphorical discourse represents a fitting method of study of AN, echoing the metaphorical role of food and the body in cases of disordered eating (Bruch, 1973; Skårderud, 2007a; Woodman, 1980). In AN, food holds symbolic function becoming the focus for depression, anger, anxiety, sexuality, control, or defiance (Woodman, 1980). Woodman (1980) also notes, “food becomes the scapegoat for every emotion, and forms the nucleus around which the personality revolves” (p. 21), while the body becomes a concretized metaphor for emotions and the self (Skårderud, 2007a). With metaphor saturating the lived experience of AN, employing the use of metaphorical language for this study’s purposes fits seamlessly. Moreover, the use of metaphorical language may serve as a means of safeguarding the intimate internal world, promoting safety, and allowing space for distance that typically exists between the body and the self in cases of AN (Lester, 1997). Additionally, the use of metaphorical language may also contribute to the healing journey. As Woodman (Crumley & Reid, 2009) noticed, stemming from personal experience as well as

psychotherapeutic observation, poetic language can be both a healing and an empowering medium of expression for the embodied mind.

During the first interview, each woman participating in the study was invited to complete the same set of six body-centric sentence stems, which were displayed on six individual cards (Appendix F). The cards were arranged on a table, and women were guided to complete as many or as few sentence stems, in whatever order they so chose, initially completely sentence stems based on how they currently experienced their bodies. They were then asked to complete the same sentence stems, as many or as few in whatever order, based on how they experienced their bodies at the worst of their eating disorder. Lastly, they were asked to complete the sentence stems, as many or as few in whatever order, based on how they hope to experience their body in the future. This dialogue was then transcribed and arranged as poetic verse, reflecting the expressive nature and phrasing of each women's words. As Chadwick (2016) contended, "The use of poetic styles of transcription are important tools in moving embodied methodologies into the realm of qualitative interpretation and analysis."

### **Data Analysis**

**Research team approach.** Honouring the feminist-relational paradigmatic lens of this research project, data analysis was completed as a research team consisting of my supervisor, two research assistants, and myself. Conceptual frameworks of AN etiology and theories of embodiment were purposefully bracketed during the data analysis process, and the members of the research team were briefed only on methods of data collection, with minimal instruction given for what to attend to while coding transcripts. Research team members initially coded all transcripts individually, and then discussed and finalized as a team. Subsequently, patterns of meaning, or themes, across all transcripts were identified, discussed, and finalized as a team.

Coding and thematic analysis was conducted in accordance with the phases outlined by Braun and Clarke (2012), as described in the following text.

**Inductive coding and thematic analysis.** Integral to feminist-informed research, inductive data coding and analysis were chosen due to the importance of research being shaped by what emerges from the data (Mertens, 2015). Moreover, Braun and Clarke (2012) note that “inductive TA [thematic analysis] often is experiential in its orientation... assuming a knowable world and “giving voice” to experiences and meanings of that world, as reported in the data.” Emphasis was placed on giving voice and meaning to the experiences emerging from the data itself, rather than imposing predetermined concepts or frameworks (p. 59). Data coding and analysis was conducted in accordance with the six phases of thematic analysis, as outlined by Braun and Clarke (2012). First of all, the research team took time to become familiar with the data, reading and rereading each transcript while making notes of impressions as they arose. Next, initial codes were generated, with labels being given to phrases or portions of the data pertaining to affective or embodied experience. After codes were identified and discussed as a research team, attention was given to exploring emerging themes, representing patterns in responses or meaning. Identified codes were also entered into the qualitative research software NVivo 10 to enhance organization and analysis of codes and themes. Once identified, potential themes were reviewed collaboratively, as a research team, focusing on strength of fit between the data and themes. As part of this step, identified themes were visually mapped, along with all codes, in order to assure that themes captured coding of data accurately and entirely. Next, the names of each theme were appraised, reevaluated, and adapted if need be, so as to provide appropriate descriptions and interpretations of the associated data. Lastly, finalized themes and their relationships with one another were

illustrated and described, as presented in the following chapter. All qualitative data and data analysis documents were maintained and stored electronically as encrypted files, password-protected on the researcher's personal computer until the completion of the study.

**Temporal reflections.** Based on participants' completion of sentence stems for past, present, and future, data was organized according to reflections on three points of the recovery process: at the worst of the eating disorder, in recovery, and towards body-self unity. Each point of reflection, with associated embodiment and affective themes and subthemes, was outlined in succession and compared to one another. Thus, analysis of shifts in embodied and affective experience with recovery from AN was facilitated, enabling comparison of themes from past-, present-, and future-oriented discourse.

**Body-self patterns.** Encompassing thematic patterns across the recovery discourse, three distinctive body-selves emerged from the data: the bifurcated body-self, the recovering body-self, and the unified body-self. Body-selves can be thought of as a framework or model, illustrating patterns in how themes emerge in relation to one another. Just as themes represent a way of categorizing and interpreting codes, these body-self patterns serve as a means of comprehensively organizing and interpreting themes.

### **Methodological Rigour and Quality**

The quality and trustworthiness of qualitative research, according to Morrow (2005), should be evaluated in light of the research paradigm and the discipline in which the research is situated. As this research is guided by a transformative paradigm, criteria for evaluating quality ultimately centre on concerns for social justice and human rights (Mertens, 2015; Mertens, Holms, & Harris, 2009). Reflecting such concerns, specific criteria for evaluation of

rigour and quality, and the steps proposed to uphold each principle throughout the research process are outlined in the following text.

**Fairness and representation.** This criterion refers to inclusion of multiple viewpoints, welcoming and honouring varying perspectives throughout the research process (Mertens, 2015; Morrow, 2005). Through inclusion of women from an array of ages and cultural and ethnic backgrounds, in addition to incorporation of a range of voices along the spectrum of AN severity, representation of diversity is pursued. Likewise, involvement of each woman in the interpretation process fosters representation and honours diverse perspectives. Each woman is viewed as the expert of her own lived experience and therefore holds the most robust ability to bring understanding through involvement in the research. Therefore, it is stressed that, rather than data being collected and analyzed solely by the researcher, each woman is invited to reflect on and contribute to the analytic process of data (i.e., poetic discourse).

**Ontological authenticity.** This criterion refers to “the degree to which the individual’s or group’s conscious experience of the world became more informed or sophisticated” (Mertens, 2015, p. 273). Mertens (2015) suggests that member checks with respondents or audit trails documenting changes in individuals’ constructions throughout the research process are ways of upholding this criterion. As discussed in the previous text, inclusion of participants’ voices throughout the analytic process is stressed as a means of accurately representing and sharing insights from their lived experiences. Likewise, memo-keeping by the researcher and regular consultation with the researcher’s supervisor are exercises aimed at ontological authenticity, recording and dialoguing about shifts in perspective, understanding, and experience with and through the research process.

**Community.** Founded in the recognition that research takes place within and affects a community, it is necessary for the researcher to know the community well enough to extend research outcomes to actively benefit the community (Mertens, 2015). Moreover, it is important for the researcher to demonstrate that trust and mutuality was fostered with the participants (Mertens, 2015). Utilizing clinicians specializing in eating disorder treatment in the participant recruitment process serves as an explicit bridge formed between the researcher and the community being researched. Women recruited for participation in the study through their place of psychotherapeutic treatment are likely to enter into the research process with a sense of trust founded on the rapport existing with their therapist and place of treatment. Additionally, fostering a sense of reciprocal relationship between researcher, clinicians, and research participants serving as experts in their own right links back to the important role of community in transformative research. Here, women who are receiving or have received treatment from clinicians then become the crux of insight revealed through research, which serves as a vehicle to further inform clinical treatment.

**Attention to voice.** Reflecting feminist commentaries, the researcher must actively seek to draw out those who are marginalized and silenced within dominant culture (Mertens, 2015). Alluding to the emphasis placed on fairness and representation, approaching research from the perspective that each participant is the expert on her own lived experience draws attention to voice of each women involved in the research. Moreover, the majority of women invited to participate in this research represent a marginalized and silenced demographic. At its core, AN is often associated with a physical manifestation of longing for control that has been usurped from its victim (Bruch, 1973; Steiger, 1995; Woodman, 1980). Likewise, Western society at large continues to exert dominance over and foster disconnect from the female body and

female self, cultivating a sense of the feminine body-for-other (Lester, 1997; Malson & Swann, 1999; Sáenz-Herrero & Díez-Alegría, 2015). This research stems from a critical examination and response to such norms, seeking to give voice to women and endeavoring to reclaim ownership of their embodied experiences.

**Critical reflexivity.** This criterion refers to the need for the researcher to acknowledge the fact that their research findings represent but a portion of the breadth of viewpoints on what is being investigated (Mertens, 2015). As Mertens (2015) outlines, all knowledge is contextual, and therefore requires the researcher to be cognizant of the limitations of their research outcomes. Heeding this stance, this research seeks to capture a snapshot of sorts, providing insight into the lived experience of a particular cohort of women with AN. It is recognized that women participating in the study will likely have undergone different forms of treatment on their journey to recovery. Additionally, limitations associated with the small proposed sample size are acknowledged. For these reasons, this study is approached as a piece of the larger empirical puzzle urging movement away from eating disorder research and treatment that focuses on food and body weight and towards emotional and embodied experience.

**Reciprocity.** Transformative research at its core must be propelled by the intention of contributing or giving back to the community involved in or investigated by the research (Mertens, 2015). As previously noted, this research is approached with the intention of contributing to understanding and treatment of AN. On a more immediate scale, it is also hoped that participation in the research process will be emancipating and empowering on a personal level for each of the women involved. Given the therapeutic power of poetic expression combined with the ability to contribute to advancement in the field of eating



disorder research through one's own experience, this research purposefully seeks to honour the experiences of women involved.

**Catalytic authenticity and social change.** The criterion of catalytic authenticity refers to the extent to which research encourages action (Mertens, 2015). In line with a feminist approach to study of AN as discussed in the previous text, this research aims to challenge dominant understanding of disordered eating. Namely, through investigating emotional and embodied experience of women with AN, a larger critical examination of the social and cultural context in which these women are situated is implied. If there are themes of female disembodiment and disconnection emerging from the research, then the audience is beseeched to ask why and how such phenomena has infiltrated the female experience. Such action ties into an all-encompassing final criterion for quality, asserting that research must ultimately contribute in some manner to social change, as an extension of catalytic authenticity (Mertens, 2015). Through insight and increased understanding of the female affective and embodied experience as it pertains to AN etiology, development, and recovery, it is hoped that contextual critique will fuel an insatiable desire for change within the academic community, clinicians, and boarder audience, seeking to reclaim and nurture the depth of connection between women, their emotional experience, and their embodied selves.

## CHAPTER FOUR: RESULTS

This chapter opens with an introduction to each woman who participated in the study, providing an overview of their backgrounds in relation to individual AN recovery process. Subsequently, the study's results are organized and presented according to reflections on three points of the AN recovery process. With each point of reflection, 'body-selves' are outlined, describing overarching patterns in themes and their relationship with one another. Lastly, themes are identified and discussed as they emerged from body centered poetic discourse, in accordance with the three points of reflection on the AN recovery process. Complete body-self poems are presented at the end of the chapter, organized according to speaker.

### **Women's Backgrounds**

**Rebekah.** Rebekah's gentle presence and contemplative intentionality were reflected in the way she described her experience with AN. She is 21 years old, currently an undergraduate student studying Fine Arts, and comes from a Caucasian, Christian family of origin. She was first diagnosed with AN, restricting type, nearly five years ago when she was 16 years old. She also described struggling with persistent depression and anxiety throughout this time. Despite the severity of her eating disorder and depression, she was never hospitalized as part of her treatment. Instead, she sought out counselling through government and privatized services, and has received ongoing counselling since being diagnosed with AN. One of her therapists in particular was mentioned as being especially pivotal in Rebekah's recovery journey. The two women stay in touch on a regular basis even though Rebekah no longer meets with her for counselling. Rebekah described herself as nearly fully recovered, although she admitted that she still finds herself working on her relationship with food and acceptance of her body as being beautiful.

**Devlin.** Upon hearing Devlin's journey with AN, one is struck by both immense sadness and awe of her sheer resilience. Devlin is 26 years old, currently an undergraduate university student, and comes from a close-knit Caucasian family of origin. She is an only child and described being exceptionally close to her mother, expressing that she views her as one of her best friends. Devlin's determination is undeniable, also evidenced by her goal to pursue an education and ultimately a career in neuropsychology. She was first diagnosed with AN, restricting type, when she was 18 years old, where she was hospitalized and received extensive inpatient treatment. Along with battling AN, she also was diagnosed with depression and conversion disorder, which left her wheelchair-bound for a period of time. This experience, she described, instilled a deep gratitude for being able to once again walk on her own. She also struggled with self-harming behaviour and referred to the scars left on her body as she reflected on the constant reminder that her body is of what she has overcome. After about two years of initial hospitalization without any improvement, her parents sought the expertise of an eating disorder specialist from abroad. Upon hearing Devlin's case, this specialist came to visit her and then agreed to have her admitted and treated at an intensive eating disorders program overseas. Devlin made great progress here and moved back home after about a year and a half. She now describes herself as having been in recovery for the past three years, but still struggles most days with being in her body. Devlin's desire to be adequate, to be enough, reverberated profoundly as she told her story.

**Paix.** Paix settled on her pseudonym because of its French-to-English translation: peace. She described her journey with AN as one aimed at finding peace to replace the radiating anxiety that she has struggled with. Paix is a 22-year-old undergraduate university student studying English. She comes from a tight-knit Caucasian, Christian family of origin.

She has a passionate heart for helping others and an exuberant energy that comes through in the way she expresses herself. She was first diagnosed with AN, restricting type, when she was 15 years old, where she was initially hospitalized and treated as an inpatient. After about two months of inpatient treatment, she was discharged and attended a day treatment program through the hospital. She described this experience as being distressing and unhelpful, explaining that she felt out of place and learned strategies for continued weight loss from the other women receiving treatment. After being dismissed from the day treatment program due to not being able to meet weekly weight gain requirements, Paix's parents sought privatized counselling services. Here, she received eye movement repossessing and desensitization (EMDR) as part of her treatment, which she noted to be very beneficial. She now describes herself as fully recovered, and expressed that she recently has begun to experience a newfound connectedness with her body.

**Lorelai.** Upon first meeting Lorelai, one is inevitably struck by her sincerity. As she dialogued about her experience with AN, wisdom and humility pervaded her words. Lorelai is a 25-year-old graduate student studying Theology who comes from a Caucasian, Christian family of origin. She was first diagnosed with AN, restricting type, when she was 15 years old. At this time, she was also diagnosed with major depressive disorder, and described battling suicidal ideation and substance abuse as well. She briefly alluded to a history of childhood trauma, although she avoided unearthing details. For Lorelai, AN treatment began with outpatient services through a local hospital and was followed by privatized counselling, totaling about three years cumulatively. She describes herself as being in the process of recovery, but only recently has begun to open up about her past history of AN. The battle to feel comfortable in her body has been unrelenting, and Lorelai expressed that that

disconnecting from her body in the past is how she “did not die.” She linked this separation between her self and her body to a desire for avoiding painful emotions. Although this way of disconnecting functioned as preservation, she noted that she has been working towards being more present in her body. For her, giving voice to her experience through this study was a way to press into her struggle with her body; to turn towards rather than continuing to disconnect.

**Anna.** Anna’s engagement with the topic of women and embodied experience in Western culture revealed her activist and advocate character. She dialogued at length about the limitation of language and the English word ‘body,’ which lead to conversation about the term ‘body-self.’ Anna is a 28-year-old doctoral student studying abroad and pursuing a career in Linguistics, who comes from a Caucasian family of origin. She was first diagnosed with comorbid AN and BN when she was 16 years old, and then later with generalized anxiety disorder and obsessive-compulsive personality disorder. She was hospitalized and received inpatient treatment twice. First when she was 16 years old, and then again when she was 19 years old. She also received outpatient and privatized counselling services, and noted that she engages in ongoing counselling for reasons related to personal growth and wellbeing. Poignantly, Anna described herself as nearly entirely recovered from AN, and yet believes she will never reach full recovery due to the nature of being a woman immersed in our Western culture. For her, this poses a problem due to the current of discontent that women experience with their bodies. Through her words, it becomes clear that she is passionate about participating in changing this current.

**Phoenix.** As the pseudonym that she chose might suggest, Phoenix has a confidence that may not be expected from a woman with a history of feeling at odds with her body. She expressed herself with a certain boldness, unapologetic and assertive, which comes through

clearly in her body-self poems. She is a 28-year-old undergraduate university student, studying Rehabilitation Science, and comes from a Caucasian family of origin. Phoenix was diagnosed with AN when she was 14 years old and received treatment through government counselling services. She also received comorbid diagnoses of depression and generalized anxiety disorder. Phoenix described how she had been impacted by the tragic and unexpected death of her brother, something that had triggered depression and suicidal ideation for her. After about eight years of counselling for both AN and grief work, Phoenix now describes herself as fully recovered from her eating disorder. She spoke openly about her involvement in sports and how she has come to view her body as valuable not because of its appearance, but because it is strong, skilled, and athletic. Although she described embracing her body for what it can do, she too expressed experiencing tension being a woman situated in Western culture. Speaking of the normative discontent women experience with their bodies, Phoenix commented on how praise for thinness parallels value placed on remaining youthful in appearance.

### **Organizing the data**

From past-, present-, and future-oriented poetic discourse, reflections on three points of the AN recovery process were articulated: at the worst of the eating disorder, in recovery, and towards body-self unity. Out of each reflection point and corresponding themes that emerged, three body-self patterns were identified: the bifurcated body-self, the recovered body-self, and the unified body-self. These body-selves outlined in the following text are presented to provide an illustration of patterns in and relationships between embodied and affective themes, representing a cohesive image of the female body-self at different points of recovery.

Reflection points and body-selves are presented in succession to facilitate comparison and

observation of shifts in embodiment and affective themes with recovery from AN. It is valuable to make explicit the tension between categorizing and presenting results in a linear, written fashion while seeking to uphold the values and principles core to embodied qualitative research. As a means of addressing the research question, discourse was analyzed and presented chronologically. From this discourse and identified themes, body-self patterns emerged as parallel to the points of reflection on the AN recovery process and are likewise presented in succession. There is an inescapable discordance surfacing from aiming to capture and do justice to the subjective lived experience of the women included in this study while also adhering to academic standards of research. Thus, the reader is invited to engage with this tension, bearing in mind the challenge of amalgamating embodied expression with concrete forms of analysis and data presentation.

**Themes.** Thematic analysis of poetic discourse resulted in the identification of eleven embodiment and three affective themes. Embodiment themes that emerged included: the body experienced as an object vs. the body experienced as subjective; the body as bad, insufficient, devalued vs. the body as good, sufficient, valued; disconnection from the object-body and all that the body facilitates connection with vs. connection with the body-self and all that the body facilitates connection with; danger or lack of safety vs. safety, secure space to exist; restriction vs. freedom, and the body as a way of knowing or experiencing. Affective themes included: negative or absent affect vs. positive affect, and hunger or longing. With recovery from AN, poetic discourse displayed a pattern of shifting from negative embodied experience, characterized by experiencing the body as bad, disconnected, and restricting to positive embodied experience, characterized by experiencing the body as valuable, connected, and freeing. The shift in affective experience with recovery from AN was intertwined with

embodied experience. Negative affect or absence of affect was gradually replaced with positive affect as facets of embodied experience shifted from negative to positive. Taken as a whole, body-centered poetic discourse richly illustrates recovery from AN as restoration of embodied lived experience. The following figure depicts themes and how they are related to one another across the three reflection points on the AN recovery process.

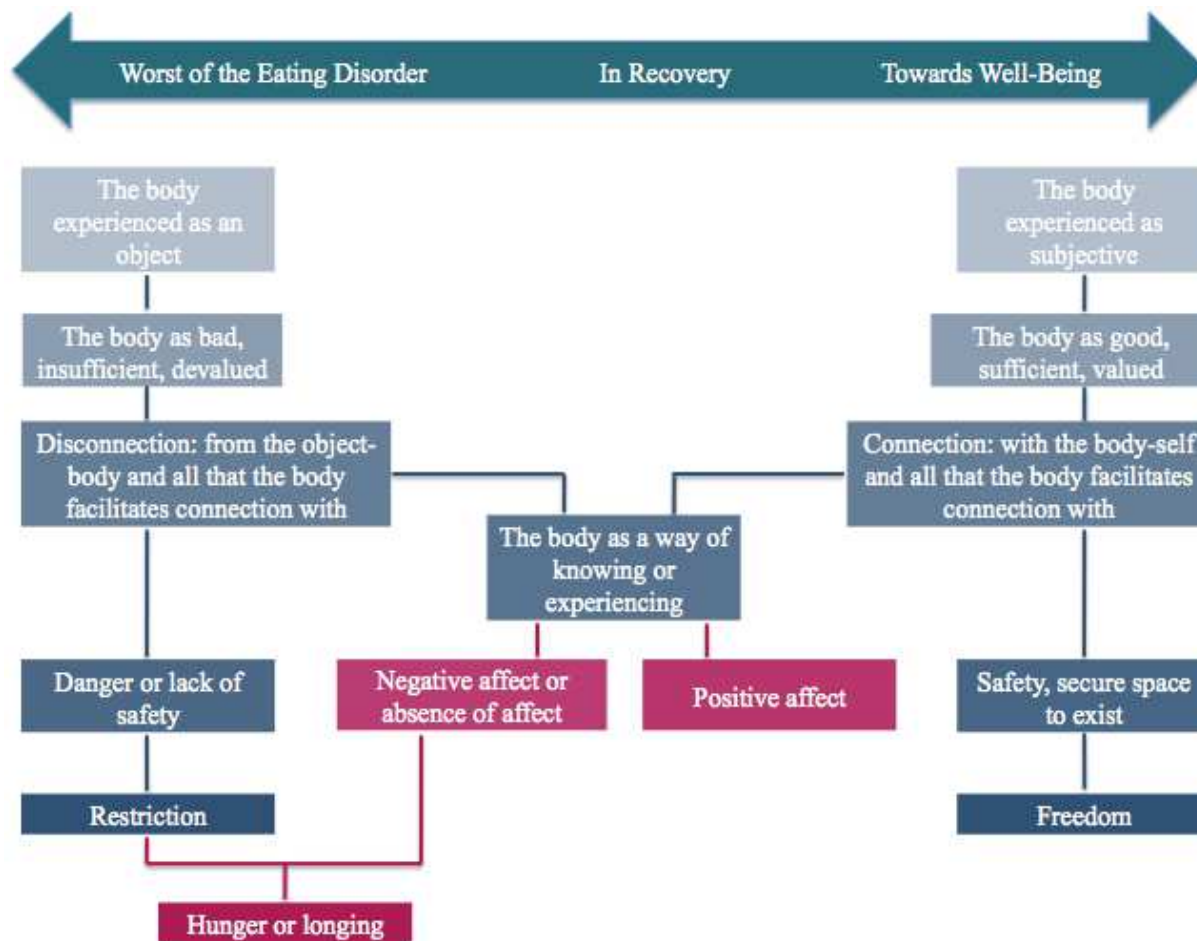


Figure 1. Embodiment and Affective Themes.

### At the Worst of the Eating Disorder

**The bifurcated body-self.** At the worst of the eating disorder, women's embodied experience was characterized by a stark division between the object-body and the self. A sense of disenfranchisement prevailed, with the body lacking both value and beauty. Moreover, there



was a clear pattern of the object-body being devalued and rejected by the self. The body was seen as foreign and not belonging to the self. Themes characterizing this body-self are identified and discussed in the following text.

**The body experienced as an object.** The most predominant underlying theme emerging from poetic discourse depicting being at the worst of the eating disorder was of the body being experienced almost completely as an object-body-for-other. Women's accounts focused on external aspects of their bodies in a way that became consuming. Nearly, if not all attention was placed on the object-body: how it looked externally, what it weighed, how its shape could be manipulated.

My body feels fat. Even though that's not necessarily a feeling, I would've argued and argued that it feels fat (Devlin).

My body reminds me of clay – clay that could be molded and moved – not hard clay. It could be molded and moved into something that you like, or that other people like, or that you'd feel more comfortable with. And you can control it in that manner. And it's material (Paix).

In addition to the body being experienced primarily as an object, the theme of the body as not belonging to the self emerged. At the worst of the eating disorder, the body was experienced as an object belonging to someone or something other than the woman.

My body is possessed. My body is not mine (Paix).

**The body as bad, insufficient, devalued.** The body as being wrong or bad, insufficient, or less than others' also emerged as a dominant theme in the eating disorder discourse. The object-body was seen as being bad, a censured problem, never measuring up to expectations or desires.

My body feels like a disappointment. My body feels too big, like a nuisance (Anna).

My body is awful; it's all wrong... My body feels criticized. My body feels like it will never be good enough (Rebekah).

At the worst of the eating disorder, body was also experienced as being ugly and inferior. It was seen as preventing the self from feeling beautiful. Moreover, to the women it symbolized failure and insufficiency.

My body prevents me from being beautiful (Devlin).

My body reminds me of all the ways that I fail, of all of the ways that I've let myself or other people down (Anna).

**The body as a way of knowing or experiencing.** At the worst of the eating disorder, there was a predominant pattern of pushing away from experiencing one's emotions or inner self. The body was described as evoking emotions, with negative, painful, or unwanted

emotions proliferating at the worst of the eating disorder. The body also was described as facilitating distraction from experiencing the inner self.

My body makes me feel angry, ashamed, disgusted, and sad because it couldn't be what I wanted (Devlin).

My body allows me to distract myself from the experience of being me (Anna).

Additionally, the body was identified as a way of knowing limits. At the worst of the eating disorder, women expressed being frustrated with the limitations of the physical body. These limitations of the body-self stirred up negative affect, such as frustration.

So I think there were limits to my body, and that was frustrating to me – that it needed things (Anna).

Moreover, the body functioned as a means of experiencing being in the world. It was a way of taking up physical space. At the worst of the eating disorder, women described a persistent desire to take up less space, to disappear.

My body prevents me from disappearing. I think the purpose of my eating disorder, in some ways, was to try to get as far away from my pain as possible, by trying to disappear. And in some ways, the paradox of the eating disorder is you feel more valuable, the less of you there is (Anna).

**Disconnection: From the object-body and all that the body facilitates connection with.** Another emerging theme was that of disconnection of the body from the self. At the worst of the eating disorder, there was a clear pattern expressed by the women of separation between the object-body and the self.

I feel less resistant about the bifurcated self, when I answer questions from this perspective [of being at the worst of my eating disorder], because it felt more than it does now [in the present] like what I was and who I was were different things (Anna).

Associated with this pattern of disembodied experience, the body was described as being foreign. The body was experienced as strange or wrong, not fitting with the self. At times, the women described a simultaneous lack of ownership of (i.e., ‘my body is not mine’) and identification with (i.e., ‘my body does not feel like me’) their bodies.

It almost felt like – I don’t know because I’ve never experienced this – but I would imagine it felt similarly to the way that someone feels if they’re transgendered. They’re in the wrong body. And I felt like I was in the wrong body (Phoenix).

My body is not mine, it is not me (Paix).

The pattern of disconnection was also seen in relation to affective experience. A sense of pushing away from or cutting off emotionality emerged from the past-oriented discourse. For some, this disconnecting appeared to be a means of self-preservation.

That is how I did not die, is not feeling anymore (Lorelai).

**Danger or lack of safety.** The theme of lacking safety emerged from the eating disorder discourse. Women's accounts were heavy-laden with patterns of antagonism. Battle language pervaded the struggle with the eating disorder and body-self. The body was often described as representing the battle site or the opponent itself.

I have to be fighting more, and eating less, or working out (Lorelai).

My body is against me. My body is my enemy (Rebekah).

Moreover, at the worst of the eating disorder the body emerged as a symbol of struggle. In one case, the body was explicitly identified as a symbol representing an internal struggle. Across the discourse as a whole, the body functioned as a concretized metaphor for the internal battle being waged within the person.

My body is a mark of my internal struggle. What I was trying to do to my body reflected what I needed to do internally (Anna).

**Restriction.** One of the most omnipresent themes emerging from past accounts of the eating disorder was that of being restricted. The irony of this theme emerging within the context of AN, a disorder characterized by caloric restriction, runs deep. Within the past-oriented discourse, emphasis was on what the body was perceived as preventing the self from doing. The body was poignantly experienced as a cage.

My body makes me feel restricted... My body feels like a cage... It was something that I was stuck in – I didn't like it, but I was just stuck in it (Paix).

My body prevents me from accomplishing what I want... I don't think my body allowed me to do anything... It prevented me from everything (Rebekah).

Linked to the pattern of the body as a cage, at the worst of the eating disorder women focused on the body-self's limitations and weaknesses. In numerous accounts, the body itself was described as being weak.

My body feels weak (but I found joy from the weakness) (Paix).

**Negative affect or absence of affect.** Linked to the body as evoking emotions, the theme of the body being tied to the experience of negative or unwanted emotions, or a lack of emotional experience emerged at the worst of the eating disorder. Disgust was an emotion most cited within the discourse, with the body stirring up disgust within the self.

My body makes me feel disgusted (Phoenix).

But on the inside, I thought that my body is disgusting (Lorelai).

Shame also emerged as dominating affective experience at the worst of the eating disorder. Women described their body as being a source of shame, or a reminder of shame and self-loathing.

My body makes me feel shame (Anna).

I look down and I'm instantly reminded of shame or the self-hatred that I have or had (Devlin).

Pain, sadness, discomfort, and anxiety also emerged as dominating affective experience. Women described their bodies as being sources of intense despair, or as evoking overwhelming anxiety.

My body makes me feel like I want to die (Phoenix).

My body makes me feel anxious... My body is anxious... Being in that cage that prevents me from being myself and doing things, that caused anxiety (Paix)

At the end of the affect continuum, a lack of feeling or emotion was expressed at the worst of the eating disorder. One woman in particular described a persistent numbness or void in emotional experience.

My body feels typically nothing (Lorelai).

**Hunger or longing.** A final theme emerging from the eating disorder discourse was that of intense hunger, desire, or longing. Again, the irony of this theme within the context of AN is glaring, with the women's expression of 'hunger,' of insatiable longing for non-physical needs to be met, juxtaposing with physical rejection of food. Desire for control, enacted through the body, emerged as one of the most common patterns of longing.

I would work so hard to have [my body] do a certain thing and look a certain way, and respond to exercise and what I was eating in a certain predictable way (Phoenix).

My body allows me to control things. If I could control my body, then it felt like I had control of other things (Paix).

Longing for body-self to be desirable or acceptable emerged as another component of this 'hunger.' Women described a perceived connection between manipulating the body to be a certain way and the longing to be more desired by others.



My body made me feel wanted. At the worst of it, I was of obviously the lightest. I was. So it made me feel wanted... My body allows me to be accepted – that's how it felt, anyways (Lorelai).

Longing for body-self to be valuable, or to simply be enough also emerged from the discourse. The pursuit of feeling valuable or good enough was acted out through the body, representing the self's internal strife.

[My body] is a symbol of all of my desires to feel like I'm valuable (Anna).

My body feels like it's never good enough. I took a lot of my self-hatred at the time – I put it all on my body. I might not have said 'I'm not good enough' but I would've focused on destroying my body to punish myself for that (Devlin).

At the deepest level, a pattern of insatiable striving wove through each woman's account of being at her worst of the eating disorder. There was a ravenous longing after the illusory goals, striving after something other or more than what the body-self was or represented. At times, women stated that they were not even sure what they were chasing after, yet they continued to be consumed by pining after something else or something more.

So [my body] only really allowed me to feel miserable, and to chase perfection, but never be able to attain it (Rebekah).

And so constantly having that separation between what I was and what I wanted made me very sad... [my body] couldn't be what I wanted. And what I wanted was what I thought would make me happy; or would bring me love – or whatever I wanted (Devlin).

### **In Recovery**

**The recovered body-self.** The word recovery in this context was chosen to reflect the theme of the object-body being recovered by the self. Through the present-oriented poetic discourse, it becomes clear the women are at varying points along the continuum of recovery from AN. Although each account reflects this range in recovery stage, there is an evident shift in how the body is experienced, contrasting with the past eating disorder discourse. Moreover, recovery discourse is characterized by prevailing tension between themes of positive and negative embodied and affective experience. There is an overarching trend of struggling with experiencing the body as an object vs. the body as subjective, the body as bad vs. the body as good, the body as disconnected vs. the body as connected, etc. Affective themes reflect this dynamic, with clear tension between negative and positive affect including the experience of shame vs. pride, and anxiety vs. peace. Themes characterizing this body-self are identified and discussed in the following text.

**The body experienced as an object.** The body here continues to be experienced as an object by the majority of the women, yet the object-body is now perceived as belonging to the self. The body is experienced as an object-for-self. As evidence of this, in some cases the emphasis on body-as-object persists, with women experiencing their bodies as if being looked at from a third-person perspective.

My body makes me feel inferior. That is based on the comparison, because, obviously, everyone I see is much prettier or much thinner (Devlin).

Similarly, the pattern of the body as not belonging to self was still present at times, yet less prevalent. Most strikingly, to a large extent replacing the thread of the body not belonging to the self, there is an emergence of ownership language when referring to the body.

My body still doesn't feel like it's mine... But I want it to feel like it's mine (Rebekah).

My body is mine (Paix).

**The body experienced as subjective.** Also emerging as a new pattern, the body begins to be experienced as a body-for-self. Extending beyond the self owning or possessing the body, in some cases there is a rejection of the body-as-object coupled with the body as being experiential.

My body is for doing things, not for looking a certain way (Paix).

Moreover, the self identifying with the body emerges within recovery. Extending beyond the self claiming the body, there is also the development, in one case, of the self identifying with the body; a union between the self and the body. The body does not simply belong to the self, but rather is recognized as the self.

My body is me... I feel more than ever that there isn't a distinction between myself and my body, in terms of mind-body dualism, so I feel very congruent as a self. I feel just as much that I am my toes, as I am in my head, walking around in this body... My body allows me to be me, because there is no me without a body (Anna).

**The body as bad, insufficient, devalued.** This shift in the way the body is experience is further evidenced by the near-absence of the theme of the body as bad. This theme, once dominant in the past-oriented discourse, remises with recovery. The only sign of this sentiment remaining is Anna's description of the underlying female dissatisfaction with the body, embedded within the fabric of Western culture.

Maybe then, being born a female body, that has prevented me from, in some way, being given the gift of loving myself automatically. Because it means something to be a female, to have the body that I have means something in our culture... And so we [women] are groomed, and shaped, and scripted to feel dissatisfaction with our bodies (Anna).

The pattern of the body as symbol of insufficiency continues to emerge in a couple cases. However women describe their bodies as symbolizing insufficiency or inferiority only at times, as opposed to representing a relentless baseline state.

My body makes me feel inferior... especially if I'm stressed or having a difficult day, even if I don't get enough sleep, then I'll constantly having this running track in my

head: 'she's so much better, you need to be better' that constant sort of voice, or the need to compare (Devlin).

But sometimes my body makes me feel unhappy, sick, and not enough (Rebekah).

**The body as good, sufficient, valued.** As the thread of the body as bad dissipates from the present-oriented discourse, a new pattern surfaces in its place. The body as good, valuable, and even sacred begins to emerge with recovery.

And because [my body] is me, that it is also good, and lovable, and valuable... and meaningful in this world (Anna).

My body is sacred. My body is a temple. My body is valued, and has worth. My body is a work of art (Paix).

As the pattern of the body being perceived as good emerges, so too does a pattern of acceptance of the body as it is. Women begin to express a sense of agreement with their bodies, being less driven to manipulate their bodies to fit some elusive ideal.

And now that I'm not [trying to control my body] anymore, it's the way that it wants to be, the way that it should be. And it just feels natural, and it feels OK, and it feels like home (Phoenix).

My body reminds me of a Michael Angelo statue. Back in that time they really concentrated on anatomy of the body in all those statues and so I think art back then was less about what it should look like, and more about what it actually does look like – looking at the muscles and things like that – that’s kind of what it reminds me of (Paix).

In direct contrast with the body as a symbol of insufficiency present at the worst of the eating disorder, a new body symbolism emerges with recovery: the body as a symbol of victory. The women begin to describe their bodies as symbolic of overcoming struggle and of being resilient.

I think about my body – it’s like some people look down at their arms and see scars from where they were self-harming, and so they look down and think, ‘wow, look how far I’ve come... It feels free in a way that’s new and exciting and victorious (Anna).

As the body begins to be perceived as good, beauty emerges in place of previous ugliness. The body-self is slowly recognized as being beautiful, or as having the capacity to be beautiful.

Sometimes, my body makes me feel well, and whole, and beautiful (Rebekah).

**The body as a way of knowing or experiencing.** Throughout recovery, the body continues to function as a way of knowing emotions, limits, and one’s place in the world. In the present-oriented discourse, the body continues to evoke emotion. However tension

characterizing emotional experience is evident as women describe their bodies as evoking mixtures of discomfort and pride, rather than the shame and disgust laden past.

And I guess I would say, whenever I go there at all, my body reminds me of feeling (Lorelai).

My body makes me feel proud, and like a stinging ache (Anna).

The body also continues to function as a way of knowing limits, with reference again made to the limitations of the body-self. However, with recovery, expression of care replaces previous frustration as a response to encountering limits.

My body has limits and the more that I learn to take care of myself, the more I am able to recognize what I/it needs. So maybe my body prevents me now – because I'm listening to it – it prevents me from abusing it (Anna).

The body also continues to function as a way of taking up space, of being in the world. The difference that is seen through recovery, however, is the pattern of embracing the body as way of the self existing in the world rather than desiring to disappear.

My body is where I live (Phoenix).

If I think about my body as representing this journey of being a self in this world, that I can see how far I've come... [my body] is allowed to take up space (Anna).

In addition to embracing the body as a way of being in the world, the thread of feeling alive through the body begins to emerge. The body not only is experienced as a way for the self to exist in the world, but it is also a way for the self to feel alive in this world.

My body allows me to be alive... My body allows me to experience life (Devlin).

**Disconnection: From the object-body and all that the body facilitates connection with.** The theme of disconnection persists into recovery, with a pattern of the body being disconnected. The body is still experienced by some women as being disconnected from the self, holding implications for the relationship between the self and the numerous aspects of lived experience that the body facilitates connection with.

My body is disconnected... Because that relationship [between my body and self] is so disconnected that my body can prevent me from enjoying things (Rebekah).

My body is disconnected from me in a big way. It's very similar to my body feels typically nothing, in that I think that's how I dealt with it. That is how I've recovered, is disconnecting from my body. (whether you call it recovery or not) (Lorelai).



Experience of the body as being foreign diminishes throughout recovery. Within the present-oriented discourse, only one of the women continued to describe her body as foreign.

My body feels foreign. It doesn't feel necessarily connected to me; I feel like, 'why am I in this body?' (Rebekah).

Similarly, disconnection from emotions was described only once. In this case, the woman expressed an enduring disconnection with her body that also facilitates disconnection with her emotions.

It is probably still that [state of not feeling], that I live in... [my body] prevents me from being emotionally connected (Lorelai).

**Connection: With the body-self and all that the body facilitates connection with.**

Through recovery, the theme of connection begins to emerge. In stark contrast with patterns of disconnection between the body, self, and affective experience, a pattern of connection with the self and with others begins to emerge in the present-oriented discourse. Along with the previously noted threads of the self claiming the body as its own, and even identifying with the body at times, the pattern of the as body enabling relationship with others begins to emerge. Connection between the self and the body surfaces alongside connection with others.

My body allows me to be present with my loved ones (Devlin).

[My body allows me] to be in relationship with people (Rebekah).

**Danger or lack of safety.** Language denoting conflict continues into the present-oriented discourse, yet largely lacks the previous pattern of the body being an enemy. Instead, tension pervades the recovery discourse, with women describing a push-pull between past articles (restriction, discomfort, inadequacy) and the desire for healing, or between what the body-self is and what it is not.

My body feels like a battlefield. It's constantly at war with itself and it feels like it's trying to be healthy, and at the same time not wanting to be (Rebekah).

If I'm upset about something or stressed, then absolutely it feels true that I cannot be happy in the body that I'm in. And then there are times that I remember that I can walk and I forget that my body is not what I want (Devlin).

**Safety, secure space to exist.** Replacing the previous theme of danger or lack of safety, a pattern of safety and security begins to emerge. A desire for the body to feel like a safe place, and at times a gained sense of security within one's own body are each expressed.

And I want [my body] to feel safe (Rebekah).

My body feels like home (Phoenix).

Care for the body-self is also associated with this emerging security. Women begin to express the importance of and desire to take care of their body-self because it is through the body that they exist.

If you're not kind to your body, where are you going to live? (Phoenix).

**Restriction.** The previously prevailing theme of restriction begins to remit with recovery. The body is seen as restricting at times, but this pattern is far less pervasive than at the worst of the eating disorder. Remnants of this theme emerge as the body at times continuing to be experienced as a cage.

My body makes me feel kind of trapped and ashamed (Lorelai).

My body prevents me from – not all the time – but my body prevents me from living, and living life to the full (Rebekah).

**Freedom.** In contrast with the theme of restriction, a pattern of freedom begins to emerge. Women describe their bodies as linked to experiencing freedom, with the body itself feeling free or alternatively allowing the self to feel free.

My body allows me to break down barriers (Phoenix).

[My body is] free, too. It feels free in a way that's new and exciting and victorious (Anna).

Freedom through expression also begins to emerge through recovery. The body is experienced by some of the women as enabling expression of oneself in the world.

My body allows me to express myself (Paix).

Experiencing freedom through movement also emerges. The body enables movement and the freedom that comes along with movement, which may be as elementary as walking or expansive and exploratory. This movement was especially precious to some women who described the inability to be physically active at the worst of their eating disorder, due to comorbid conversion disorder or medically enforced restrictions on activity for weight-gaining purposes.

My body allows me to walk – I try not to take for granted that I can walk (Devlin).

My body allows me to move... My body allows me to explore. My body allows me to be adventurous. My body allows me to be daring (Paix).

Going hand-in-hand with freedom through movement, experiencing freedom through ability also emerged within the recovery discourse. The body allows the self to feel able and engaged.

[My body allows me] to engage in activities, to kind of be limitless in a sense (Rebekah).

Moreover, a pattern of strength and power emerges. Women begin to describe feeling strong or powerful through the body. The majority of women cited this pattern throughout recovery.

My body feels powerful. More powerful than it's ever felt (Anna).

[My body] allows me to carry things. It allows me to be strong, and to work at being stronger (Paix).

Also contributing to the theme of freedom, sovereignty begins to emerge within the recovery discourse. Tied to the self claiming the body as its own, sovereignty over the body is also expressed.

For so long, being tube-fed and being certified and sort of controlled on every aspect of my body, it is an empowering feeling to know that this is my body and I get to take care of it and make decisions (Devlin).

**Negative affect or absence of affect.** The theme of negative affect continues into recovery, although it becomes less dominating of the women's lived experiences. Disgust and

shame, which were chief at the worst of the eating disorder, are expressed only once in the present-oriented discourse.

My body feels disgusting... I look down [at my body] and I'm instantly reminded of shame or the self-hatred that I have or had (Devlin).

Likewise, the experience of pain, sadness, and discomfort remit with recovery. Pain remains associated with the body, yet lacks its overwhelming, agonizing quality seen at the worst of the eating disorder.

It's been a painful experience, to be a self in this body in this world (Anna).

I often feel very sick or exhausted. So my body can prevent me from feeling happy, or just being in the moment, or things like that (Rebekah).

Once again, at the end of the affective spectrum, numbness remains present in one case. For one woman, she describes a persistent absence of emotional experience into carrying into the present.

My body feels typically nothing (Lorelai).

**Positive affect.** Remarkably, positive or pleasant emotions begin to surface with recovery. Once entirely lacking from poetic discourse, women express emotions that

contradict with previously prevailing negative affect. Namely, contrasting with the pattern of anxiety, sadness, and shame associated with being at the worst of the eating disorder, peace, happiness, and pride begin to emerge within the present-oriented discourse.

My body makes me feel happy... My body feels at peace. My body feels rested... My body allows me to express joy (Paix).

My body makes me feel proud (Anna).

**Hunger or longing.** The dominant theme of insatiable hunger or longing seen at the worst of the eating disorder begins to dissipate with recovery. Remaining pangs of desire for the body-self to be more acceptable or different from how it actually is continue to emerge. However, the present-oriented discourse is characterized by a sort of restlessness, lacking the fervent drive seen at the worst of the eating disorder, yet not having arrived at a place of ease with the body-self.

Feeling unhappy will my body will remind me of what I did and why I wanted to do it, in terms of starving myself to get it to be what I hoped for (Devlin).

I'd say my body is trying to accept itself. Or my body is trying to get me to accept it (Rebekah).

### **Towards Body-Self Unity**

**The unified body-self.** Recovery of the body by the self is sometimes followed by unification of the self with the body. Perceiving the body as an object nearly entirely dissipates, along with ownership language referring to the body. In its place emerges the desire for and experience of body-self unity. The body once was an object that could be held as a possession, yet when the body is experienced subjectively, the question of its ownership is no longer relevant. The only trace of the body-as-object that remains in the future-oriented discourse is one instance of the self claiming the body, which is stated in conjunction with an expression of body-self unity, “This is me, this is my body” (Devlin). Themes characterizing this body-self are identified and discussed in the following text.

**The body experienced as subjective.** A pattern of the body experienced as subjective emerges, characterized by a rejection of the body-as-object. The notion of the body-as-object seen at the worst of the eating disorder does not passively dissolve, it is actively rejected.

My body is not a material object (Paix).

Moreover, a pattern of the self identifying with the body surfaces within the future-oriented discourse. There is a resounding sense of unity between the body and self that emerges, with the body being described as integral to who the person, the self, is. The body does not become all-consuming, nor does it become eclipsed by the self. Rather, the body and the self become unified, paradoxically two entities making up a single person.



I want to continue looking at my body as me. My body is me. I've just started to feel that way, and I want to even more so have that unity, knowing that my body is me, and it's my mind and my body and my soul (Paix).

My body isn't my entire identity, but is part of me, and I accept it... It feels like a part of me, not something that's disconnected (Rebekah).

**The body as good, sufficient, valued.** Along with the self identifying with the body, within the future-oriented discourse the body continues to be experienced as good and of worth.

My body is good (Lorelai).

My body is valuable and is of worth (Paix).

Acceptance of body as it is also continues to emerge. Women describe accepting their bodies as they are, maintaining allowance for their bodies to be "normal" and free from aspirations of a lofty ideal.

My body is fine the way it is, and is acceptable (Rebekah).

My body feels normal. I think for me, and maybe anyone, it's really lofty of a goal to say my body feels amazing all the time – I'm bound to have days where I don't feel that good

in my body, but not to the point where it destroys me or brings me down. I'd really like to know what it's like to have a normal relationship with my body. Be able to accept those days and carry on... I'd like to be able to accept my body unapologetically (Devlin).

The pattern of the body as a symbol of victory continues as well. Representing one of the most prominent patterns emerging from the future-oriented discourse is the body as a symbol of being victorious, resilient, and having the ability to overcome trials. As each woman describes this body symbol, past shame is clearly replaced with resounding pride and gratitude.

My body reminds me of my past – in a good way. It reminds me of what I've gone through, but instead of feeling shame, I feel gratitude. That sense of purpose; 'this is what I want to do with my life' (Devlin).

My body reminds me of my story, being here in the world, of what I've been through, and where I've been. I like the idea even of stretch marks as being like war paint. I imagine that, if I have scars from gaining weight or having a baby, that those will be reminders of victory (Anna).

Fitting with themes of the body as good and acceptable the way it is, references to ugliness or a lack of beauty once again are nowhere to be found. Instead, the body is referenced as being beautiful.

And [my body] is beautiful (Rebekah).

**The body as a way of knowing or experiencing.** The theme of acceptance carries into the notion of the body as a way of knowing or experiencing. Within the future-oriented discourse, the body continues to evoke emotions, but such emotions are no longer painful or unwanted.

My body reminds me of my feelings, but that's ok... feelings aren't bad (Lorelai).

Similarly, the body also continues to function as way of knowing limits, yet this is perceived as a crucial part of caring for oneself, or even caring for others. Women describe their bodies as a way of gauging and refraining from what is harmful.

My body prevents me from overdoing it, exhausting myself (Lorelai).

My body prevents me from – as an experiential thermometer – it prevents me from hurting myself, or other people, or making mistakes or from getting into danger. My body prevents me from doing things I don't want to do, or are unhealthy for me (Anna).

Within the future-oriented discourse, the body also continues to facilitate being in the world, which is embraced is good and desirable. Moreover, the body is described as a means not only of existing, but an avenue for feeling alive in the world.

My body allows me to be in this world. And that's good... my body allows me to be present in the world. To exist (Anna).

My body makes me feel alive (Lorelai).

**Connection: With the body-self and all that the body facilitates connection with.** A pattern of connection between the self, body, and others in the external world continues in the future-oriented discourse. Emerging is a sense not only of connection but also of congruency between the self and the body.

My body feels like I feel (Anna).

[I want to continue] to not be so dualistic in that thinking – that what I do to my body effects me, at the core, who I am (Paix).

Connection with others also emerges as a prominent pattern. There is a continued thread of the body facilitating connection between the self and others. It is through the body that women find connection with loved ones.

My body feels open and connected... My body allows me to connect with myself, and to others (Lorelai).

[My body] allows me to love other people. It allows me to help other people (Rebekah).

**Safety, secure space to exist.** Another theme that remains evident in future-oriented discourse is that of safety. The body continues to be experienced as a safe, secure place. Moreover, this safety and security continue to promote a desire to care for the body-self.

My body is a safe place (Lorelai).

[I want] in the future for [my body] to feel at ease... knowing that it's being treated well (Paix).

Arising alongside this care for the body-self, the body is described as feeling healthy. The body-self that is cared for emerges with a desire for the body-self to be healed.

My body feels healthy inwardly... it would be nice in the future if my body could just feel healed inside – there isn't this constant agitation of food and stress and all those things. It feels healed (Rebekah).

**Freedom.** The theme of freedom continues to emerge in future-oriented discourse. Remarkably, previous themes of restriction present even into recovery are entirely absent here. Freedom is again experienced through the body facilitating expression of the self.

My body allows me to express who I feel like I really am (Rebekah).

Likewise, the body continues to facilitate movement, expansiveness, and exploration. Juxtaposing past descriptions of the body as a cage, the body becomes a vehicle for being in and experiencing the world.

My body is a way that I move, and breathe, and live in this world. And that is good (Anna).

My body allows me to explore, and to dare. It allows me to be daring (Paix).

Additionally, the pattern of freedom through ability remains present in future-oriented discourse. The body continues to represent an avenue for feeling able, capable, and productive.

My body makes me feel able... to exercise, to do everyday life (Rebekah).

My body allows me to work and have a career... My body allows me to be a mom and to have kids... my body makes me feel capable and strong (Devlin).

Contributing to the theme of freedom, strength and power increase in prominence throughout the future-oriented discourse. Strength emerges alongside ability, often being intertwined with one another. The body enabling the self to experience freedom is also a strong and powerful body.

My body makes me feel capable and strong (Devlin).

My body is for kicking ass (Phoenix).

**Positive affect.** The final theme emerging from future-oriented discourse is that of positive affect. Emotions including peace, happiness, and gratitude continue to emerge, entirely replacing difficult emotions like anxiety, sadness, and shame that pervaded eating disorder discourse. The body emerges as a source of peace, contentment and happiness, and prompts gratitude stemming from its ability to endure and be healthy.

I want to continue for my body to make me happy. And for my body to continue to make me feel peaceful and calm (Paix).

My body makes me feel grateful. I'd like to feel what it's like to be in my body or look at my body and be grateful that it's still going – after everything I put it through... My body is a gift. I'd like to recognize that it's a gift and be grateful for it and really recognize that it is special and created (Devlin).

### **Summary**

From the embodiment and affective themes emerging from poetic discourse, relationships between individual themes were delineated. Although presented as dichotomous, embodiment and affective themes are more accurately conceptualized as on a continuum: (a) the body experienced as an object vs. the body experienced as subjective; (b) the body as bad, insufficient, devalued vs. the body as good, sufficient, valued; (c) disconnection from the

object-body and all that the body facilitates connection with vs. connection with the body-self and all that the body facilitates connection with; (d) danger or lack of safety vs. safety, secure space to exist; (e) restriction vs. freedom; and (f) negative or absent affect vs. positive affect. Embodied themes may also be thought of as layers, with the foremost layer comprised of the body experienced as an object or subjective. This layer of embodied experience then trickles down to other themes. Affective themes emerge alongside embodiment themes, paralleling embodied experience. For example, as embodied experience is increasingly negative and detached, so too is affective experience. The theme of hunger or longing emerges only within the context of the eating disorder, appearing to stem from both negative affective and negative embodied experience.



**Body-Self Poems****Rebekah: At the worst of the eating disorder**

My body is awful;  
    it's all wrong.

My body is against me.

My body is my enemy.

My body is worthless.

My body feels ugly.

My body feels fat.

My body feels weak.

My body feels criticized.

My body feels like it will never be good enough.

My body makes me feel sick.

My body makes me feel depressed.

My body makes me feel anxious,  
    stressed,  
    overwhelmed.

My body feels like it's my only identity,  
    like I'm only what my body is.

My body reminds me of failure,  
    imperfection.

My body reminds me of disgust,  
    and worthlessness.

My body prevents me from feeling beautiful.

My body prevents me from accomplishing what I want.

I don't think my body allowed me to do anything.

It prevented me from everything.

    I was so caught up with what it looked like,  
    and how much I weighed,  
    and how much I ate or didn't eat

So it only really allowed me

    to feel miserable,  
    and to chase perfection, but never be able to attain it.

**Rebekah: In recovery**

My body feels like a battlefield.

It's constantly at war with itself  
and it feels like it's trying to be healthy,  
and at the same time not wanting to be.

Sometimes, my body makes me feel well, and whole, and beautiful.  
But sometimes my body makes me feel unhappy, sick, and not enough.

My body allows me to experience life,  
to be in relationship with people,  
to engage in activities,  
to kind of be limitless in a sense.

I'd say my body is trying to accept itself.  
Or my body is trying to get me to accept it.

My body is disconnected.

My body prevents me from –  
not all the time – but  
my body prevents me from living,  
and living life to the full.  
And that's very connected to mental *me*  
because that relationship is so disconnected  
that my body can prevent me from enjoying things,  
because I am so preoccupied with what my body looks like or feels like.  
I often feel very sick or exhausted.  
So my body can prevent me from feeling happy,  
or just being in the moment,  
or things like that.

My body still doesn't feel like it's mine,  
and it doesn't feel safe.

But I want it to feel like it's mine,  
And I want it to feel safe.

**Rebekah: Towards body-self unity**

My body allows me to express who I feel like I really am.

It allows me to love other people.

It allows me to help other people

My body allows me to fulfill the will that God has for me.

My body is a safe place.

My body isn't my entire identity,

but is part of me,

and I accept it.

My body is fine the way it is,

and is acceptable,

and is beautiful.

My body makes me feel healthy.

It makes me feel strong.

My body makes me feel able.

My body feels healthy,

and beautiful.

My body feels healthy.

It feels like a part of me,

not something that's disconnected.

My body feels healthy in a way where I have strength to go through my day,

to exercise,

to do everyday life,

because often I haven't and don't feel like I am able to do those things.

And also, my body feels healthy inwardly.

I feel like I have had a lot of sickness and illness because of my eating disorder,

and so it would be nice in the future if my body could just feel healed inside –

there isn't this constant agitation of food and stress and all those things.

It feels healed.

My body reminds me of what's most important.

So instead of reminding me of failure,

or of imperfect pieces,

it reminds me more of the ability to live.

And it reminds me of the gift I've been given, of a healthy body.  
In the future I'd like to see my body reminding me of what I've been through,  
in a way where it cultivates me to help other people  
and to maintain a healthy body and mindset.

**Devlin: At the worst of the eating disorder**

My body is my enemy.  
it was never good enough,  
never thin enough.

My body makes me feel angry,  
ashamed,  
disgusted,  
and sad because it couldn't be what I wanted.  
And what I wanted was what I thought would make me happy;  
or would bring me love – or whatever I wanted.  
And so constantly having that separation between what I was and what I wanted  
made me very sad.  
Around people I made that anger  
because I didn't want to show that I was really hurting.

My body prevents me from being beautiful.  
My body prevents me from having friends –  
I truly believed that.

My body feels fat.  
Even though that's not necessarily a feeling,  
I would've argued and argued that it feels fat.  
My body feels like it's never good enough.  
I took a lot of my self-hatred at the time –  
I put it all on my body.  
I might not have said 'I'm not good enough'  
but I would've focused on destroying my body to punish myself for that.

My body allows me to run every day.

I was constantly turned to what my body wasn't,  
couldn't do.  
I never really thought to consider the good things  
or what it made me capable of doing.

**Devlin: In recovery**

My body feels disgusting.

My body feels foreign.

It doesn't feel necessarily connected to me;  
I feel like, 'why am I in this body?'

My body reminds me of my past.

I have a lot of scars,  
I look down and I'm instantly reminded of shame or the self-hatred that I have  
or had.

Feeling unhappy will my body will remind me of what I did,  
in terms of starving myself  
to get it to be what I hoped for.

So when I look at my body now, it reminds me of my past  
in that I'm also wishful.

I wish I could be thin  
but I don't want to have the mindset of an eating disorder.

At least once a day I'm reminded of where I've come from  
in terms of the eating disorder.

But my body allows me to be alive.

My body allows me to be present with my loved ones.

My body allows me to experience life.

My body allows me to walk –

I try not to take for granted that I can walk.

My body prevents me from being happy.

In some ways that is true,  
but it would depend on the time.

If I'm upset about something or stressed,  
then absolutely it feels true that I cannot be happy in the body that I'm in.

And then there are times that I remember that I can walk  
and I forget that my body is not what I want.

My body is mine.

For so long, being tube-fed  
and being certified

and sort of controlled on every aspect of my body,  
it is an empowering feeling to know that this is my body  
and I get to take care of it and make decisions.

And I know it could easily go to, 'then I get to restrict,'

I could easily go there – but that’s not what I mean.  
I mean, almost an empowerment  
or like a rejoicing that this is my body.  
It doesn’t need to be controlled by anyone else.  
My body is imperfect,  
which can cause stress sometimes.

My body makes me feel frustrated  
and angry sometimes.  
On the other hand, my body makes me feel strong.  
My body makes me feel inferior.  
That is based on the comparison,  
because, obviously, everyone I see is much prettier or much thinner.  
And especially if I’m stressed or having a difficult day,  
even if I don’t get enough sleep,  
then I’ll constantly having this running track in my head:  
‘she’s so much better, you need to be better’  
that constant sort of voice, or the need to compare.

**Devlin: Towards body-self unity**

My body makes me feel grateful.

I'd like to feel what it's like to be in my body  
or look at my body  
and be grateful  
that it's still going – after everything I put it through.

My body is a gift.

I'd like to recognize that it's a gift  
and be grateful for it  
and really recognize that it is special and created.

My body allows me to work and have a career.

My body allows me to be present with my loved ones.

My body allows me to be a mom and to have kids.

My body reminds me of my past – in a good way.

It reminds me of what I've gone through,  
but instead of feeling shame, I feel gratitude.  
That sense of purpose;  
'this is what I want to do with my life.'

My body feels normal.

I think for me, and maybe anyone, it's really lofty of a goal  
to say my body feels amazing all the time –  
I'm bound to have days where I don't feel that good in my body,  
but not to the point where it destroys me or brings me down.  
I'd really like to know what it's like to have a normal relationship with my body.  
Be able to accept those days and carry on,  
and also to have days where I can look in the mirror and be like,  
'I like how I look' and then leave, or go out –  
not just stay home because I feel like I'm so ugly  
that I can't leave my house.

My body feels like me.

I'd like to be able to accept my body  
unapologetically.  
'This is me,  
this is my body.'

My body prevents me from going backwards

with that sense of gratitude and recognizing that my body is a gift.  
Being able to remember my past,  
take into account, 'this is my body,'  
and have that acceptance that I wouldn't want to hurt it and go backwards.



My body makes me feel capable and strong.

**Paix: At the worst of the eating disorder**

My body is possessed.

My body is not mine,  
it is not me.

(I always felt like my eating disorder self was not the real me –  
It's like the me that I'm afraid of being)

My body makes me feel anxious.

My body makes me feel restricted.

My body feels like a cage.

My body feels weak

(but I found joy from the weakness).

At the time, I felt like my body was preventing me from being myself,

Because I felt like it was a nuisance, in a way.

It was something that I was stuck in –

I didn't like it, but I was just stuck in it.

My body is anxious.

Being in that cage that prevents me from being myself and doing things,  
that caused anxiety.

My body allows me to control things.

If I could control my body,

then it felt like I had control of other things

My body reminds me of clay –

clay that could be molded and moved – not hard clay.

It could be molded and moved into something that you like,

or that other people like, or that you'd feel more comfortable with.

And you can control it in that manner.

And it's material.

**Paix: In recovery**

My body is sacred.  
My body is a temple.  
My body is valued,  
    and has worth.  
My body is a work of art.

My body allows me to move.  
My body allows me to express myself.

My body reminds me of a Michael Angelo statue.  
    Back in that time they really concentrated on anatomy of the body in all those statues  
    and so I think art back then was less about what it should look like,  
    and more about what it actually does look like –  
        looking at the muscles and things like that –  
    that's kind of what it reminds me of.

My body makes me feel happy,  
    easy one, but it's true.  
My body makes me feel comfortable,  
    like I used to not, but I feel comfortable in it now.  
My body makes me feel free.

My body doesn't prevent me from doing anything, I don't think.

It allows me to do so many things, like I said,  
    to move.  
    to express myself.  
It allows me to carry things.  
It allows me to be strong,  
    and to work at being stronger.

My body feels at peace.  
My body feels rested.

My body allows me to explore.  
My body allows me to be adventurous.  
My body allows me to be daring.  
My body allows me to express joy.

My body is mine.

**Paix: Towards body-self unity**

I want to continue looking at my body as me.

My body is me.

I've just started to feel that way, and I want to even more so have that unity,  
knowing that my body is me,  
and it's my mind and my body and my soul.

And to not be so dualistic in that thinking –  
that what I do to my body effects me,  
at the core,  
who I am.

My body allows me to explore,  
and to dare.

It allows me to be daring.

I want my body to allow me to, even more so, be strong.

I want to have more strength.

I want my body to just simply remind me of me.

And of all that I've been through;  
how far I've come.

And I want it to reflect who I am.

I want to continue for me body to make me happy.

And for my body to continue to make me feel peaceful and calm,  
and strong.

And I want my body to continue feeling strong.

And in the future for it to feel at ease,  
not anxious,  
and not stressed,  
knowing that it's being treated well.

My body is valuable and is of worth.

My body is not a material object.

I don't want my body to prevent me from doing anything.

**Lorelai: At the worst of the eating disorder**

My body feels  
typically  
nothing.

My body made me feel wanted.  
At the worst of it, I was of obviously the lightest.  
I was.  
So it made me feel wanted.

My body allows me to be accepted –  
that's how it felt, anyways.  
But on the inside, I thought that  
my body is disgusting.

My body reminds me of feelings.

My body prevents me from being who I want to be,  
because it felt like such a constant –  
there's no safety,  
there's no 'I've arrived'  
like, 'yes, I've gotten to this, I'm this weight, and this is how it will stay.'  
The way that I feel others perceive me,  
a social ideal of physical attractiveness,  
that's not going to stay the same.  
I have to be fighting more,  
and eating less,  
or working out.  
Everything becomes consumed by that.  
There's no safety in it.

**Lorelai: In recovery**

My body feels  
typically  
nothing.

My body makes me feel  
kind of trapped and ashamed.

My body allows me to interact in the world I live.

My body is disconnected from me  
in a big way.  
It's very similar to my body feels typically nothing,  
in that I think that's how I dealt with it.  
That is how I've recovered,  
is disconnecting from my body.  
(whether you call it recovery or not)  
That is how I did not die,  
is not feeling anymore.  
It is probably still that, that I live in.

And I guess I would say, whenever I go there at all,  
my body reminds me of feeling.

It's very confusing, but my body also prevents me from being emotionally connected.

**Lorelai: Towards body-self unity**

My body feels open  
and connected.

My body makes me feel alive.

My body allows me to connect with myself,  
and to others.

My body is good.

My body reminds me of my feelings,  
but that's ok.  
Feelings aren't bad.

My body prevents me from overdoing it,  
exhausting myself.

**Anna: At the worst of the eating disorder**

My body prevents me from disappearing.

I think the purpose of my eating disorder, in some ways,  
was to try to get as far away from my pain as possible,  
by trying to disappear.

And in some ways, the paradox of the eating disorder is  
you feel more valuable,  
the less of you there is.

So I think there were limits to my body,  
and that was frustrating to me –  
that it needed things.

So it prevented me from getting thinner.

My body is a mark of my internal struggle.

What I was trying to do to my body  
reflected what I needed to do internally.

Control and manage,  
and punish.

Make docile – like Foucault's *docile bodies* –

Groom it so that it performs for you in the way that you want it to,  
so that you are more powerful.

I'd be more powerful in disappearing.

My body makes me feel shame.

(I feel less resistant about the bifurcated self,  
when I answer questions from this perspective,  
because it felt more than it does now  
like what I was and who I was were different things.)

So my body makes me feel shame.

But I think, looking back, that was the projection of my experience of myself.  
Those aren't different things.

My body feels like a disappointment.

My body feels too big,  
like a nuisance.

My body allows me to control my world around me.

My body allows me to distract myself from the experience of being me.

My body reminds me of all the ways that I fail,

of all of the ways that I've let myself or other people down,  
and is a symbol of all of my desires to feel like I'm valuable.



**Anna: In recovery**

My body is me.

I feel more than ever that there isn't a distinction between myself and my body,  
in terms of mind-body dualism,  
so I feel very congruent as a self.

I feel just as much that I am my toes,  
as I am in my head,  
walking around in this body.

And so I would say that my body is me.

And because it is me, that it is also good,  
and lovable,  
and valuable,  
and worth taking care of,  
and is meaningful in this world,  
and is allowed to take up space.

My body makes me feel –

I don't really know how to answer that question,  
because, again, it kind of implies that I have to disconnect from myself  
to evaluate it from the outside.

(I feel these two stems are similar:

my body makes me feel, and  
my body feels,  
because I feel more like a congruent self.)

But if I was to step outside of that, I would say,

my body makes me feel proud,  
and like a stinging ache.

If I think about my body as representing this journey of being a self in this world,  
that I can see how far I've come, and also  
it's been a painful experience,  
to be a self in this body in this world.

And so, I think if I objectively try to step outside of it,

I think about my body –  
it's like some people look down at their arms  
and see scars from where they were self-harming,  
and so they look down and think, 'wow, look how far I've come,'  
but also, 'ouch, that was a hard time.'

So I feel like my whole lived experience,  
my whole body-physical-self represents that,  
because it hasn't always been safe to be in my body,  
and so it's a loaded thing.

My body feels powerful.

More powerful than it's ever felt.

And I would say free, too.

It feels free in a way that's new and exciting and victorious.

My body allows me to be me,

because there is no me without a body.

I feel conflicted because my body prevents me from and allows me to –

I feel this desire, this want to say, 'but it doesn't give me permission to do anything.'

But I think that's a statement that reflects the privilege of being able-bodied,  
and youthful,

and maybe even having lived in a Caucasian body as well.

That my body has never prevented me,

from the colour of my skin,

or the way that it functions,

from doing anything really.

It's been my mental struggle with my body,

that's prevented me from doing things.

Maybe then, being born a female body,

that has prevented me from, in some way, being given the gift  
of loving myself automatically.

Because it means something to be a female,

to have the body that I have means something in our culture.

And so we are groomed,

and shaped,

and scripted to feel dissatisfaction with our bodies.

I want to say that my body doesn't prevent me from anything –

I recognize that's privilege,

but I also think that being born female means

that I have a harder chance of loving myself in my body,

just because of what it means to be female.

That being said, my body has limits and

the more that I learn to take care of myself,

the more I am able to recognize what I/it needs.

So maybe my body prevents me now – because I'm listening to it –

it prevents me from abusing it.

**Anna: Towards body-self unity**

My body feels like I feel.

My body is a way that I move,  
and breathe,  
and live in this world.  
And that is good.

My body allows me to be in this world.  
And that's good.

My body prevents me from – as an experiential thermometer –  
it prevents me from hurting myself, or other people,  
or making mistakes  
or from getting into danger.

My body prevents me from doing things I don't want to do,  
or are unhealthy for me.  
And that'll likely change in the future –  
age happens, and there's a physiological decline in my ability –  
I might say my body prevents me from doing things I used to do.  
But how I'd like to feel is that I just have this congruent experience of being a self.

My body reminds me of my story,  
being here in the world,  
of what I've been through,  
and where I've been.

I like the idea even of stretch marks as being like war paint.  
I imagine that, if I have scars from gaining weight or having a baby,  
that those will be reminders of victory.

My body allows me to be present in the world.  
To exist.

**Phoenix: At the worst of the eating disorder**

My body makes me feel disgusted.

My body is betraying me.

I used to write that all the time in my journal,  
about how I would work so hard to have it do a certain thing  
and look a certain way,  
and respond to exercise  
and what I was eating in a certain predictable way.  
And then it stopped doing that.

My body prevents me from feeling OK.

My body reminds me of the fact that I can't trust it.

My body makes me feel like I want to die.

**Phoenix: In recovery**

My body makes me feel powerful.

My body feels like home.

I spent so much time feeling uncomfortable.

Uncomfortable in a way that was intolerable most of the time,

it almost felt like – I don't know because I've never experienced this –

but I would image it felt similarly to the way that someone feels

if they're transgendered.

They're in the wrong body.

And I felt like I was in the wrong body.

And I spent so much time trying to change it,

and micromanage it,

and control it,

and distort it into what I thought it should be.

And now that I'm not doing that anymore, it's the way that it wants to be,

the way that it should be.

And it just feels natural,

and it feels OK,

and it feels like home.

My body is where I live.

If you're not kind to your body,

where are you going to live?

My body allows me to break down barriers.

My body is for doing things,

not for looking a certain way.

**Phoenix: Towards body-self unity**

My body prevents me from looking young forever.

That's something I'm struggling with right now:

I tell myself, I didn't come out of eight years of treatment only to switch from  
feeling like my body is not thin enough,  
to feeling like it doesn't look young enough.

It's impossible to live in our culture and feel OK about yourself all the time.

Or even probably most of the time.

I feel OK with myself most of the time,

but there always is going to be something.

We're made to feel like our body is a project –  
it needs this, that, or the other.

My body makes me feel content.

My body reminds me that I am resilient.

My body allows me to be myself.

My body is for kicking ass.

## CHAPTER SIX: DISCUSSION

I will open this section with some personal reflections emerging from my interaction with the research participants and the research process as a whole. Next, I will outline the strengths and limitations of this study. I will then focus on expatiating the pattern of embodiment and affective themes as they shift throughout recovery from AN. Subsequently, I will present this study's thematic findings within the framework of the Developmental Theory of Embodiment (Piran & Teall, 2012), and alongside dimensions of embodied experience as identified by Piran (2016). I will then discuss the implications of this study's results in light of the expanding the body of literature examining female embodied experience. Finally, I will outline future research, clinical, and sociocultural implications.

### **Researcher's Reflections**

Out of the interactive, reflexive nature of this research, dialogue with participants as well as immersion in the data collection and analysis yielded personal reflections on the study's findings and implications. First, a word of caution regarding the conclusions drawn from this study is in place, in light of the purpose of this research. These findings show how women's embodied affective experience shifts at different points of the recovery process and thus highlight that this experience is intimately interwoven with the recovery process. Although some of the current findings may have implications for AN preventative and treatment measures, these results do not lend themselves to causal attributions regarding AN treatment or prevention. Although women's reflections on their recovery process revealed several shifts in their embodied affective experience these accounts do not represent evidence that the recovery process necessarily stems exclusively from these changes in the embodied experience. This interpretation of the findings align with the stated purpose of this study, namely to explore

women's embodied affective experience in the process of recovery from AN. Whereas this research sought to explore women's emotional and embodied experiences, the mechanism of change reflected in the shifts reported by participants was not the focal point of investigation.

Secondly, it is important to note that all women who participated in this study were self-identified as 'recovered' by clinical standards. Thus, it is valuable to recognize that these women represent a portion of women who, against discouraging reported rates of recovery, has found healing, namely in terms of AN symptom remission. Treatment approaches and recovery trajectories differed among these women, yet participants shared the commonality of having experienced significant change by the clinically defined standards of recovering from AN (American Psychological Association, 2013). From this commonality, it is posited that we may glean knowledge of key components that may have contributed to or been a part of efficacious treatment outcomes. Moreover, on numerous occasions participants expressed without prompting how they have come to experience their bodies differently throughout their journey of recovery from AN. Each woman participating in the study described how coming to experience and accept their body subjectively has been central in finding peace, and even joy, manifesting along with clinical AN symptom remission. Such observations implore attention and curiosity. These findings invite attention and curiosity regarding this shift in embodied experience and its role in healing.

Also tied to this study's findings and recovery from AN is the palpable tension between refeeding measures aimed at preserving life, on one hand, and honouring women's embodied agency, on the other hand. This matter will be discussed in greater detail in a latter section, however it is important to once again reflect on the purpose of this research. Although this study does not directly concern or speak to treatment of AN, it does invite mental health and



medical professionals to consider the significance of body-self relationship when advocating for and offering treatment options. As a starting point, intentionally involving women as a part of their treatment planning and care team meetings sets precedence that their voice is central to decisions regarding their body-selves. It is my hope that this study's findings may spur critical dialogue regarding mainstream approaches to AN that, at times, are characterized by disembodied treatment and violations of the body agency.

Lastly, through discussion with women participating in this research, the matter of language regarding embodied experience arose and invites further reflection. Grappling alongside one of the participants with the word 'body' as a limited reference to the physical self, I was struck by the power that language holds. That participants eventually proposed the term 'body-self' as a way to expand the conversation and to enhance the way we speak about the embodied self. Through this conversation and the research process as a whole, we are confronted with the difficulty of capturing nuanced subjective lived experience, particularly affective embodied experience. However, it also becomes clearer that dialogue holds the ability to expand viewpoints, or, contrarily, to perpetuate biases. There is value even in dialoguing about what the word 'body' evokes and means. Through beginning such conversation, we broaden awareness that we might think about, speak about, and experience our bodies differently. Moreover, emphasizing the experience of being in one's body, as opposed to focusing on cognitions, attitudes, and evaluations about physical characteristics of one's body, lends itself to facilitating exploration of subjective, embodied lived experience. Thus, we are challenged as researchers, clinicians, and family members to evaluate, and if need be, adjust the ways in which we address matters of the embodied self.

### Strengths and Limitations of The Study

For this study, the inclusion criteria were the AN diagnosis and current ability to live independently (i.e., not currently requiring medical intervention or inpatient treatment). Thus, participants who had an existing relationship with the researcher were not excluded. Consequently, two of the women included in the study had existing relationships with myself: one being a relative and the other a colleague. As this research was approached from a transformative feminist paradigm, which emphasizes interaction, reflexivity, and understanding between the researcher and participant, such existing relationships may have been an asset. Moreover, as this research study sought to incorporate qualities that are often overlooked by empirical quantitative research including relationality and vulnerability, increased comfort between participants and the researcher likely served to enhance outcomes, as rapport and trust had already been built between the researcher and these participants.

The English language, specifically surrounding the use of the word ‘body,’ also represents a potential limitation of this research. Recall that in comparison to other languages such as German and French, which have nuanced words for referring to the body-object or the body-subject, English has the singular word ‘body.’ In contrast to *Körper* or *corps objectif*, referring to the body as an observed object, and *Leib* or *corps propre*, referring to the body as a subjective lived reality, English does not distinguish as readily between the concepts of subject and object body (Husserl, 1998; Merleau-Ponty, 2012). Instead, the English word ‘body’ tends to more closely align with *Körper* or *corps objectif*, evoking notions of the physical body. As a result of this limitation in English diction, choosing the word ‘body’ as a way to guide reflection through completion of the sentence stem activity may also have inadvertently invited a biased reflection of participants’ experiences on their bodies from an objective standpoint.

However, through poetic discourse generated by sentence stems it became apparent that every woman participating in the study was capable, without prompting, of distinguishing between and articulating experiences of both the object-body (i.e., statements of preoccupation with body appearance, weight, etc.) and subject-body (i.e., statements of the body feeling like or being oneself). Despite this limitation of the English word, sentence stems employing the word ‘body’ appeared to generate discourse that included a wide array of embodied experience characterized by subject- and object-body references alike. However, for potential future application of these sentence stems in either clinical or research settings, alternatives in wording may be explored. For example, employing the term ‘body-self’ as an alternative to the word ‘body’ would be fitting, drawing upon this study’s findings and the reflections of participants, as mentioned previously.

Another potential limitation of the study hinges on data from participants’ retrospective and prospective accounts of their embodied experience throughout recovery from AN. For instance, given the span of time between participants’ being at the worst of their eating disorder and their involvement in the study, accurate recollection of past embodiment and affective experience cannot be guaranteed. Additionally, variable periods of time elapsed since the AN diagnosis for each participant (i.e., five to 12 years prior to these interviews), may contribute to potential discrepancies in retrospective accounts of AN, as does participants subjectively defining the ‘worst’ of their eating disorder. These factors represent points within the data that may be defined, experienced, and recollected differently from individual to individual. However, due to malnutrition’s impact on cognitive functioning, capacity for insight and reflection at the worst of the eating disorder likely would have been limited. In this way inviting retrospective accounts of the worst part of one’s struggle with AN may have facilitated

a depth of insight into this period of time that otherwise would not have been possible. Additionally, inviting individual interpretation of being at the ‘worst’ of one’s battle with AN lends itself appropriately to the nature of this study, which focused on the embodied lived experience; a concept that is inherently subjective, and to which imposing externally determined criteria to would be both inappropriate and invalid.

Associated with the reflective and subjective nature of the study’s method of inquiry, poetic discourse generated by sentence stems proved to be profoundly moving on many occasions, facilitating deepening of insight and understanding for the researcher and research participants alike. The majority of women expressed how engaging in the sentence stem activity challenged them to think about their relationship with their body in an uncommon and perspective-expanding manner. Moreover, upon reviewing transcribed arrangements of personal poetic discourse, women resoundingly noted that they were touched in some way or another by witnessing their experiences arranged as poems. Two of the women stated that they intended to use their poems as a tangible reminder of where they had come from and what they hoped for through their journey with AN, finding encouragement through the poetic expression of their embodied recovery stories.

### **The Body, Affect, and Sociocultural Context in AN**

**Recovering from AN: Seeking restoration of embodied experience.** Illustrated by way of thematic analysis, poetic discourse gathered through this study conveys women’s journey of recovery from AN as a process of restoration of embodied experience. Recovery here is used to describe the physical and psychological process of healing from AN, while restoration refers to the movement towards a unified embodied lived experience or body-self unity. Paralleling the deliberate choice of the use of the word ‘recovery,’ the term ‘restoration’

is likewise used with intentionality. Similarly alluding to clinical terms associated with AN (i.e., weight restoration), restoration here is used in a reformatory way, referring to the act of reestablishing holistic embodied experience.

Depicting this process, at worst of each woman's battle with AN, a pattern of body-for-other clearly emerged, with the object-body separated from the self. The body was entirely experienced as deplorable, devalued, and disgusting, symbolizing insufficiency and struggle. It was an antagonist to the self, an encasing enemy that was both foreign and tormenting. A sense of disenfranchisement, of the object-body belonging to and existing for the other, prevailed. Moreover, the self appeared ravenous, not for physical nourishment but for sustenance of intangible form; insatiable hunger bubbling up from a void in one's sense of being adequate. The 'body that is not mine' accompanied a self characterized by the desire to become smaller and to disappear.

As the recovery journey progressed, women's experiences revealed an unmistakable pattern of the 'self recovering the body.' Recovery, defined as both "the act or process of becoming healthy after an illness or injury" and "the return of something that has been lost, stolen" is polysemous in this context (Merriam-Webster, 2012). Women's accounts vividly illustrated how during recovery from AN the self gradually claimed ownership of the previously estranged or discarded object-body, as a first attempt to re-connect self and body. Moreover, although at this stage the body remained predominantly experienced as an object that the self possesses and inhabits, 'body-for-self' language (e.g., 'the body is mine') entered the dialogue. At the same time, the themes of the body as deplorable, devalued, and antagonistic receded from the discourse. The 'body that is mine' became associated primarily

with strength, power, and agency, although elements of tension and ambivalence in the relationship between self and body could still be detected as remnants of the previous struggles

Although potentially idyllic, a pattern of the self identifying and finding unity with the body emerged when women were invited to reflect on how they see their recovery journey in the future. Each woman was not only able to identify and conceive of this picture of holistic lived experience, but also to express striving for such an idea. To find full healing, the reclaimed body is accepted as an integral part of the self. When observed in contrast with alarming accounts of disgust and distain for the one's own body at the worst of the eating disorder, it is astounding that these women would ever desire to find unity with their previously scornful bodies. There is an undeniable shift not only in how the body is experienced, but also in how it is perceived by the self. The body becomes a symbol of victory, representing one's strength, resilience, and ability to overcome trials. The body becomes a subjective site of lived experience, enabling the self to feel *alive*. And the 'body that is me' becomes expansive and free in the world.

**Individual and systemic recovery.** With recovery from AN being a notoriously slippery, elusive beast characterized by high chronicity and relapse rates (Cater et al., 2004; Steinhausen, 2002), it is important to draw attention to this study's findings as they related to matters of recovery. All women that participated in the study met the DSM-5 criteria for what is considered as recovered from AN. Namely, each woman reported refraining from restricting energy intake, and maintained what would medically be deemed a 'healthy' body weight. Yet through the individual poetic discourse employed in this study, it became clear that some women continued to battle with their body-self relationship. This evokes the question of what it truly means to have 'recovered' from AN. Illustrating the complexities of recovery, one

women described having a “normal level of discontent with [her] body,” when discussing her relationship with her body prior to her eating disorder (Phoenix). A second woman echoed this sentiment when speaking of her perception of her current stage of recovery:

I’ll always be a 9.5 out of 10 in recovery, because maybe, like we could think about it theoretically, the normative discontent for women in their experience of their bodies in North America, and so I think we all need to recover. I think, as women in North America, we all need to recover. I would say that most people, their journey of recovery might be different, and maybe it’s not as severe, where they start, but that we need to have a total sociocultural revolution in the way that we view our bodies and ourselves as women. And I think that until I’m in perfect unity with myself, I think I’ll always be in recovery. (Anna)

What these two women described mirrors verbatim what Rodin and colleagues coined ‘a normative discontent,’ linking the experience of shame with women’s prevailing state of preoccupation with bodily physical appearance (Rodin, Silberstein & Striegel-Moore, 1984). The elusiveness of full recovery from AN is often attributed to individual factors or the nature of the disorder itself (Carter et al., 2004). Yet what these women identify as a baseline for female lived experience in Western society, a *normal* discontent with the body-self, presents a barrier to attainment of body-self unity. Women diagnosed with AN retain a hope that recovery to a certain normative baseline is indeed possible; however, this said baseline is rife with objectification and violations of body ownership that render wholly positive female embodied experience arguably out of reach. Recovery from AN, and ultimately recovery of the female embodied experience, thus extends deep into Western sociocultural’s fabric,

requiring reformation of the threads that contribute to objectification, censure, and bifurcation of the female body-self.

**AN in the context of female experience of embodiment.** Results of this study markedly parallel Piran's (2016) work on Experience of Embodiment (EE). As previously noted, Piran (2016) outlines that the construct of EE consists of five dimensions: (a) body connection and comfort vs. disrupted connection and discomfort; (b) agency and functionality vs. restricted agency and restraint; (c) experience and expression of desire vs. disrupted connection to desire; (d) attuned self-care vs. disrupted attunement, self-harm, and neglect; and (e) inhabiting the body as a subjective site vs. inhabiting the body as an objectified site. Each of these dimensions is described as ranging from positive to negative, with EE thus experienced along a continuum (Piran, 2016). Similarly, women included in this study described their embodied experience of AN and recovery in a manner indicative of a continuum, with experience of embodiment and affect unmistakably shifting from negative, associated with AN, to positive, associated with recovery and movement towards body-self unity. Negative embodiment themes including the body experienced as an object, restriction, and disconnection clearly parallel dimensions of inhabiting the body as an objectified site, restricted agency and restraint, and disrupted connection and discomfort. Likewise, positive embodiment themes including the body experienced as subjective, freedom, and connection parallel the dimensions of inhabiting the body as a subjective site, agency and functionality, and body connection and comfort. Moreover, the positive embodiment theme of the body as good, sufficient, valued fits within the EE dimension of attuned self-care, while the negative embodiment theme of the body as bad, insufficient, devalued fits within the EE dimension of disrupted attunement, self-harm, and neglect. In order for there to be care, there certainly has



to be value found in the object or subject receiving the care. There also are clear connections between the theme of danger or lack of safety and the EE dimensions of disrupted connection to desire, and disrupted attunement, self-harm, and neglect. Similarly, the theme of safety shares connections with the EE dimensions of experience and expression of desire, and attuned self-care. It is reasonable that when the body is experienced as a safe place, it also becomes safe to attune to and express one's needs and desires.

In light of the parallels between embodiment themes emerging from this study's poetic discourse and the dimensions of EE as identified by Piran (2016), it becomes apparent that women's experience of embodiment over the course of recovery from AN can be described as a shift from an overwhelmingly negative experience of embodiment to a positive experience of embodiment across numerous facets. Within the larger framework of the Developmental Theory of Embodiment (Piran & Teall, 2012), AN is clearly characterized by disembodied experience, extending beyond discontent with one's physical body and involving a disconnection from affective and subjective experience of one's body. It is also fitting to wonder if such disembodiment arises from complex interactions between the embodied self and the culture that the self exists within, as the Developmental Theory of Embodiment proposes (Piran & Teall, 2012). Speaking to this possibility, each woman participating in the study described experiences of the body-self as being situated in and influenced by sociocultural factors (i.e., comparisons made between the body-self and other women, desire to be a mother, normative female discontent with the body, etc.). However, the exact contributing sociocultural factors and interactions that such disembodied experience arose from remains undetermined. The Tripartite Adverse Social Experiences model does provide a window into possible factors, displaying that violations of body ownership, such as childhood and adult

sexual and physical abuse, as well as exposure to prejudicial treatment, including exposure to weightism and sexism, are associated with eating disorder development (Piran & Thompson, 2008). Markedly, the notion of violations to body ownership aligns strongly with the pattern of lacking body ownership associated with AN as seen in this study's data. Thus, it is likely that models including Piran and Thompson's (2008) could provide future insight into the process of how women with AN come to experience disembodiment.

### **Implications and Recommendations**

In this section I will first discuss the clinical and broader societal implications of this study's findings, organized within a framework of the embodied and affective themes identified, and associated recommendations for AN treatment and prevention measures. Next, I will outline directions for future research, as informed by this study and its outcomes.

**Clinical and sociocultural.** As a foundation for this study's clinical and societal implications is the shift from experiencing the body as an object vs. the body as subjective seen with AN recovery. Countering currents of objectification, emphasizing female subjective experience of the body is an apt starting point for seeking positive embodied experience. Encouraging girls and women to engage with their bodies subjectively, within intra- and interpersonal contexts alike, conveys that the female body does not solely exist for the other. It is essential for experiencing joy, pleasure, and closeness with others, and facilitates expression of the self, passions, desires, and needs. Drawing upon the influence of the family system to create a shift in female embodied experience, for example, parents might guide their daughter's attention to how strong her body feels when she is able to lift something heavy, or how her body feels when she is excited. Likewise, clinically, psychotherapists might guide clients to attend to internal sensations as an avenue of cultivating positive ways of being in one's body.

This may include inviting the client to notice body sensations that accompany emotional states, and recognizing sensations of discomfort and pleasure within the body.

Linked to emphasizing the subjective experience of the body, it is also crucial to address the underlying current of equating the female body with insufficiency within the Western cultural landscape. As portrayed vividly by this study's data, disembodied experience as consistent with AN cases is also dominated by perceiving the body as deplorable, insufficient, devalued. It is reasonable that the female body may become a site of manipulation, shame, and disgust in such cases when it is regularly objectified and devalued. Consequently, it is imperative to refuse to participate in systems and culturally imbedded patterns of devaluing the female body, and instead aim to foster appreciation for the female body regardless of external appearance. Moreover, communicating, whether implicitly or explicitly, messages that the female body is problematically provocative, indecent, or in need of external censorship contributes not only to the objectification of the female body, but also to the notion that the female body is inherently offensive. From a clinical standpoint, openly discussing clients' experiences of their bodies in a manner that is welcoming and free from judgment can provide space for the female body to be perceived as valuable.

From a place of recognizing the importance of the body in the lived experience of being with others and being in the world, it is also important to purposefully foster awareness of and appreciation for the facilitative role of the body. Connection with the body-self and all that the body facilitates connection with may be both healing for women battling AN, as well as preventative of eating disorder development by way of cultivating positive embodied experience. Although the body is the bridge between the self and the surrounding world, this relationship is often overlooked. From societal and clinical standpoints alike, emphasizing

engagement and connection with the body as a way of knowing and experiencing may contribute to positive ways of being in the body.

Subsequently, when the body is experienced as a subjective site of lived experience that is also valuable and connected to the self, the body is more likely to be experienced as a safe space to exist. In this way, safety within one's own body may be cultivated through emphasizing subjective experiencing of the body, connection with the body, and value of the body. As is the nature of any relationship, the depth of knowing and strength of connection with the object of relation directly impacts safety and security found in and through the relationship. In terms of societal and clinical implications, once again, aiming to create space for embodied experience that is both welcoming and free from judgment is foundational. Practically, parents, family members, and partners should exercise principles of consent and respect for body ownership with their children, significant others, and spouses. Clinicians may also help reestablish the body as a safe place by way of teaching clients relaxation and grounding techniques that utilize the body. Seeking to develop safety within one's own body might then be linked to emphasizing subjective connection with a body that is upheld as valuable, not because of how it appears but because it is an integral part of being a person in this world.

A fifth avenue through which positive embodied experience may be approached is that of freedom. As identified within this study's results, embodied freedom is multi-faceted. For women in this study, freedom encompasses movement, ability, strength, self-expression, and sovereignty. Such freedom parallels the EE dimension of agency and functionality vs. restricted agency and restraint identified by Piran (2016), which is described as "acting in and on the world with agency both physically and through the power of voice" (p. 49). Voice here,

referring to the ability to express oneself or express views that one is passionate about, mirrors the subtheme of freedom through expression, as identified in this study's poetic discourse. Just as Piran (2016) notes, women who maintain or recapture physical agency and voice report more positive embodied experiences, this study's findings display that regaining freedom of movement and expression are associated with recovery from AN. As restriction, both in physical and vocal dimensions, are associated with AN and negative embodied experience in the general female population (Piran, 2016), prevention of AN development and promotion of well-being should emphasize the importance of freedom and agency. Namely, challenging the normative decline seen with adolescence of females participating in physically exuberate activities such as sports, may represent a means of promoting freedom through experiencing physical ability, strength, and movement. Likewise, encouraging girls and women to engage in outlets of self-expression and passion, rather than contributing to culturally embedded acts of female silencing, represents a means of promoting positive embodied experience and consequent possible prevention of AN development.

On the topic of freedom vs. restriction as pertaining to positive embodied experience and AN prevention and treatment measures, results of this study in conjunction with the growing body of literature regarding positive vs. negative embodied experience implore critical examination of mainstream approaches to eating disorder treatment. A most glaring contradiction to this pattern of freedom is the restriction that commonly accompanies AN treatment. Namely, mainstream treatment approaches such as the Maudsley Approach's refeeding, which guides parents to take control of and supervise their child's eating routine during weight restoration (Kass et al., 2013), to extreme interventions like nasogastric tube feeding are characterized by usurping agency from the client/patient. Under British

Columbia's Mental Health Act (1996), a person may be detained, with rights suspended, by a medical facility if deemed by medical physicians as being too ill to be capable of validly requesting for or consenting to treatment. In extreme cases of AN, the individual may be "certified," detained, and force-fed via intravenous or tubal methods. Such cases are fraught with ethical tension, particularly involving the principles of autonomy and duty to protect (Canadian Psychological Association, 2000). It goes without saying that the most compelling argument for involuntary treatment of AN through methods such as forced feeding is to prevent mortality (Matusek & Wright, 2010). Alternatively, it is also argued that while involuntary treatment prolongs life, usurping the individual's autonomy may be at the least, counterproductive, and at the worst, devastating to one's chance of recovery (Matusek & Wright, 2010). While health professionals are bound to uphold principles of beneficence and protection, this study's findings in conjunction with existing literature on experience of embodiment implore the medical and mental health communities to reevaluate approaches to AN treatment from an embodiment-informed perspective.

**Future research.** The findings of this study contribute to literature standing testament to the need for continued research investigating issues of women's health, such as AN development and etiology, as located at the intersection of body, self, and culture (Beyer, Launeanu, & Chan, 2015; Beyer, Launeanu, Chan, Kwee & McBride, 2016). Namely, expanding research of sociocultural and developmental factors that contribute to positive and negative embodied experience represents an invaluable contribution to understanding female health and well-being. This area of research has recently been spearheaded by Piran (2016), investigating embodied experience in girls and women in general, however, it would be valuable to further extend this area of research focusing on females with a history of AN.

Focusing on factors contributing to the development of disembodied experience vs. positive embodied experience in AN would further elucidate why certain individuals develop disordered eating while others do not, ultimately enhancing treatment approaches and informing preventative measures.

Moreover, research investigating the sequence of themes emerging from this study would be a valuable contribution to AN prevention. Namely, examining the occurrence of experiencing the body as an object and experiencing the body as deplorable and invaluable within the context of AN would help further explain female disembodied experience as associated with eating disorder development. Although these themes emerge as dominating female disembodied experience, it remains unclear whether body objectification and devaluation emerge as parallel or sequential processes.

Additionally, due to violations of body ownership having been identified as contributing to the development of eating disorders (Piran & Thompson, 2008), exploring the relationship between such violations and the emergence of experiencing a lack of body ownership, as seen in AN cases, represents a valuable future research direction. Furthermore, it would be useful to investigate what kinds of ‘violations’ contribute to a lack of body ownership. As previously mentioned, The Tripartite Adverse Social Experiences model identifies violations as childhood and adult sexual and physical abuse (Piran & Thompson, 2008). However, it is likely that less blatant violations (e.g., certain medical procedures, culturally embedded implicit control of female sexuality, etc.) might also be experienced as violations of body ownership, ultimately contributing to female disembodied experience and development of AN.

Lastly, out of critical evaluation of refeeding and involuntary treatment approaches to AN, research investigating embodiment-informed collaborative alternatives to weight

restoration are greatly needed. As elucidated by embodiment-informed research of disordered eating such as this study, negative or disembodied experience pervades cases of AN. Current approaches to AN treatment pose the risk of widening the chasm between the body and the self, and proliferating violations of body ownership rather than seeking to honour the embodied lived experience. Investigating outcomes of alternative treatment options that emphasize body-self connection in addition to freedom through agency and self-expression represent hopeful and necessary research directions.

### **Conclusion**

Women's poetic discourse illustrating their process of recovery from AN displayed a clear shift from disembodied experience to embodied experience, and the movement from negative embodied experience, characterized by experiencing the body as deplorable, disconnected, and restricting to positive embodied experience, characterized by experiencing the body as valuable, connected, capable, and freeing. Affective experience emerged as deeply intertwined with embodied experience, as negative affect or absence of affect was gradually replaced with positive affect, paralleling the shift from negative to positive embodied experience. In sum, body-centered poetic discourse displays recovery from AN as restoration of embodied lived experience.

This study's findings in conjunction with the broader area of literature on embodied female experience point to some important challenges for the way we approach the female body-self as parents, siblings, partners, researchers, and clinicians. As articulated by Fredrickson and Roberts (1997), "when objectified, women are treated *as bodies* – and in particular, as bodies that exist for the use and pleasure of others" (p. 176). Through focusing on and evaluating the female body from an external standpoint, the female body-self then



comes to exist primarily as an object-body-for-other. The female lived experience becomes a fragmented and disembodied existence. Consequently, we are further confronted with the dilemma of how current conceptualization and treatment of AN proliferates disembodiment through emphasis placed on external aspects of body shape, weight, and image, and interventions involving control of the individual's body usurp agency through imposed limitations in physical activity and forced feeding for the purpose of weight restoration. This study's findings support the need for reframing AN as at the intersection of affective and embodied experience and sociocultural factors as opposed to the dominant yet inadequate emphasis on food and the object body, while also calling for reformation of AN treatment and prevention. It is imperative to acknowledge and honour the role of the body in women's recovery journey from AN, turning to treatment approaches that emphasize body-self connection, and embodied freedom and agency. Moreover, attention should be turned to prevention measures that are characterized by replacing objectification with valuing of the female body-self, and promoting subjective embodied experience.

For women to reclaim and recover their bodies as belonging to their selves is a great step in the right direction, but there is also a need to go beyond ownership and towards unification of the feminine body-self. It is important to note that the body, with recovery, does not become all-consuming of self or self-identity, nor does it retreat into the shadow of the self. Rather, body-self unity is paradoxically characterized by two parts coexisting as one. To seek such unity is to honour of the connection between the body and the self. Moreover, it involves nurturing the sense of value for the female body, teaching women that we have the right to take up space, providing a safe place for women to reconnect subjectively with their bodies, and

fostering connection through encouraging the female body-self to be expansive, powerful, and free.

Through the medium of poetic discourse, this research illustrates each woman's journey of recovery from AN as a story of restoration: reclamation of the lost or stolen body-self, and revelation of goodness and value of the body-subject. We witness a story of the female 'body that is not mine,' to the 'body that is mine,' to the 'body that is me.' A story of the female embodied self as bifurcated, recovered, and then unified. It is my hope that this story reverberates, propelling movement to seek restoration of the female body-self, once consumed with the act of disappearing, now bursting forth, alive and electric in the world.

### References

- Abraham, K. (1920). Manifestation of the female castration complex. In E. Jones, D. Bryan, & A. Strachey (Eds.). *Selected Papers on Psychoanalysis* (pp. 338-369). E. Jones, D. Bryan, and A. Strachey. London: Hogarth Press.
- Allan, H. T. (2005). Gender and embodiment in nursing: The role of the female chaperone in the infertility clinic. *Nursing Inquiry*, 12, 175-183.
- American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5<sup>th</sup> ed). Washington, DC: American Psychiatric Association.
- Barsalou, L. W. (1999). Perceptual symbol system. *Behavioral and Brain Sciences*, 22, 577-609.
- Beadle, J. N., Paradiso, S., Salerno, A., & McCormick, L. M. (2013). Alexithymia, emotional empathy, and self-regulation in anorexia nervosa. *Annals of Clinical Psychiatry*, 25(2), 107-120.
- Beyer, C., Launeanu, M., & Chan, E. (2015). *Seeking the body electric: Re-conceptualizing anorexia through embodiment and feminist lenses*. Presentation, CPSY Research Colloquium, Trinity Western University.
- Beyer, C., Launeanu, M., Chan, E., Kwee, J., & McBride, H. (2016). *Seeking the body electric: Understanding eating disorders through embodiment and feminist-existential lenses*. Presentation, CPA Convention.
- Bracegirdle, C. E. (2012). Discovering embodiment: A poetic method. *Body, Movement and Dance in Psychotherapy: An International Journal for Theory, Research and Practice*, 7, 201-214. doi:10.1080/174332979.2011.645879.

- Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper. (Eds). *APA handbook of research methods in psychology: Vol. 2. Research designs*. Washington, DC: American Psychological Association.
- British Columbia's Mental Health Act (1996). Retrieved from the British Columbia Laws website: [http://www.bclaws.ca/civix/document/id/complete/statreg/96288\\_01](http://www.bclaws.ca/civix/document/id/complete/statreg/96288_01)
- Bruch, H. (1962). Perceptual and conceptual disturbances in anorexia nervosa. *Psychosomatic Medicine, 24*, 187-194.
- Bruch, H. (1973). *Eating disorders: Obesity, anorexia nervosa, and the person within*. USA: Basic Books.
- Bruch, H. (1982). Psychotherapy in anorexia nervosa. *International Journal of Eating Disorders, 4*, 3-14.
- Canadian Mental Health Association. (2015). *Eating disorders*. Retrieved from [http://www.cmha.ca/mental\\_health/facts-about-eating-disorders/#.VYeOcuDo3c](http://www.cmha.ca/mental_health/facts-about-eating-disorders/#.VYeOcuDo3c)
- Canadian Psychological Association. (2000). Canadian code of ethics for psychologists (3<sup>rd</sup> ed.). Retrieved January 11, 2016, from [http://www.cpa.ca/docs/File/Ethics/cpa\\_code\\_2000\\_eng\\_jp\\_jan2014.pdf](http://www.cpa.ca/docs/File/Ethics/cpa_code_2000_eng_jp_jan2014.pdf)
- Caparrotta, L., & Ghaffari, K. (2006). A historical overview of the psychodynamic contributions to the understanding of eating disorders. *Psychoanalytic Psychotherapy, 20*(3), 175-196. doi:10.1080/02668730600868807
- Carter, J. C., Blackmore, E., Sutandar-Pinnock, K., & Woodside, D. B. (2004). Replase in anorexia nervosa: A survival analysis. *Psychological Medicine, 34*, 671-679. doi:10.1017/S0033291703001168

Chadwick, R. (2016). Embodied methodologies: Challenges, reflections and strategies.

*Qualitative Research*, 21, 1-21. doi:10.1177/1468794116656035

Chen, M., & Bargh, J. A. (1999). Consequences of automatic evaluation: Immediate behavioral predispositions to approach or avoid the stimulus. *Personality and Social Psychology Bulletin*, 25, 215-224. doi:10.1177/0146167299025002007

*Bulletin*, 25, 215-224. doi:10.1177/0146167299025002007

Clark, A. (1999). An embodied cognitive science? *Trends in Cognitive Sciences*, 3, 345-351. doi:10.1016/S1364-6613(99)01361-3

Crumley, R. & Reid, A. G. (2009). *Marion Woodman: Dancing in the flames*. Canada: Capri Films.

Damasio, A. (1994). *Descartes' error: Emotion reason and the human brain*. New York: Avon Books.

Damasio, A. (1999). *The feeling of what happens*. New York: Harcourt Brace.

Devault, M. L. (1990). Talking and listening from women's standpoint: Feminist strategies for interviewing and analysis. *Social Problems*, 37, 96-116.

Dionne, M. (2002). The variability of body image: The influence of body-composition information and emotional reactivity on young women's body dissatisfaction (Doctoral dissertation). York University, Toronto.

Dolhanty, J., & Greenberg, L. S. (2007). Emotion-focused therapy in the treatment of eating disorders. *European Psychotherapy*, 7, 97-116.

Dolhanty, J., & Greenberg, L. S. (2009). Emotion-focused therapy in a case of anorexia nervosa. *Clinical Psychology and Psychotherapy*, 16, 366-382. doi:10.1002/cpp.624

- Fredrickson, B. L., & Roberts, T. (1997). Objectification theory: Toward understanding women's lived experiences and mental health risks. *Psychology Of Women Quarterly*, 21(2), 173-206. doi:10.1111/j.1471-6402.1997.tb00108.x
- Freud, S. (1895). Draft G. *SE, 1*, 278.
- Fox, J. R. E. (2009). A qualitative exploration of the perception of emotions in anorexia nervosa: A basic emotion and developmental perspective. *Journal of Clinical Psychology and Psychotherapy*, 16, 276-302.
- Galsworthy-Francis, L., & Allan, S. (2014). Cognitive behavioural therapy for anorexia nervosa: A systematic review. *Clinical Psychology Review*, 34, 54-72.  
doi:10.1016/j.cpr.2013.11.001
- Greenber, L. S. (2010). Emotion-focused therapy: A clinical synthesis. *Focus: The Journal of Lifelong Learning in Psychiatry*, 8, 32-42.
- Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.
- Goldman, R. N., & Greenberg, L. S. (2015). Fundamentals of emotion-focused therapy. In R. N. Goldman, & L. S. Greenberg, *Case formulation in emotion-focused therapy: Co-creating clinical maps for change* (pp. 21-42). Washington, DC, US: American Psychological Association. doi:10.1037/14523-002
- Gull, W. W. (1874). Anorexia nervosa. *Transactions of the Clinical Society of London*, 7, 22-28.
- Hay, P. (2013). A systematic review of evidence for psychological treatments in eating disorders: 2005–2012. *International Journal Of Eating Disorders*, 46(5), 462-469.

- Heidegger, M. (1949). *Existence and being*. (D. Scott, R. F. C. Hull, & A. Crick, Trans.). Chicago: Henry Regenry Company.
- Husserl, E. (1998). *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy. Vol. 1, General introduction to a pure phenomenology*. (F. Kersten, Trans.). Dordrecht: Kluwer, Academic Publishers. (Original work published 1976)
- James, W. (1884). What is an emotion? *Mind*, 9, 188-205.
- James, W. (1994). The physical basis of emotion. *Psychological Review*, 2, 205-210.
- Kass, A. E., Kolko, R. P., & Wilfley, D. E. (2013). Psychological treatments for eating disorders. *Current Opinion Psychiatry*, 6, 549-555.  
doi:10.1097/YCO.0b013e328365a30a
- Katzman, M. A., & Lee, S. (1996). Beyond body image: The integration of feminist and transcultural theories in the understanding of self starvation. *Journal of Eating Disorders*, 22, 385-394.
- Kyriacou, O., Easter, A., & Tchanturia, K. (2009). Comparing views of patients, parents and clinicians on emotions in anorexia: A qualitative study. *Journal of Health Psychology* 14, 843-854.
- Lasègue, C. (1873). On hysterical anorexia. *Medical Times Gazene*, 2, 265-266.
- Lester, R. J. (1997). The (dis)embodied self in anorexia nervosa. *Social Science and Medicine*, 44, 479-489.
- Lipsman, N, Woodside, D. B., & Lozano, A. M. (2014). Trends in anorexia nervosa research: An analysis of the top 100 most cited works. *European Eating Disorders Review*, 22, 9-14.

- Malson, H. (1999). Womæn under erasure: Anorexic bodies in postmodern context. *Journal of Community and Applied Social Psychology, 9*, 137-153.
- Malson, H., & Swann, C. (1999). Prepared for consumption: (Dis)orders of eating and embodiment. *Journal of Community & Applied Social Psychology, 9*, 397-405.
- Matusek, J. A., & Write, M. (2010). Ethical dilemmas in treating clients with eating disorders: A review and applications of an integrative ethical decision-making model. *European Eating Disorders Review, 18*, 434-452.
- Mazis, G. (1993). *Emotion and embodiment*. New York: Peter Lang.
- Mental Health Act. (1996). Retrieved from the Province of British Columbia website, [http://www.bclaws.ca/EPLibraries/bclaws\\_new/document/ID/freeside/00\\_96288\\_01](http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96288_01)
- Merleau-Ponty, M. (2012). *Phenomenology of Perception*. (D. L. Landes, Trans.). New York, NY: Routledge. (Original work published 1945).
- Merriam-Webster. (2012) Recovery, In *Merriam-Webster.com*. Retrieved July 15, 2016, from <http://www.merriam-webster.com/dictionary/recovery>
- Mertens, D. M. (2007). Transformative paradigm: Mixed methods and social justice. *Journal of Mixed Methods Research, 3*, 212-225. doi:10.1177/1558689807302811
- Mertens, D. M. (2015). *Research and evaluation in education and psychology* (4<sup>th</sup> ed.). Thousand Oaks, CA: SAGE Publications, Inc.
- Mertens, D. M., Holms, H., & Harris, R. (2009). Transformative research and ethics. In D. M. Mertens & P. E. Ginsberg (Eds.), *Handbook of social research ethics* (pp. 85-102). Thousand Oaks, CA: Sage.
- Miller, M. L. (1991). Understanding the eating-disordered patient: Engaging the concrete. *Bulletin Of The Menninger Clinic, 55*(1), 85-95.



- Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*, 250-260.  
doi:10.1037/00220167.52.2.250
- Niedenthal, P. M. (2007). Embodying emotion. *Science, 316*, 1002-1005.  
doi:10.1126/science.1136930
- Niedenthal, P. M., Barsalou, L., Weinkielman, P., Krauth-Gruber, S., & Ric, F. (2005). Embodiment in attitudes, social perception, and emotion. *Personality and Social Psychology Review, 9*, 184-211.
- Neumann, R., & Strack, F. (2000). "Mood contagion": The automatic transfer of mood between persons. *Journal of Personality and Social Psychology, 79*, 211-223.  
doi:10.1037/0022-3514.79.2.211
- Oldershaw, A., Hambrook, D., Stahl, D., Tchanturia, K., Treasure, J., & Schmidt, U. (2011). The socio-emotional processing stream in Anorexia Nervosa. *Neuroscience and Biobehavioural Reviews, 35*(3), 970-988.
- Oosterwijk, S., Winkielman, P., Pecher, D., Zeelenberg, R., Rotteveel, M., & Fischer, A. H. (2012). Mental states inside out: Processing sentences that differ in internal and external focus produces switching costs. *Memory and Cognition, 40*, 93-100.  
doi:10.3758/x13421-011-0134-8
- Peltola, H. R., & Saresma, T. (2014). Spatial and bodily metaphors in narrating the experience of listening to sad music. *Musicae Scientiae, 18*, 292-306.
- Piran, N. (2016). Embodied possibilities and disruptions: The emergence of the experience of embodiment construct from qualitative studies with girls and women. *Body Image, 18*, 43-60. doi:10.1016/j.bodyim.2016.04.007

- Piran, N., Carter, W., Thompson, S., & Pajouhandeh, P. (2002). Powerful girls: A contradiction in terms? Young women speak about the experience of growing up in a girls' body. In S. Abbey (Ed.), *Ways of knowing in and through the body: Diverse perspectives on embodiment* (pp. 206-210). Welland, ON: Soleil Publishing.
- Piran, N., & Teall, T. (2012). The developmental theory of embodiment. In G. McVey, M. P. Levine, N. Piran, & H. B. Ferguson. (Eds.), *Preventing eating-related and weight-related disorders: Collaborative research, advocacy, and policy change* (pp. 169-198). Waterloo, ON: Wilfred Laurier University Press.
- Piran, N., & Thompson, S. (2008). A study of the adverse social experiences model to the development of eating disorders. *International Journal Of Health Promotion & Education, 46*, 65-71.
- Racine, S. E., & Wildes, J. E. (2013). Emotion dysregulation and symptoms of anorexia nervosa: The unique roles of lack of emotional awareness and impulse control difficulties when upset. *International Journal Of Eating Disorders, 46*(7), 713-720.  
doi:10.1002/eat.22145
- Robinson, A. L., Dolhanty, J., & Greenberg, L. (2015). Emotion-focused family therapy for eating disorders in children and adolescents. *Clinical Psychology & Psychotherapy, 22*, 75-82. doi:10.1002/cpp.1861
- Rodin, J., Silberstein, L., & Striegel-Moore, R. (1984). Women and weight: A normative discontent. *Nebraska Symposium On Motivation, 32*, 267-307.
- Rommel, D., Nandrino, J., Antoine, P., & Dodin, V. (2013). Emotional differentiation and parental bonding in inpatients suffering from eating disorders. *British Journal of Clinical Psychology, 52*, 215-229.

- Sáenz-Herrero, M., & Díez-Alegría, C. (2015). Gender and Corporality, Corporeality, and Body Image. In M. Sáenz-Herrero, *Psychopathology in women: Incorporating gender perspective into descriptive psychopathology* (1<sup>st</sup> Ed., pp. 113-142). Switzerland: Springer International Publishing. doi:10.1007/978-3-319-05870-2\_6
- Sartre, J. P. (1943). *Being and Nothingness*. New York, NY: Washington Square Press.
- Schilder, P. (1964). *The image and appearance of the human body*. New York, NY: John Wiley and Sons.
- Schmidt, U., Oldershaw, A., Jichi, F., Sternheim, L., Startup, H., McIntosh, V.,... Treasure, J. (2012). Out-patient psychological therapies for adults with anorexia nervosa: Randomised controlled trial. *The British Journal of Psychiatry*, 5, 392-399. doi:10.1192/bjp.bp.112.112078.
- Skårderud, F. (2007a). Eating one's words, part I: 'Concretised metaphors' and reflective function in anorexia nervosa – An interview study. *European Eating Disorders Review*, 15(3), 163-174. doi:10.1002/erv.777
- Skårderud, F. (2007b). Eating one's words, Part II: The embodied mind and reflective function in anorexia nervosa – Theory. *European Eating Disorders Review*, 15(4), 243-252. doi:10.1002/erv.778
- Spackman, M. P., & Miller, D. (2008). Embodying emotions: What emotion theorists can learn from simulations of emotions. *Minds & Machines*, 18, 357-372. doi:10.1007/s11023-008-9105-7
- Stanghellini, G., Castellini, G., Brogna, P., Faravelli, C., & Ricca, V. (2012). Identity and eating disorders (IDEA): A Questionnaire Evaluating Identity and embodiment in eating disorder patients. *Psychopathology*, 45, 147-158. doi:10.1159/000330258.

- Steiger, H. (1995). Review. *Transcultural Psychiatric Research Review*, 64-69.
- Steinhausen, H. C. (2002). The outcome of anorexia nervosa in the 20<sup>th</sup> century. *American Journal of Psychiatry*, 159, 1284-1293.
- Sutton, B. (2011). Playful cards, serious talk: A qualitative research technique to elicit women's embodied experiences. *Qualitative Research*, 11, 177-196.
- Taylor, G. J., Bagby, R. M., & Parker, J. D. A. (1991). The Alexithymia construct: A potential paradigm for psychosomatic medicine. *Psychosomatics*, 32, 153-164.
- Thompson, J. K. (1990). Body image disturbance: Assessment and treatment. Psychology practitioner guidebooks. *Elmsford NY: Pergamon Press*.
- Underwood, M. (2013). Body as choice or body as compulsion: An experiential perspective on body-self relations and the boundary between normal and pathological. *Health Sociology Review*, 22, 377-388.
- Varela, F. J. (1996). Neurophenomenology: A methodological remedy for the hard problem. *Journal of Consciousness Studies*, 4, 330-349
- Whitman, W. (2004). *The Complete Poems*. London, England: Penguin Books, Ltd. (Original work published 1975).
- Williams, M. S., Thomsen, S. R., & McCoy, J. K. (2003). Looking for an accurate mirror: A model for the relationship between media use and anorexia. *Eating Behaviors*, 4, 127-134. doi:10.1016/S1471-0153(03)00015-1
- Wilson, M. (2002). Six views of embodied cognition. *Psychonomic Bulletin and Review*, 9, 625-636. doi:1-0.3758/BF03196322
- Winkielman, P., Niedenthal, P., & Oberman, L. (2008). The embodied emotional mind. In G. R. Semin & E. R. Smith (Eds.), *Embodied grounding: Social, cognitive, affective, and*

*neuroscientific approaches* (pp. 263-288). New York, NY: Cambridge University Press. doi:10.1017/CB09780511805837.012

Winkielman, P., Niedenthal, P., Wielgosz, J., Eelen, J., & Kavanagh, L. C. (2015).

Embodiment of cognition and emotion. In M. Mikulincer, P. R. Shaver, E. Borgida, J. A. Bargh, M. Mikulincer, P. R. Shaver, Borgida, E., & J. A. Bargh (Eds.), *APA handbook of personality and social psychology, Volume 1: Attitudes and social cognition* (pp. 151-175). Washington, DC: American Psychological Association.

Woodman, M. (1980). *The owl was a baker's daughter*. Toronto, Canada: *Inner City Books*.

**APPENDIX A: RECRUITMENT POSTER**

HAVE YOU BEEN  
STRUGGLING WITH  
ANOREXIA?



If you've been diagnosed with anorexia (in the past or currently), we are seeking women 19 years and older to participate in a research study.



IF YOU WOULD LIKE TO HEAR MORE:

Please contact Chelsea Beyer

**APPENDIX B: SEMI-STRUCTURE PHONE INTERVIEW SCRIPT**

Hello, my name is Chelsea Beyer and I am a student at Trinity Western University, in the MA Counselling Psychology program. Thank you for expressing interest in participating in this research study and taking the time to contact me. This study is exploring women's experiences of their bodies and emotions throughout recovery from anorexia. As each person's journey with anorexia is very personal in nature, I wanted to take the time to express to you that participation in this study will require open dialogue about your own experience. We will focus on your personal experience with anorexia symptoms, as well as your personal emotional experience and then way you perceive and relate to your body. Along with the completion of two questionnaires, participation in the study involves two interviews, approximately 60 and 90 minutes in length. I also would like for you to know that your insight and experiences shared will be safeguarded, that information shared will remain confidential, and that you will be invited to participate in interpreting the information that you provide. You are the expert in your personal journey, and I wish to honour your story and the stories of other women contributing to this research. Do you feel that this research is something that you are interested in and comfortable with?

*(If interviewee answers "yes" then proceed with interview. If interviewee answers "no" then conclude interview, thank individual for their time, and offer resource list.)*

In order to assess whether you may be a good fit for this particular study, I have a few questions to ask you. All information that you share with me will remain confidential. Some of the following questions involve personal, potentially uncomfortable topics. If you are unsure about how to answer one of the questions, or if you do not feel comfortable answering a question, let me know. I can help clarify the question, or we can move onto the next one if you so choose. Do you agree to proceeding with the questions?

*(If interviewee answers "yes", continue with the following questions)*

1. Do you feel comfortable communicating (both written and orally) in English?
2. Do you identify yourself as female?
3. What is your birth date?
4. Have you been diagnosed, in the past (5 years) or currently, with anorexia? If so, by whom? And when?
5. Have you been diagnosed, in the past or currently, with any other psychological illnesses? If so, by whom? And when?
6. Are you currently receiving treatment for anorexia or any other psychological concern or illness? If so, what type of treatment? And for how long (less than 6 months, 6 months to 2 years, greater than 2 years or no longer requiring treatment)?

7. On a scale from 1 to 10 (1 being the very beginning stages of recovery and 10 being complete recovery/remission), where do you currently perceive yourself being in your recovery from anorexia?
8. Have you ever been hospitalized for anorexia or any other psychological illness? If so, when?

The next set of questions focus specifically on eating behaviours and attitudes:

For the next seven questions, consider the past 28 days. Of the past 28 days, please note approximately how many days (no days, 1-5 days, 6-12 days, 13-15 days, 16-22 days, 23-27 days, everyday) you find each item below being applicable:

- i. How many days have you been deliberately trying to limit the amount of food you eat to influence your shape or weight?  
(No days, 1-5 days, 6-12 days, 13-15 days, 16-22 days, 23-27 days, everyday)
- ii. How many days has thinking about food, eating, or calories made it very difficult to concentrate on things you are interested in (e.g., working, following a conversation, reading)?  
(No days, 1-5 days, 6-12 days, 13-15 days, 16-22 days, 23-27 days, everyday)
- iii. How many days has thinking about shape or weight made it very difficult to concentrate on things you are interested in (e.g., working, following a conversation, or reading)?  
(No days, 1-5 days, 6-12 days, 13-15 days, 16-22 days, 23-27 days, everyday)
- iv. Have you had a definite fear that you might gain weight?  
(No days, 1-5 days, 6-12 days, 13-15 days, 16-22 days, 23-27 days, everyday)
- v. Over the past 28 days, how many times have you eaten what other people would regard as an unusually large amount of food (given the circumstances)?
- vi. Over the past 28 days, how many times have you made yourself sick (vomit), taken laxatives, or exercised in a “driven” or “compulsive” way as a means of controlling your weight, shape, or amount of fat?
- vii. Do/did these episodes of eating and/or compensatory behaviours (vomiting, laxative use, exercise) occur during a period of being “under weight,” as defined by a mental health or medical professional?

The remaining questions focus more generally on mental health:

9. Have you ever seriously thought about harming yourself or attempted to take your own life? If so, when?



10. On a scale of 0 to 10 (0 being 'not at all' and 10 being 'all the time'), how often do you think about your own death or dying?
11. Have you, in the past or currently, used alcohol or any illicit substances? If so, when? Which substance? And how often?
12. Has there ever been a time, in the past or currently, not being under the influence of alcohol or drugs, where you saw or heard things that you or others around you believed were not really there? If so, when?
13. Has there ever been a time, not being under the influence of alcohol or drugs, when prolonged periods of time have passed without you having any memory of them? If so, on a scale of 0 to 10 (0 being never, 10 being always) how often does this happen?
14. Has there ever been a time, not being under the influence of alcohol or drugs, when you have felt as though you are standing next to yourself or watching yourself as if you were looking at another person? If so, on a scale of 0 to 10 (0 being never, 10 being always) how often does this happen?
15. Has there ever been a time, not being under the influence of alcohol or drugs, where you noticed or found evidence of you having done something that you could not remember doing? If so, on a scale of 0 to 10 (0 being never, 10 being always) how often does this happen?

That marks the end of the set of questions that I have for you. Do you have any questions or concerns of your own?

*(Based on inclusion/exclusion criteria and the responses provided throughout the interview, the interviewee will be invited to participate in the study or informed that they are not the right fit for this particular study.)*

**APPEDIX C: DEBRIEFING AND RESOURCE LIST**

Thank you sincerely for your time and willingness to dialogue with the researcher. Given the sensitive nature of this research study's topic, there is potential for research-related questions and dialogue to evoke psychological and/or emotional discomfort or distress. If you have any questions or concerns, or if you feel distressed in any way, please do not hesitate to let the researcher know. The researcher is available to address any questions, concerns, or distress associated with this research study and its topic in person, by email or by phone. If you are interested in the results of the research study, you are welcome to request to be contacted by the researcher upon study completion.

Additionally, a list of resources has been compiled for your reference in case of psychological and/or emotional distress. You are also encouraged to speak with your individual therapist about any topics regarding anorexia, emotional experience, and bodily experience raised throughout research participation, if applicable.

**Lower Mainland**Fraser River Counselling

604-513-2113

Trinity Western University, main campus, 7600 Glover Road, Langley

Nicomekl Elementary School, 20050 53<sup>rd</sup> Ave., Langley

Sweeney Neighborhood Centre, Abbotsford

Langley Mental Health Centre

604-514-7940

305-20300 Fraser Highway, Langley

Fraser Health Crisis Line

604-951-8855 or 1-877-820-7444

**APPENDIX D: INFORMED CONSENT FORM****Consent to Participate in the Research Study**

**Title of Project:** Embodied and Emotional Experience in Anorexia

**Principal Investigator:** This study is being conducted by Chelsea Beyer under the supervision of Mihaela Launeanu, Ph.D., R.C.C.

**Purpose of the Study:** This study aims to explore women's embodied and emotional experience throughout treatment and recovery from anorexia.

**Procedures**

If you agree to participate in this study, after you have read, understood, and signed this informed consent form, you will be asked to take part in two interviews. These interviews will be approximately 60 and 90 minutes in length, respectively, and scheduled at a time and place decided between yourself and the researcher. Interviews may be held either at Fraser River Counselling or at your personal place of therapy, as applicable. Both interviews will be audio and video recorded so that the researcher may transcribe the dialogue that takes place. During the first interview, you will be presented with a selection of open-ended statements prompting dialogue about your experience with your body and anorexia. You will be free to choose which open-ended statements you would like to respond to, and in which order. A second interview will be then arranged, approximately one week following the first interview. At this time the researcher will share the transcribed arrangement of your responses from the first interview and invite your feedback.

**Potential Risks of Research Participation**

Each person's journey with anorexia is very personal in nature and participation in this study requires reflection on and open dialogue about one's own experiences. For these reasons, participation in this study may involve discussing or answering questions on topics that are uncomfortable or distressing. If you choose to participate in the study, you may answer only to the extent that you feel comfortable or decline to answer questions that you find distressful. You may also take a break from or discontinue the interview process if you become uncomfortable or distressed. At the conclusion of participation, each individual will also be debriefed and offered a list of resources.

**Potential Benefits of Research Participation**

Insight and experiences shared by you will be safeguarded, information shared will be handled with great care, and you will be invited to aid in interpreting the information you provide during the two interviews. You are seen as the expert in your own personal journey, and this research seeks to honour your story. Taking part in this research may benefit you through the opportunity to reflect on and share your experience with anorexia, which may contribute to newfound insight and emotional healing. Moreover, through sharing personal experience you are contributing to an enhanced understanding of anorexia etiology, informing future research, treatment, and prevention.

### Statement of Confidentiality

All information shared within this research setting is entirely confidential. All information gathered will be cleared of your name or any other identifying information, and a pseudonym will be used in place. All information, including interview videos, will be kept as password protected electronic files stored on a password protected computer to which only the researchers who are directly involved in the study will have access to. Data will be destroyed by the research team following completion of the study. Confidentiality of information shared through participation in this research will be maintained under every circumstance, with exception only to the following situations:

- When there is a clear risk of substantial harm to yourself or threat of harm towards another person.
- When there is reason to believe that a child or a vulnerable adult is at risk of harm, including physical, sexual, or emotional abuse or exploitation.
- When a court-of-law requires the release of personal information.

### Voluntary Participation and the Right to Withdraw

Participation in this study is completely voluntary. You have the right to refuse to participate. You also have the right to withdraw from the study at any time without penalty, and if you so choose, to ask for withdrawal of any or all of the data you have provided from inclusion in the research. If you so choose, upon withdrawal from study participation, such data provided will be destroyed. You may direct such requests to any member of the research team.

If there are any questions or concerns regarding information covered on this form, or participation in this study in general, please do not hesitate to ask the researcher, Chelsea Beyer, or her supervisor, Mihaela Launeanu, for clarification.

If you have any concerns about your treatment or rights as a research participant, you may contact Ms. Sue Funk in the Office of Research, Trinity Western University at 604-513-2142 or sue.funk@twu.ca.

**The following signature confirms that the below named individual has read and understands the rights involved in the research participation process, and hereby agrees to participate in this research study.**

Date: \_\_\_\_\_

Participant Name \_\_\_\_\_ Participant

Signature \_\_\_\_\_

Witness Name \_\_\_\_\_ Witness Signature

\_\_\_\_\_

**APPENDIX E: DEMOGRAPHICS INFORMATION FORM**

Participant Name: \_\_\_\_\_

Please check all that apply to you, and fill in the blanks as indicated below.

## Ethnicity

- Caucasian
- African Canadian/American
- First Nations, Inuit, or Métis
- East Asian
- South Asian
- Hispanic or Latino
- Other \_\_\_\_\_

## Household Income

- Less than \$20, 000
- \$20,000-\$39,999
- \$40,000-\$59,000
- Greater than \$60,000

## Highest Level of Education

- Some high school
- High school diploma
- Some university/college
- University (undergraduate) degree or diploma
- Some post-graduate studies
- Post-graduate degree

## Employment

- Unemployed
- Part-time
- Full-time
- Full-time student
- Other \_\_\_\_\_

## Counselling History, Services Received

- Hospital inpatient counselling services
- Hospital outpatient counselling services
- Residential treatment
- Government counselling services
- Privatized counselling services
- Other \_\_\_\_\_

Please state cumulative duration of counselling services received (in years and months):

\_\_\_\_\_

Please state reason(s) for counselling services received:

\_\_\_\_\_

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Please state any mental illness diagnoses you have received:

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Please state any current medications you are taking:

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**APPENDIX F: SENTENCE STEM CARDS**

My body  
reminds me  
of...

My body  
allows me  
to...

My body  
feels...

My body is...

My body  
prevents me  
from...

My body  
makes me  
feel...