One Size Fails All: Reconceptualizing Eating Disorders Through an Intersectional Feminist Lens

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Abstract

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This thesis employed an intersectional feminist lens to examine the multiple experiences of self-identified young women/non-binary individuals with eating disorders and the current discourse surrounding these disorders. Further, this research aimed to identify the symptoms and the social, political, and economic effects that individuals with eating disorders have experienced, and how these symptoms and effects have influenced social/personal life and institutional relations. The study provides both theoretical and methodological implications for understanding how eating disorders are a social justice issue. I argue that eating disorders are largely a symptom of dominant power systems that have been designed to control our bodies. I propose a more nuanced understanding of eating disorders rooted in lived experiences will provide the necessary space for creating ethical intervention. Further, I propose that, within therapeutic relationships, there needs to be a shift away from providing service and more emphasis on providing care.

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Preface

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Acknowledgement

I would like to begin with a land acknowledgment. This research took place in Mi'kma'ki, the ancestral and unceded territory of the original Mi'kmaq People.

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Chapter 1: Introduction

The COVID-19 pandemic has had a variety of diverse impacts that have affected specific groups of people in very different ways. This has been a particularly concerning time for individuals with eating disorders. According to Rodger et al. (2020), the current global context has caused concern for an increase in risk and symptoms related to eating disorders (ED), a decrease in protective factors against EDs, and a plethora of barriers to access relevant support and care. They highlight several reasons why this is true, including disruptions and restrictions to daily activities and movements, media effects, and emotional distress and fear of contagion. It should be noted, however, that certain groups of people are more likely to experience eating disorders than other groups. The risk factors associated with these vulnerable groups (women, young adults, 2SLGBTQIA+ folks, racialized people) have become heightened due to the COVID-19 pandemic. The current global context has demonstrated great need for a nuanced way of understanding eating disorders, particularly regarding differently positioned people.

Psychological, biological, and sociocultural and political issues contribute to a wide range of risk factors. The National Eating Disorders Association highlights some of these specific risk factors ("Risk Factors", 2018):

1. Biological: Having a close relative with an eating disorder, having a close relative with a mental health condition, history of dieting, negative energy balance, and Type 1 (insulin-dependent) diabetes
2. Psychological: Perfectionism, body image dissatisfaction, personal history of anxiety disorder, and behavioural inflexibility
3. Sociocultural: Weight stigma, teasing or bullying, appearance ideal internalization, limited social networks, acculturation, and historical trauma

From a critical intersectional feminist lens, sociocultural risk factors are of particular interest. Previous research has indicated that women are at a significantly higher risk of experiencing an eating disorder than men (Striegel-Moore et al., 2009). Despite the efforts of feminist, critical race, girlhood, and fat studies scholars, much of the available literature has failed to acknowledge many other demographic and sociocultural factors that are potential risk factors for developing an eating disorder such as race, ethnicity, class, sexuality, ability, religion, and other experiences/identities. Further, the intersection of these overlapping identities and how they are experienced by each individual person contributes to the development and experience of eating disorders.

The current study examined the real, unique, and diverse experiences of self-identified women with eating disorders and how these experiences are framed and understood. Two types of ethnographic qualitative methods were used to collect data - from participants who are current residents of the province of Nova Scotia on Mi'kma'ki. The first was an online qualitative survey, including a demographic questionnaire and open-ended survey. The second method was in-depth expert interviews. Participants consisted of (1) 26 self-identified women and/or non-binary individuals with eating disorders, (2) four service providers for clients in the eating disorder community. Participants with eating disorders were self-diagnosed and/or medically diagnosed.

This research used an intersectional feminist analysis to examine the multiple experiences of self-identified young women with eating disorders and the current discourse surrounding these disorders. Further, this research aimed to identify the symptoms and the social, political, and economic effects that individuals with eating disorders have experienced, and how these symptoms and effects have influenced social/personal life and institutional relations. The current study interrogated dominant eating disorder discourse by asking the following questions: (1) What impact has dominant eating disorder discourse had on our understanding of eating disorders and related interventions? (2) How have economic, political, and social factors affected patterns of eating disorders within the Canadian context? (3) How can an intersectional feminist framework provide a nuanced way of understanding eating disorders and the way they are treated?

The study provides both theoretical and methodological implications for understanding how eating disorders are a social justice issue. I argue that eating disorders are largely a symptom of dominant power systems that have been designed to control our bodies. Dominant eating disorder discourse, as presented through a medical and psychological lens, fails to acknowledge the multiplicities of different social locations and how these social locations influence the understanding, experience, and intervention of eating disorders. I propose a more nuanced understanding of eating disorders rooted in lived experiences will provide the necessary space for creating ethical intervention. Further, I propose that, within therapeutic relationships, there needs to be a shift away from providing service and more emphasis on providing care.

This thesis begins with a section committed to positioning myself within the research and is titled *Positioning the Researcher*. Next is *Chapter 2: Review of Literature and Theoretical Frameworks* which features an overview of relevant literature and theoretical frameworks including: Intersectionality, Normalization and Disciplinary Power, A History of Feminist Theory and Eating Disorders, Intersectional Feminist Theory and Eating Disorders, Critical Whiteness Studies, Fatphobia and Fat Studies, and Girlhood Studies. Following this is *Chapter 3: Methodology* which explores power relations and researcher dilemmas, the research methods used, the process of transcription, coding, and data analysis, and positioning the participants within the research regarding their demographics. The next 3 chapters are analytical chapters which explore the major themes yielded from the research as well as their corresponding subthemes. They are as follows: *Chapter 4: "You Should Probably Lose Weight": From Normalizing Eating Disorders to Pathologizing Fatness, Chapter 5: "The BMI requirement is stupid": Definitions, Diagnoses, and Recommendations,* and *Chapter 6: Interview Participant Reflections and Recommendations.* The final chapter, *Chapter 7: Conclusions, Contributions, and Implications* discusses contributions, limitations, ethical dilemmas, implications for future research, and final thoughts.

Positioning the Researcher

When conducting any type of research, especially research that deals with high-risk populations of human subjects, researcher self-reflexivity is crucial. This is done through positioning the researcher within the research. This process is characterized by turning the lens back onto oneself to take responsibility for how one is situated within the research process (Burck, 2005). Further, one must consider how their position may affect those who are being studied, the setting, the questions being asked, the data being collected, and how the data is interpreted.

To begin, it must be noted that my research is taking place in Mi'kma'ki – the ancestral and unceded territory of the Mi'kmaq People. Colonial Canada, and therefore Nova Scotia, is a white settler nation. Forced removal, assimilation, genocide, and other colonial methods were used to steal this sacred land from Indigenous peoples. Canada was built on colonial, patriarchal, capitalistic, and heteronormative values. It is crucial to acknowledge this brutal history when conducting research on this land to ensure that these toxic values are not reproduced through the research itself. Specifically, I acknowledge the multiplicity of eating disorders and lack of traditional food security associated with colonization, including residential schools and the foster care system that has deeply affected Indigenous youth intergenerationally.

It is also important that I acknowledge my own social location and relationship to the topic. I am a white, cisgender woman with thin privilege who grew up in an urban community on Unama'ki (Cape Breton Island), the ancestral and unceded territory of the Mi'kmaq people. I come from a middle-class family and often had access to the resources I needed such as family doctors, dentists, psychologists, and psychiatrists. Through this identity, I experience a certain amount of privilege that those who come from other social locations may not.

Although I grew up in a middle-class household, I spent most of the duration of this program away from family in a low-income household. As a student, I have a lot of expenses and, at times, little to no income. I have relied on scholarships, student loans, and government support to survive. My dependence on loans throughout my educational journey has resulted in a large sum of debt that I have not yet been able to repay. Fortunately, however, I have been living with my partner for the past year who has provided both financial and emotional support.

I also identify as pansexual and often have great difficulty navigating this identity. Finally, I have been diagnosed as someone with a permanent disability. I suffer from several mental illnesses including generalized anxiety disorder, social anxiety disorder, depression, anorexia nervosa, body dysmorphia, and obsessive-compulsive disorder. Each of these illnesses interactively influence my daily life, my ability to function as a student, and my research interests.

I chose to study how eating disorders are currently understood because it is a topic that is very personal to me. As someone currently in recovery for my eating disorder, it has been both interesting and disheartening to see how the pandemic has affected this community that I am a part of. I am also curious to know how other's experiences have been both similar to and different from my own. Further, I want to explore how each person's unique social location has played a role in their experience with eating disorders.

The purpose of this study is to provide insight into a very concerning and timely social issue while being as transparent as possible. While yielding interesting data is a goal of this study, the main goal is to use these findings to create potential solutions for this very serious problem. I truly hope my research can, at the very least, be used to provide insight into this subject and create change within my own community of Nova Scotia.

Chapter 2: Review of Literature and Theoretical Frameworks

This literature review explores a variety of concepts, theories, and frameworks that I believe are fundamental for situating the current study within the greater socio-geo-political context surrounding eating disorders. It begins with an exploration of intersectionality as this is the theoretical and analytical framework that weaves through this entire thesis. Next, I explore Foucault's (1997) concepts of normalization and disciplinary power and how they relate to the body as I believe these concepts play an important role when engaging with intersectionality. Third, I provide an overview of how popular feminisms have engaged with eating disorder discourse throughout history. Fourth, I present how intersectional feminism, in particular, engages with eating disorder discourse. Finally, I discuss contributions from the fields of critical whiteness studies, fat studies, and girlhood studies.

Intersectionality

Intersectionality is an analytical framework and theory of discrimination useful for understanding how the many characteristics of one's identity combine, intersect, and overlap to create different forms of discrimination and privilege (Bunjun, 2010; Collins, 2019; Crenshaw, 1991). These interacting characteristics can include race, gender, class, sexuality, religion, ability, ethnicity, culture, citizenship, language, and other political and social locations. The term intersectionality was coined in 1989 by Kimberlé Crenshaw, an American civil rights activist and critical race scholar. However, the conceptualization of intersectionality was first brought forth by Indigenous women and Black/Latinx/women of colour feminist lesbians in North America in the 1980s (e.g. Combahee River Collective (Eisenstein, 1978), Collins, 1993, Crenshaw, 1991). Although officially introduced as an analytical framework, intersectionality has evolved into a theory, a praxis, and even a way of being.

Patricia Hill Collins' (2019) recent work positions intersectionality as critical social theory. It provides insight into how intersectionality, when used as critical inquiry, can provide an important thinking tool and can help us to transgress the current limits of our knowledge. In her book, *Intersectionality as Critical Social Theory*, Collins' (2019) argues that "intersectionality is far broader than what most people, including many of its practitioners, imagine it to be" (p. 2). She refers to intersectionality as an "umbrella term" that encompasses many different ideas and tools that might be used for social change. She notes that although intersectionality is in the process of blossoming into a critical social theory used to address social problems and social changes, it is important that "its practitioners simultaneously understand and cultivate intersectionality as *critical* social theory (p. 2, emphasis original). The following excerpt from her book offers a summative argument as for why intersectionality as critical social inquiry is crucial:

> Social theories aim to *explain* the social world, offering interpretations for how and why things are the way they are as well as what they might or might not become. Because theories explain the social world, they affect the social world, even though their influence may not be apparent. Some social theories have the power to oppress, and do so quite effectively, without most people realizing the power of theory in maintaining an unjust social order (p. 4, emphasis original).

Rather than simply explaining the social world, the current study aims to address and challenge how the social world has constructed eating disorders. Collins (2019) continues:

> Other social theories have sparked considerable social action, providing critical explanations of the social world that catalyzed rebellions small and large. Social theories justify or challenge existing social orders. Within this universe of social theory, critical social theory both explains and criticizes existing social inequalities, with an eye toward creating possibilities for change. Stated differently, critical social theories aim to reform what is in the hope of transforming it into something else (p. 4-5).

Of these social-action-sparking social theories, there is one in particular that initiates social action and academic scholarship while employing a social justice lens. This social theory is intersectionality:

> Because intersectionality straddles traditions of social action and academic scholarship, it is uniquely positioned to develop critical theoretical analyses of the social world. Intersectionality can develop a critical social theory that reflects the wide array of ideas and actors that currently fall under its expansive umbrella. Yet it cannot do so without thinking systematically about the contours of critical social theory as well as its own theoretical knowledge and theorizing practices. As a work in progress, intersectionality is a critical social theory in the making, one that may already be doing substantial theoretical work without being recognized as such (Collins, 2019, p. 51).

Because much of the research on and treatment available for eating disorders does not take the depth of complexities of one's simultaneously intersecting identities and experiences into consideration, I argue that intersectionality offers nuanced ways of understanding and treating eating disorders.

Normalization and Disciplinary Power

Michel Foucault's (1977) concept of normalization will play a key role throughout this research. Therefore, we must explore what exactly this concept is and how it relates to the current study. In his revolutionary texts, *Discipline and Punish* and *The History of Sexuality*, Foucault likens normalization to power and social control. He states:

> Normalization consists first of all in positing a model, an optimal model that is constructed in terms of a certain result, and the operation of disciplinary normalization consists in trying to get people, movements, and actions to conform to this model, the normal being precisely that which can conform to this norm, and the abnormal that which is incapable of conforming to the norm. In other words, it is not the normal and the abnormal that is fundamental and primary in disciplinary normalization, it is the norm. That is, there is an originally prescriptive character of the norm and the determination and the identification of the normal and the abnormal becomes possible in relation to this posited norm (Foucault et al., 2007, p. 1977-1978).

Simply put, normalization is the process of creating an ideal, or norm, and then offering rewards or punishments based on one's ability to conform to or deviate from said ideal. In order to fully understand this concept, however, we must also understand Foucault’s concept of disciplinary power.

Disciplinary power involves obtaining compliance through institutions and interactions such as spatial regulation, social categorization, control, mass surveillance, corrective treatment, discrimination, and other methods that encourage individuals to govern their own behaviours; rather than by violence, physical force, discipline, training, or law (Foucault, 1995; Ceven et al., 2021). The human body, in particular, is not exempt from this disciplinary power. Tsouluhas (1999) sheds light on this notion of an “internalized disciplinarian” and how it:

> is crucial to an understanding of how culture maintains its grip on the female body. Consuming the disciplinary practices of femininity - practices which produce docile bodies habituated to exhaustive forms of self-surveillance - women learn to view themselves as if through the lens of the dominant gaze (p. 7).

She also describes how Foucault’s concept of disciplinary power “can be applied to an understanding of eating disorders and the way in which dominant discourses of femininity work to sustain women's disembodiment and, ultimately, their disempowerment” (p. 8). Within the current social context of the settler global North, we are surrounded by idealized norms of the body. Hesse-Biber (2007, p. 45) provides an example of this when she compares women’s bodies to cultural artifacts as they are “continually molded by history and culture.” She asserts that:

> Subjected to such pressures, the “natural body” gets lost. What replaces it may be the bewigged eighteenth-century countess, the wasp-waisted Victorian housewife, the leggy flapper, or the waif modeling Calvin Klein jeans. All are bodily reflections of the play of power within a society (p. 45).

To be white, straight, cisgender, thin, able-bodied, and adorned in the latest fashion trends is to be acceptable with the dominant sociocultural standards of the settler global North. Deviating from these norms forces people outward toward the margins of society. The more norms that you deviate from, the further out you move.

So how exactly are eating disorders, and subsequently fatphobia, normalized, accepted, and even encouraged? Ultimately, much of this normalization can be attributed to diet culture. Diet culture goes much deeper than the promotion of fad diets. Under a capitalist regime, it is impossible to escape the persistent inundation of products that are designed up help us "love" ourselves. These products often target our bodies and appearance. Navigating this capitalist minefield is a great challenge. A system that promotes self-hatred and social comparison while simultaneously co-opting movements of self-love leaves little space for individual or collective healing. Hesse-Biber (2007) offers a critique of capitalism as she dives deeply into consumer products in general and how women are told that the perfect body is only achievable through consumerism:

> [Women] can change the color of their eyes with tinted contacts; they can have tanned skin by using self-tanning lotion. They can buy cellulite control cream, spot firming cream, even contouring shower and bath firming gel to get rid of the "dimpled" look. One diet pill, called Meridia, is supposed to allow the consumer to "lose weight and actually keep it off." Meridia's accompanying pamphlet for patients says, "The most common side effects include headache, dry mouth, anorexia, constipation, and insomnia." …Many women believe that in order to lose weight they need to buy something – a pill, a food plan, or a membership in a self-help group (p. 75).

It is alarming that companies such as Meridia disclose that anorexia, a full-blown eating disorder, is a potential side effect of their product. For those who are aware of the presence of diet culture and can see the man behind the mirror, it is probably obvious that diet pills are connected to the development or maintenance of an eating disorder. However, for the company to openly discloses this fact and for the general public (especially promoters and consumers of this product) to look past it as if it is comparable to any regular side effect is deeply disturbing.

Eating disorders are, large in part, a product of oppressive power systems; the social categories to which we belong need to be acknowledged to fully understand people's experiences of them. Tsouluhas (1999) summarizes how eating disorders are a symptom of disciplinary power and how they are often a result of backlash against women's liberation. She states:

> The dramatic increase of eating disorders in contemporary Western society is symptomatic of a cultural backlash against women's increased independence. At a particular historical moment when it would appear that culture has loosened its grip on the female body, many women continue a long-standing legacy of efforts to squeeze their feet into glass slippers – that is, into one impossible form or another. This situation reflects a profound contradiction in the lives of women in Western patriarchal culture…such practices as self-starvation, laxative abuse, and excessive exercise are continuous (albeit extreme) responses to culture's perpetual glamorization of a female body that is cellulite-free, firm, and in control of its desires and impulses - precisely those desires and impulses which threaten to corrupt the stability of the patriarchal order (p. i).

It should be noted that disciplinary power not only strives to govern women's bodies but exerts its power over anyone occupying marginalized positionalities. Patriarchy, capitalism, and colonialism work to reinforce one another to ensure that this disciplinary power continues its reign. Eating disorders are clearly an example of how these complex systems assert their dominance and maintain power.

A History of Feminist Theory and Eating Disorders

Much of the available research on eating disorders has been presented through a medical, psychological, or psychiatric lens. Nevertheless, feminism has contributed valuable information to eating disorder discourse. It is difficult to amalgamate all feminist theories on eating disorders under one umbrella. However, most feminist literature emphasizes the oppressive social and cultural factors (expectations surrounding appearance, weight, appetite, sexuality, and social roles) that influence eating disorder pathology (Holmes, 2016).

According to Malson and Ryan (2008), eating disorders are implicated by cultural ideologies of gender, such as idealizations of thinness, as core criterion of western feminine beauty standards. Many feminist scholars argue that western, normative beauty is an extension of capitalist, colonial, patriarchal regimes (Havlin & Báez, 2018). Susan Bordo (2003) supports this claim as she connects popular culture representations of beauty to female pathology, particularly eating disorders. She argues that women's beauty regimes are not only sexist, but also largely Eurocentric. It is argued, however, that for some, "beauty is not a frivolous concept nor practice. In many corners of the world, if and how one chooses to challenge beauty regimes cannot only lead to marginalization but also sometimes violence" (Havlin & Báez, 2018, p. 13-14). Further, these westernized cultural discourses and practices that are involved in the normalization of feminine beauty standards are inseparable from the constructions of eating disorders (Hepworth & Griffin, 1995). Malson and Ryan (2008) state:

> From this perspective, 'eating disorders' are theorized not as distinct clinical entities, but as complex, heterogeneous and shifting collectivities of sociohistorically located subjectivities, bodies and body management practices that are constituted within and by (rather than outside of) the normative discursive contexts of contemporary western cultures (p. 113).

Consequently, the full scope of eating disorders cannot be understood without taking culture and context into consideration. Without this, researchers, clinicians, and other service providers are at risk of reproducing these harmful cultural norms and conditions.

Many feminist theorists have contributed to a deeper understanding of the social and political contexts in which eating disorders are produced and sustained. They have attempted to deviate from the authoritative perspectives put forth by the fields of psychology and medicine. While these contributions are important, we cannot ignore the degree to which these dominant, mainstream, Eurocentric forms of feminism have largely centered the voices and experiences of thin, cisgender, white women of the settler global North. Much of the popular literature put forth on this topic was, and often continues to be, a product of white feminists. Many feminists offer critiques of dominant eating disorder discourse. However, these more liberal feminisms tend to offer less radical, more palatable critiques. Therefore, I argue that an intersectional approach offers challenges to and critiques of pre-existing theories on eating disorders and helps to fill these gaps.

Intersectional Feminist Theory and Eating Disorders

For decades, eating disorders have been a persistent issue for young women across the globe. Defined as serious mental and physical health conditions related to persistent eating behaviours that are characterized by negatively impacted health, emotions, and ability to function in important sectors of life ("Eating disorders - Symptoms and Causes" 2021), the high prevalence of eating disorders among young women warrants its significant attention.

It should be noted that most of the available research on eating disorders focuses on young white women as this community of women are most likely to report their illnesses and seek help (Standing Committee on the Status of Women, 2014). However, eating disorders can and do affect anyone, regardless of age, race, gender, sexuality, ethnicity, or socio-economic background (Birmingham et al., 2005). Morris (1999), Hankivsky and Christoffersen (2008), and Hankivsky et al. (2010) acknowledge the importance of addressing weaknesses in most health research, specifically eating disorder research:

> One central weakness has been that, despite its efforts to be inclusive, the traditional foci of Canadian health research on women tends to essentialize the category of women (that is, assumes that all women, regardless of age, cultural background, geographical location, socioeconomic status, religion, sexual orientation and other categories of difference, share exactly the same experiences, views, and priorities), and further, gives too much primacy to gender over other key determinants and does not adequately address the interactions among all determinants of health. Consequently, the issues and priorities of many vulnerable women, including members of ethnic, racial, and linguistic minorities, [Indigenous] women, low-income women, lesbians, and women with disabilities are usually excluded from mainstream women's health research (Hankivsky et al., 2010, p. 1).

Unfortunately, many medical research studies essentialize the category of women. This reproduces the harm that the researchers may have intended to avoid. When the stereotypical patient profile is not met, fear, shame, and stigma may be attached to seeking help. Further, healthcare professionals may have more difficulty recognizing eating disorders in these diverse populations as opposed to young white women (Standing Committee on the Status of Women, 2014).

While psychology has provided an enormous body of research and information on the topic of eating disorders, many psychological perspectives do not effectively consider or examine the historical and contemporary socio-geo-political contexts in which eating disorders exist. Further, little acknowledgment is given to the patriarchal, colonial, capitalist values that Western medicine is built upon and how these systems of power work together to oppress those under their reign. This is not to say that the work done in the field of psychology and medicine should be rejected. Rather, I argue that it needs to be approached with a different lens – an intersectional feminist lens. Sharma (2019) stresses that feminist theory allows:

> clinicians and educators to move from theory to action and build bridges of solidarity between the medical academy and the communities they are called to serve (p. 572) … Feminist pedagogical approaches involve challenging assumptions and examining the hidden curriculum of our institutions (p. 573) …[F]eminist pedagogy is concerned with the provision of meaningful and competent care to patients of all races, ethnicities, sexual orientations, and genders (p. 574).

Employing an intersectional feminist approach to eating disorder research and clinical practice can help challenge the harmful assumptions and effects of eating disorders. An intersectional feminist approach can be taken in a variety of ways, such as through "the questions that are asked, the theoretical frameworks through which those questions are asked, the methodologies used, and how research is translated into action, or rather how scholars engage in praxis and service delivery" (Sharma, 2019).

Intersectionality can help identify how one's social and political locations influence experiences with eating disorders. Patriarchal, capitalistic, and colonial systems of oppression intersect and interact with one another to create ideologies and environments embedded with socio-political-psychological values and beliefs that put people at risk of developing and sustaining eating disorders. These three systems of power manifest in ways that create harmful environments and effects for those living under them. Patriarchy manifests as (negative) body image and fatphobia, capitalism manifests as diets, products, and ableism, and colonialism manifests as food (in)security, deviant body image, and biological determinism. Capitalism, in particular, "is and has always been a racialized and gendered enterprise that has guaranteed the global domination of a predominantly white, male capitalist class" (Monzo, 2020, p. 49). Further, capitalism benefits from the management of bodies, labour, and control of women (especially Indigenous women, Black women, and women of colour):

> Through psychological, physical, and emotional violence, women are commodified as pawns of pleasure, denied the right to control their own bodies…Sexism…complicit in capitalist production, secures the next generation of workers socialized to accept the status quo and to reproduce a class-based, racialized, and gendered division of labor that secures the power of heterosexuality, white people, men, and the ruling class (Monzo, 2020, p. 55).

Those who fall outside the categories of heterosexual, white, male, and upper-class risk having their bodies policed, commodified, and controlled both explicitly and implicitly. For example, Halvin and Báez (2018) note that trans women often become targets when they do not pass as cis women. Therefore, conforming to western, normative beauty standards can be a method of survival for some. These people, whose "deviant" bodies do not neatly fit the mold, face an incredible amount of pressure to conform, putting them at great risk for developing an eating disorder.

In terms of demographics, eating disorders have stereotypically been associated with young, white, middle/upper-class, thin, cisgender women of Anglo and European descent (Becker et al., 2003). Despite this, eating disorders are equal opportunity illnesses, as demonstrated by epidemiologic data, that can affect anyone from any social location (Becker et al., 2003). Burke et al. (2020) argue that intersectionality-informed approaches are what is needed to better understand the disparities in research, diagnosis, and treatment of eating disorders in marginalized groups. They propose that:

> the intersectional approach acknowledges that disease risk for an individual who lies at the intersection of two high-risk identities may be greater than the sum of the risk born by each identity in isolation. In other words, this approach allows for the possibility that the effect of one identity (e.g., gender) may depend upon the existence of another identity (e.g., race/ethnicity) (p. 1605-1606).

For example, a Black poor woman with a disability and a white poor woman with a disability may share the experience of identifying as a woman, as poor, and as living with a disability. However, the way that their social locations in terms of race, class, and ability identities intersect, and the ways in which their lived histories influence their experiences with eating disorders will differ. In fact, Becker et al. (2003) argue that there are disparities in psychiatric diagnoses and access to care based on ethnicity; these disparities are believed to connect back to three major sources: (1) poor fit of psychiatric diagnostic categories with ethnically diverse explanatory models and presentations of illness; (2) differential help seeking patterns for illness; and (3) clinician error or bias.

Another high-risk identity that is often overlooked in eating disorder research is fat people. In fact, much of the available research and discourse surrounding eating disorders is very fat-phobic. From a Western perspective, fatphobia can be described as “a pathological fear of fatness often manifested as negative attitude and stereotypes about fat people” (Robinson et al., 1993, p. 468). It is important to recognize, however, that this definition can and does vary across different communities within Canada. Despite this, Western influence of fashion, beauty, and products, on historically non-white communities has been prominent. This has been true for centuries as observed through the global imperialism that occurred during the Victorian era and enlightenment period:

> All of the nation-states of Europe viewed the inhabitants of the empires they established abroad as their racial inferiors, typically either as “barbarians” or “savages.” Racism then gave rise to one of the standard justifications for imperialism, the so-called “civilizing mission” of the “white man” to rescue the “savages” from their supposedly benighted customs and beliefs…Modern racism was strengthened by the slave trade and slavery…Meanwhile so-called “scientific racism” developed from Enlightenment natural history, leading to social Darwinism and the eugenics movement of the late nineteenth century. By 1900, the dominant view among Europeans was that most if not all of history could be explained by race warfare, with the so-called “white race” almost always coming out on top (Brantlinger, 2018, p. 736).

Although, on the surface, imperialism takes different forms from what it once did in the past, its power and influence remain ever so present. This is apparent through the Westernized beauty standards that are constantly forced upon us. Those who do not fit the thin ideal are especially underrepresented in the beauty industry and discriminated against in society as a whole.

In terms of treatment, some scholars have actually suggested that obesity prevention and eating disorders can be dealt with more effectively by merging the two together (Gotovac et al., 2020). Further, it has been proposed that:

> prevention efforts might target dieting, body dissatisfaction, media consumption, depressive symptoms, perfectionism, short sleep duration, social problems, and emotion regulation issues to assist people in developing healthier relationships with bodies and food, regardless of manifestation of symptomatology (Gotovac et al., 2020, p. 115).

Because of this, Burke et al. (2020) note that significant attention should be drawn to weight, shape, and appearance as dimensions of visible identity when conducting intersectional research on eating disorders. Weight stigma is very pervasive and can serve as a barrier to accessing treatment and support. It is the global stereotype and prevalence of thin, young, white women with eating disorders that informs public and medical opinions about what eating disorders look like, who they affect, and how to treat them (Becker et al., 2010); this can be very dangerous, or even fatal, to those who do not fit neatly within this category. In order to accurately determine which intersecting identities have the highest risk, which mechanisms are involved, and how eating disorders may differently present, an intersectional lens is necessary (Burke et al., 2020). Without this approach, it is difficult to assess who is at the highest risk and how to accurately and effectively intervene. It is time to not only contest but also deviate from the conceptual frameworks that once ruled and create nuanced frameworks that fill the gaps of those historically omitted.

Although intersectional feminist research creates space to engage in anti-oppressive work involving the body and eating disorders, I also turn to the fields of critical whiteness studies, fat studies, and girlhood studies. Each of these fields of study have put forth momentous contributions to discourse surrounding the body. Engaging with work from scholars in these fields allows for more meaningful engagement with intersectional feminism in theory and in practice. The next section takes a look at critical whiteness studies and how this field has constructed whiteness in relation to the body.

Critical Whiteness Studies

Critical Whiteness Studies, White Fragility, and White Guilt

Critical whiteness studies is a branch of critical race theory that seeks to expose the structures, both visible and invisible, that contribute to the production and reproduction of white supremacy and privilege (Applebaum, 2016). While there are some exceptions, historically, the study of race and ethnicity has primarily concerned itself with ethnic and colour-based forms of racism (Nayak, 2007, p. 737). In more recent years, there has been a shift toward the study and interrogation of whiteness. Nayak (2007, p. 738) posits that critical whiteness studies is underpinned by three core beliefs which are as follows: 1. “Whiteness is a modern invention; it has changed over time and place", 2. "Whiteness is a social norm and has become chained to an index of unspoken privileges", and 3. "The bonds of whiteness can yet be broken/deconstructed for the betterment of humanity." Whiteness is a power system that was socially constructed by and for white people. However, as Nayak (2007) shared, it is not too late for whiteness to be deconstructed to create a more equitable and just world.

While some white scholars and advocates have engaged in the field of critical whiteness and have participated in the ongoing deconstruction of whiteness, there is much work left to be done. Although well intentioned, many progressive white folks advocating for racial justice further perpetuate harm by centering their own feelings and experiences. Often, this is marked by a sense of what is known as white fragility and white guilt. The concept of white fragility is not new and can be attributed to the work of critical race scholars throughout time (i.e., bell hooks, 1992). However, Robin DiAngelo has received credit for coining the term in 2011. Moreover, it was the 2018 release of DiAngelo's book *White Fragility: Why It's So Hard for White People to Talk About Racism* that really made white fragility a buzz word. DiAngelo (2011) defines white fragility as:

> a state in which even a minimum amount of racial stress becomes intolerable, triggering a range of defensive moves. These moves include the outward display of emotions such as anger, fear, and guilt, and behaviors such as argumentation, silence, and leaving the stress-inducing situation. These behaviors, in turn, function to reinstate white racial equilibrium. Racial stress results from an interruption to what is racially familiar (p. 57).

To summarize, white fragility arises from a sense of emotional discomfort and defensiveness that occurs when white folks, who feel entitled to racial comfort, are faced with racial stress. Ultimately, white discomfort co-opts and refocuses discourse to prioritize white folks' needs and further distracts from the oppression experienced by racialized people (DiAngelo, 2018; Parasram, 2019).

Despite DiAngelo's contributions to the discussion around white fragility, it cannot go unnoticed that she herself is white. One cannot ignore the irony in that DiAngelo, a white woman, has become the dominant respondent on the topic of white fragility. This begs the question, why is the work of a white woman being centered and legitimized when critiquing whiteness in the pursuit of anti-racism? In 1992, bell hooks examined the work of post-colonial critics and shared that there was a significant body of literature committed to exploring the way white minds perceive blackness; however, "very little expressed interest in representations of whiteness in the black imagination" (p. 339). Despite few scholars alluding to such representations within their writing "only a few have dared to make explicit those perceptions of whiteness that they think will discomfort or antagonize readers" (hooks, 1992, p. 339). Further, hooks describes that "progressive white people who are anti-racist might be able to understand the way in which their cultural practice reinscribes white supremacy without promoting paralyzing guilt or denial" (p. 346). Although she did not introduce the term white fragility, it is clear that scholars such as hooks have been addressing this issue for years. Moreover, DiAngelo has been critiqued for her lack of self-awareness and "guilt-based framing" (Ghadiali, 2021) when discussing racism.

As Ghadiali (2021) noted in her critique and coding of DiAngelo's work, white guilt is a common emotion evoked when white fragility is experienced. White guilt is defined as an emotional response elicited by white individuals that occurs when they become aware of misdeeds or harm committed by their racial group and against other racialized groups (Doosje et al., 1998; Mekawi et al., 2021). As a white person studying the intersection of race, there is potential for danger. White scholars must proceed with caution when inserting themselves (and consequently their privilege) in spaces and conversations with and about racialized people. By drawing on critical whiteness studies, it is possible to explore the intersection of race in a way that involves examining and interrogating one's own positionality, without centering white experiences and feelings.

Critical Whiteness and The Body

When studying whiteness, and race more generally, the body is an obvious site for discussion. Ahmed (2007) asserts that "whiteness could be described as an ongoing and unfinished history, which orientates bodies in specific directions, affecting how they 'take up' space, and what they 'can do'" (p. 149). From this description, it can be drawn that white bodies serve as the centre of the compass, with all other bodies being positioned in relation to whiteness. Whiteness strives to direct, discipline, and control behaviours while asserting cultural inscriptions, white ideals, and norms over racialized bodies (Leonardo, 2004; Azzarito et al., 2017). Therefore, when discussing the body, how it is conceptualized, and how it is perceived, including race in this discussion is necessary.

When considering how race shapes people's lives, we often think of injustices committed against racialized bodies. While this does occur and warrants attention, Frankenberg (1993) proposes that race shapes the lives of white bodies too. In fact, she posits that we all live racially structured lives where "any system of differentiation shapes those on whom it bestows privilege as well as those it oppresses" (p. 1). Further, Frankenberg points out that racism is not simply an issue faced by people of colour that does not involve or implicate white people. Rather, it is a system of dominance and power "that shapes our daily experiences and sense of self" (p. 6). Antiracist work is not simply "an act of compassion for an 'other'" and viewing it as such "has serious consequences for how white [people] look at racism, and for how antiracist work might be framed" (Frankenberg, 1993, p. 6). By acknowledging that racial injustice implicates all of us, we can begin to understand how it shapes our own and others' perceptions of our bodies.

Frankenberg's (1993) work sets the stage for considering how race, particularly whiteness, shapes the lives of all people of all races. Yet, there is a major limitation within this body of work as Frankenberg tethers the concept of whiteness to white bodies (Nayak, 2007). Whiteness is much larger than its corporeal presentation. It is a widespread, deeply ingrained system of power that extends far past the existence of white bodies. Ahmed (2007) draws on the work of Fanon (1986) and proposes that whiteness is an orientation that has racial and historical dimensions that are beneath the surface of the corporeal body. Dimensions such as "histories of colonialism" make "the world 'white', a world that is inherited, or which is already given before the point of an individual's arrival" (Ahmed, 2007, p. 153). Failure to account for how whiteness is embodied and enacted upon results in a grave misrepresentation of how widespread and dangerous whiteness truly is. Nayak (2007) asseverates:

> What the new labour historians have shown is that people who were deemed 'not-yet-white' in one epoch may 'become' white in another. While Frankenberg would no doubt be sympathetic to contingency, by basing her account on a fixed ontology of race that links whiteness to 'white' bodies, we are unable to gain a deeper understanding of how the fictional markers of race are summoned to life in everyday performances, practices and 'doings'…whiteness and the category 'white women' do not precede these enactments but, rather, they become knowable and come alive in repetitive acts, embodied and corporeal activities (p. 742-743).

Whiteness transcends skin colour and has the potential to be enacted upon and upheld by people of all racial origins.

Since whiteness is something that is largely produced through actions, activities, and embodiment, it can be assumed that there are white people who do not "adequately" perform whiteness. By examining how whiteness affects white bodies we are able "to observe the many shades of difference that lie within this category – that some people are 'whiter' than others, some are not white enough and many are inescapably cast beneath the shadow of whiteness" (Nayak, 2007, p. 738). Despite having white skin, some people are not afforded the socio-geo-political privileges that are attributed to whiteness. Therefore, differently positioned white people do not necessarily experience whiteness in the same way. From this concept of the embodiment of whiteness, I deduce that whiteness can be likened to other privileged social categories such as straightness, wealthiness, thinness/attractiveness, maleness, being cisgender, able bodied, educated, and Christian.

White bodies who do not sufficiently embody whiteness risk being marginalized. This is evident in matters regarding western beauty standards. For example, a study by Moreno-Domínguez, Raposo, and Elipe (2019) offers confirmation "that the internalization of heterosexist values defined by the male gaze may prove relevant to identifying the scale of pressure experienced by women of different sexual orientations" (p. 6). Therefore, the degree to which white women of different sexual orientations experience this pressure may differ across their varying sexualities. As well, white women of varying body sizes are affected differently by ideal beauty standards:

> The institutional organization of retail spaces filters women into differential statuses associated with varying body types. The retailers we studied reinforce narrow cultural body ideals by segregating larger clothing and clothing for purportedly uncommon proportions either in designated sections within individual stores or across stores. The inaccessibility of extended size ranges beyond these spaces stigmatize particular body types, as evidenced by many women's interpretations of "having to" shop in specialty stores as an indicator of their failure to meet body ideals (Bishop et al., 2018, p. 197).

Inaccessibility to certain sizes, unaffordability due to "plus size fees", and other inequitable retail practices create barriers and stigmatize white women who occupy fat bodies.

Fatphobia and Fat Studies

Fatphobia

Fatphobia is characterized by the implicit and explicit biases of fat people “that is rooted in a sense of blame and presumed moral failing. Being…fat is highly stigmatized in Western Culture. Anti-fatness is intrinsically linked to anti-blackness, racism, classism, misogyny, and many other systems of oppression” (*Fatphobia*, 2021). It is an incredibly complex issue that predates its commonly known roots in medicine and related fields. While there are many components involved in understanding it, it is crucial that we acknowledge fatphobia’s racial origins and how it is rooted in racism, especially anti-Black racism.

A profound text titled *Fearing the Black Body: The Racial Origins of Fat Phobia* by Sabrina Strings (2019) illustrates how the existence of fatphobia can be traced all the way back to the Renaissance or Enlightenment era. She explains that during this period, fatness was likened to “savagery” and racial inferiority. Strings takes us on a journey from the fifteenth century to the present day and explains how fatphobia, racism, and bestiality have been intertwined with one another all throughout history (i.e., abnormalities, hormonal deficiencies; history of the connection of fat black bodies to apes as observed in the history of Saartjie “Sara” Baartman; fat people on display as “freaks” in circuses). Further, she asserts that the thin ideal is, at its centre, racialized and racist. This distinction is crucial as it emphasizes the true danger that accompanies Western, Anglo-Saxon ideals – especially in matters related to the body. Shaw (2005) discusses how:

> In Western culture, whiteness has come to be the defining zenith of physical attractiveness. The overwhelming economic and cultural authority of the West, and the success with which it has imposed Eurocentric values on subaltern populations, has had a major impact both material and social on the lives of black women throughout the Diaspora. Eurocentric ideals of feminine beauty have caused fatness and blackness to

> display an uncanny coincidence of boundaries as they are both physical attributes that immediately displaces some women from the Western beauty arena (p. 143).

Whiteness and thinness combine to produce a very narrow category of beauty that is exclusionary to most people but has influence on and impacts everyone. Qualities of physical attractiveness were born out of colonial, imperial power and are defined by the intimate relationships between race, gender, class, sexuality, and fetishism (McClintock, 1995).

Disordered eating behaviours, such as intermittent fasting and clean eating, have become viewed as a healthy/normal/acceptable tool for combatting fatness. This is largely due in part to the belief that thin is equivalent to healthy while fat is equivalent to unhealthy. Jutel (2009), drawing on the work of Zola (1983), states that:

> [M]edicine practices under what it, and society at large, considers to be noble neutrality and objectivity, justification for its role as repository of truth. Yet, cultural values are just as deeply ingrained in medicine as they are in other settings and to presume a greater objectivity of the medical eye is to overlook the fact that, 'there is no guarantee that merely doing the job of "healing" frees one from examining the context within that it is carried out' (p. 272) (p. 67).

For people who occupy fat bodies, not only is healthcare influenced by cultural values, but often they do not get the “healing” or care they need due to widespread fatphobia that has become ingrained in medicine. In the 1960s, Zola coined the term “medicalization” which refers to the influence and jurisdiction that medicine has and how it creates a form of social control – a sort of control that typically disadvantages those from vulnerable or marginalized populations (Zola, 1986). When fatphobia is upheld by medical institutions, it validates and further normalizes the already pervasive social belief that fat is bad.

McGrath (2009) addresses medicalization and its disregard of social processes by stating that medicalization:

> enables contemporary society to ignore the extent to which the processes of socialization itself produces many of the behaviors and emotions that are now labeled disorders … this

> may be one of the more disturbing results of increased medicalization: it produces a society that no longer needs to look at itself, a society that no longer feels a need to view itself as in a mirror, a society that feels no need to think about, let alone criticize, the forces it unleashes (p. 420).

Fatphobia is an excellent example of how social processes have produced behaviours and emotions that have stigmatized and pathologized fatness. In the United States, obesity is referred to as an epidemic that has plagued the country. Even the DSM had once considered obesity to be a psychiatric disorder. While obesity is not included in the DSM-5, it was included in past editions. The DSM-5 (American Psychiatric Association, 2013) does state, however, that:

> Obesity is not included in DSM-5 as a mental disorder. Obesity (excess body fat) results from the long-term excess of energy intake relative to energy expenditure. A range of genetic physiological, behavioural, and environmental factors that vary across individuals contributes to the development of obesity; thus, obesity is not considered a mental disorder. However, there are robust associations between obesity and a number of mental disorders (e.g., binge-eating disorder, depressive and bipolar disorders, schizophrenia). The side effects of some psychotropic medications contribute importantly to the development of obesity, and obesity may be a risk factor for the development of some mental disorders (e.g., depressive disorders) (p. 329).

Although it is no longer considered a “mental disorder”, the DSM-5’s discussion of obesity continues to pathologize and stigmatize fatness. Further, the notion that fatness in and of itself may be a risk factor for the development of some mental disorders needs to be contested. Is fatness truly the risk factor or is it the social construction of fatness as a problem, ugly, and unhealthy that is the risk factor? I would argue the latter. It is true there may be biological and physiological components that have been studied and connect fatness to the likelihood of developing a mental disorder. However, more weight needs to be given to the larger social, cultural, systemic, and institutional constructions of fatness and how they reproduce harm, especially in regard to mental health and wellbeing.

The BMI is an excellent example of how fat bodies have been stigmatized and policed in medical practice. Justin and Jette (2022) share that critical obesity scholars have theorized that the BMI "operates as a biopolitical tool that is fundamental to modern governance and the contemporary stigmatization of fatness" (p. 608) because it "regularizes and disciplines bodies at the population and individual level" (Evans & Colls, 2009, p.1075). Justin and Jette (2022) draw on the work of Hatch (2016) who applies a critical race analysis to understanding the BMI as a biopolitical tool that:

> …details how historical scientific racism is repackaged within modern biomedical research as it regards metabolic syndrome. Specifically, Hatch (2016: 75) argues that the BMI, along with several other indicators of metabolic syndrome, are biopolitical tools that "draw on and circulate racial meanings that construct race as a biological and genetic feature of bodies" (p. 608).

By pathologizing fatness within biomedical research and practice, fatphobia is validated and even given the guise of health promotion.

Fat Studies

The field of fat studies was born out of the desire to critically examine how fatness and fat bodies have been constructed, vilified, and pathologized. Fat studies draws inspiration from critical race theory, queer studies, and women and gender studies as it is "an interdisciplinary field of scholarship marked by an aggressive, consistent, rigorous critique of the negative assumptions, stereotypes, and stigma placed on fat and the fat body" (Rothblum & Solovay, 2009, p. 32). Fat studies encourages us to move beyond the belief that fat is bad and move toward fat acceptance and celebration. While fat studies scholars offer different approaches to understanding and combatting widespread fatphobia, there is an underlying, unifying objective that is characterized by a critical examination of how fatness and fat bodies are constructed and governed.

In 1978, Foucault introduced the term "biopower" which refers to the power that urges individuals to govern their own health and risk. Wright (2009) built upon this concept by exploring “biopedagogies”, which are guidelines for managing the body that involve moral implications for how individuals should act. When engaging with biopedagogies, one must “critically and systematically explor[e] how bodies are surveilled, coded, and disciplined under contemporary, Western, neoliberal capitalism” (LaMarre, et al., 2017, p. 250). LaMarre, Rice, and Jankowski (2017) suggest that “body becoming pedagogies” are “a way of extending beyond individualizing biopedagogies (p. 250). These pedagogies are:

> scaffolded in an embodied ethics—that is, an attunement to people’s embodied experiences, or the stories people tell about their bodily experiences and the way these stories and the bodies that tell them are situated in sociopolitical and economic milieu (LaMarre et al., 2017, p. 250).

Body becoming pedagogies encourages a shift away from the idea that “the ideal of the healthy, able, and in-control body is a temporary state and that the abject will always return whether in aging, disability, disease, fatness, or other “transgressions” of norms” (Rice, 2015, p. 6).

As previously discussed, fat bodies have continuously been stigmatized and pathologized within medical institutions. The social control asserted by these institutions have created a culture where health concerns are used to “oppress people of size” and “convey disapproval and censure” as “most people are quite willing to support the stereotype of fatness signifying ill health” (Rothblum & Solovay, 2009, p. 72). Unlike other health concerns such as cancer, “fat people are blamed for their health problems” (Rothblum & Solovay, 2009, p. 72). LaMarre, Rice, and Jankowski (2017) suggest that “using culturally and biomedically informed binary criteria like healthy/unhealthy, fit/unfit, and normal/abnormal” which “rely on normative (White, Western, able-bodied, and masculine) standards of the fit, healthy, and productive body” (p. 241) can end up influencing “people’s conceptualizations of themselves as healthy productive citizens throughout their lives, becoming lenses to evaluate all bodies” (p. 242).

Some fat studies scholars have zeroed in on how fat people with eating disorders are stigmatized and excluded within medical institutions. Fat people's "stories are often missing from literature detailing the "successes" of eating disorder prevention. This omission particularly applies to those whose bodies are multiply marginalized" (LaMarre et al., 2017, p. 247). Fat studies scholar's advocate for the application of a social justice approach to eating disorder prevention and intervention as "we must consider how marginalized people are differently impacted by these biopedagogies: who is the audience for these biopedagogies, and how do these biopedagogies intersect with lived bodily realities?" (LaMarre et al., 2017, p. 247). By occupying an intersectional orientation toward eating disorder prevention, we can draw attention to:

> the need for prevention efforts to be socially just if they are to be effective for, and embracing of, marginalized people's bodies and bodily experiences. We also challenge the idea that "obesity" prevention should be attempted at all given that it reinforces the vilification of fat and ultimately calls for the erasure of fat bodies" (LaMarre et al, 2017, p. 247-248).

An intersectional, fat positive perspective is necessary if we hope to create an inclusive approach to eating disorder prevention and intervention for all types of bodies.

The "Health at Every Size" (HAES) model is one of the most notable healthcare models to be born out of fat studies. It started through grassroots movements by fat studies scholars, advocates, and healthcare workers and is an "alternative public health model for people of all sizes" (Rothblum & Solovay, 2009, p. 72). There are 5 key elements to this model and can be described as follows (Rothblum & Solovay, 2009, p. 72-73):

> 1. Enhancing health—attending to emotional, physical and spiritual well-being, without focusing on weight loss or achieving a specific "ideal weight."
> 2. Size and self-acceptance—respecting and appreciating the wonderful diversity of body shapes, sizes, and features (including one's own!), rather than pursuing an idealized weight, shape, or physical feature.
> 3. The pleasure of eating well-eating based on internal cues of hunger, satiety, and appetite; individual nutritional needs; and enjoyment, rather than on external food plans or diets.

> 4. The joy of movement—encouraging all physical activities for the associated pleasure and health benefits, rather than following a specific routine of regimented exercise for the primary purpose of weight loss or management.
> 5. An end to weight bias—recognizing that body shape, size, or weight are not evidence of any particular way of eating, level of physical activity, personality, psychological issue, or moral character; and confirming that there is beauty and worth in EVERY body.

Rather than focusing on a person's weight/weight changes, the HAES approach emphasizes accepting oneself and engaging in healthy day-to-day practices – this has made it controversial "in a society where the pursuit of thinness is an unquestioned prescription for health and happiness" (Rothblum & Solovay, 2009, p. 72). The HAES treatment model, and other fat studies approaches, encourage us to deviate from the Eurocentric, thin-obsessed approaches that we have been plagued with for so long. Fat studies scholarship and advocacy, in general, is an essential resource for engaging with the intersection of body shape and size, and how this intersection is acknowledged through eating disorder prevention and intervention.

Girlhood Studies

Girlhood studies has roots in a variety of different disciplines such as youth and cultural studies, anthropology, sociology, history, psychology, literary criticism (Johnson et al., 2015, p. 2), and feminism and social change (Mitchell, 2021, p. v). This field of study is interdisciplinary in nature and focuses on girls, the period of being a girl, and the culture of girls while combining advocacy, perspectives, and thoughts from girls themselves (Mitchell et al., 2008). Mitchell (2021) reveals that "critical dialogue about inclusion and exclusion and about ongoing reflexivity and questioning" (p. v) lies at the heart of girlhood studies.

The body has been a common site for discussion within the field of girlhood studies. The body serves as a vessel that makes our identities visible, a vessel that is surveilled by others and enacted upon by ourselves (Foucault, 1978; Driscoll, 2002; Zaslow, 2009). In fact, Phillips (2015, p. 40) suggests that the body *is* the self for many girls. Within the studies of girls' lives, the primary focus has been "weight, dieting, body shape, eating and body dissatisfaction disorders as well as on the relationship between sexuality, representation, and the female body" (Zaslow, 2009, p. 113). In particular, many girlhood studies scholars have focused their attention on mainstream/pop culture (Zaslow, 2009) and internet technologies (Phillips, 2015) and how they contribute to girls' obsession with appearance:

> This focus on appearance has since been negotiated through a neoliberal narrative of choice: the adolescent girl may choose to be whomever she wishes. Yet, while such narratives appear to offer agency, the sheer homogeneity of the appearance produced—and that appearance is, itself, so singularly relied upon—suggests a narrowing, rather than an increasing, of options available to her (Phillips, 2015, p. 41).

Although adolescence is marked as a time of increased independence, freedom, and choice in a girl's life, it is not that simple:

> the adolescent girl remains both trapped within a body and constrained by surveillance and discipline so pervasive that she freely, or so it seems, chooses to enact their mechanisms of control (spray tans, SPANX®, nose jobs, and gym visits) upon herself, that is to say, upon her body (Phillips, 2015, p. 41).

Phillips (2015) suggests that girls' bodies are a product of media (social media emanating from the West in particular) as it is largely digital/virtual spaces where the ideal body is established.

Girlhood studies offers substantial contributions to discourse surrounding the body. Afterall, it is during girlhood that girls begin to make sense of their bodies, especially in relation to their identity. During this period in a girl's life, one begins to feel social pressure, control, and surveillance. While they may not explicitly understand the power dynamics at play over their bodies, they are introduced to societal norms that they are expected to learn and follow. This section covers only a small percentage of the contributions made within the field of girlhood studies. Nevertheless, I felt it important to acknowledge these contributions and situate the current study within this work that has been and continues to be done.

CHAPTER 3: METHODOLOGY

The current study employs an intersectional feminist framework to provide a nuanced way of understanding eating disorders and the way they are treated by asking the following questions: (1) What impact has dominant eating disorder discourse had on our understanding of eating disorders and related interventions? and (2) How have economic, political, and social factors affected patterns of eating disorders within the Canadian context? This chapter begins with a discussion of researcher dilemmas and the power relations that exist within feminist research. An introduction of the research methods used follows and includes participant recruitment, administering of the survey, the interview process, and participant demographics. This chapter also discusses the analysis of the data using Grounded Theory (Rennie, 2000) and an intersectional feminist thematic analysis.

The aim of this study was to gain in-depth insight into lived experiences with eating disorders in order to discover practical, real-world solutions. An open-ended approach that centered participants thoughts, feelings, perceptions, and experiences was critical. It should be noted, however, that this line of research is highly interpretive. Therefore, the researcher's positionality and biases will be discussed in later chapters of this thesis.

Feminist Research: Power Relations and Researcher Dilemmas

Qualitative methods were chosen due to the exploratory, open-ended, and authentic nature of this category of research. Karnieli-Miller, Strier, and Pessach (2009) state that:

> Qualitative inquiry, in general, though there are significant variations between its different paradigms and traditions, proposes to reduce power differences and encourages disclosure and authenticity between researchers and participants. It clearly departs from the traditional conception of quantitative research, whereby the researcher is the ultimate source of authority and promotes the participants' equal participation in the research process (p. 279).

Because power differences are an inherent component of research, it was important to choose research methods that attempt to minimize these differences. The study and critique of power relations is inherent to intersectional feminist research. Therefore, it would be hypocritical, and potentially even dangerous, to intentionally reproduce power differences throughout the research process. However, Karnieli-Miller, Strier, and Pessach (2009) continue by explaining that "it is precisely this admirable desire to democratize the research process, and the tendency to question traditional role boundaries, that raises multiple ethical dilemmas and serious methodological challenges" (p. 279). Because of this, researcher self-reflexivity is essential.

Collins (1999) notes the importance of acknowledging the power relations involved in the creation of outsider-within locations. She states:

> [P]eople in outsider-within locations do not all arrive there via the same mechanisms. African American women, Asian Indian women, Japanese American women, and White American women may all be considered "outsiders-within" …but quite different group histories got them there. When looking at "outsiders-within" whose status derives from cross-cutting systems of power, some "outsiders-within" are clearly better off than others (Collins, 1999, p. 86).

Although my research will focus on a group of individuals with something in common (having lived experience with an eating disorder), it is crucial that I acknowledge that no two experiences will be the same. The trajectory that each participant's life has followed, particularly their social location and where they fall on the hierarchy of power, has a significant influence on how their eating disorder presents and how it is experienced.

The purpose of this study is to provide insight into a very concerning and timely social issue while being as transparent as possible. While yielding interesting data is a goal of this study, the main goal is to use these findings to create potential solutions for this very serious problem. I truly hope my research can, at the very least, be used to provide insight into this subject and create change within my own community of Nova Scotia.

Research Methods

Two types of qualitative methods were used to collect data. The first method was a survey that consisted of a demographic questionnaire and a series of open-ended questions pertaining to lived experiences with an eating disorder(s). The second method was in-depth expert interviews with service providers for those with lived experience of an eating disorder(s). I collected data from participants that emphasized lived experiences and examined the effectiveness and accessibility of eating disorder related resources and interventions in Nova Scotia. Asking questions regarding positionality and lived experiences allowed the research to be situated within a larger socio-geo-political context.

Surveys

I opted to use open-ended surveys to create space for participants to describe their thoughts and experiences in their own words. It was important to choose a method that would yield rich data while also prioritizing participant comfort and safety. For this reason, more invasive methods of data collection (focus groups, interviews) were not chosen. To participate in the survey, individuals were required to have lived experience with an eating disorder, identify as a woman or non-binary, be between the ages 18 and 30, and live in Nova Scotia.

A combination of convenience sampling and purposive sampling was used to recruit participants. This means that several (survey) participants were recruited using my personal social media accounts which consist of my own friends, family, and acquaintances. Rather than a sample of pure convenience, however, purposive sampling was used to ensure that participant criteria was met. Virtual recruitment methods were chosen due to the ongoing high frequency of COVID-19 cases and restrictions within Nova Scotia. Word of mouth was also used to recruit participants. The resulting sample consisted of a variety of different social locations and positionalities. It should be noted, however, that there is an underwhelming amount of diversity due to limitations regarding recruitment methods, pandemic restrictions, and my own online connections.

While interview participants were being recruited via email, the survey portion of the research was distributed via social media. The survey was first created using Qualtrics. However, this tool was not compatible with the social media platforms it was being shared on. The survey was then generated using Survey Monkey, but the same issue ensued. Finally, the survey was created using Google Forms and was able to be shared across social media platforms. The social media platforms used were Facebook, Instagram, and Twitter. The survey was open for approximately one month and a total of 26 participants were recruited. Survey responses were printed for a qualitative analysis to be conducted. For the sake of privacy and confidentiality, pseudonyms have been used to refer to participants. The acronym SP, for study participant, and a number have been used to identify survey participants (ex: SP #20, SP #21, SP #22, etc.)

In-Depth Expert Interviews

A total of four participants were recruited to participate in in-depth expert interviews. Interviews were chosen for service providers as I concluded that there would be minimal risk for those involved. Interview participants were required to have experience treating individuals with eating disorders within Nova Scotia. Recruitment for interviews was targeted towards service providers in professions such as clinical/counselling psychology, psychiatry, clinical social work, and dietetics and nutrition.

A combination of convenience sampling, purposive sampling, and word of mouth were used to recruit interview participants. After receiving approval from the Saint Mary’s University Research Ethics Board in early February of 2022, the data collection process began by conducting extensive internet searches of service providers with experience treating individuals with eating disorders within Nova Scotia. A list of over 30 service providers was created and consisted of psychiatrists, psychologists, clinical social workers, and registered dieticians, with experience in private practice, public health, or both. Approximately eight recruitment emails were sent out throughout the remainder of February. However, no responses were received. Approximately ten additional recruitment emails were sent out throughout the month of March. Several service providers responded but were unable to participate. Two service providers expressed interest, both psychologists working in private practice. Individual interviews were scheduled with each service provider. A description of the research, a consent form, and a copy of the research questions were provided to participants prior to their scheduled interview (see Appendix A.4 and A.8 for a copy of these documents). Interviews then took place via zoom. Interviews were followed by transcription of the data.

Twelve more recruitment emails were distributed, and a third interview was scheduled for the month of April. The fourth and final interview participant was recruited by the previously mentioned participant and a fourth interview was scheduled during April. Research materials (interview questions and consent form) were provided to each participant in advance of the scheduled interviews to give people (a) an opportunity to reflect on the questions, and (b) enough information to make an informed decision about whether or not they wished to participate. Interviews ranged from 25 minutes to 45 minutes in length and were digitally recorded with participants' permission. For the sake of privacy and confidentiality, pseudonyms have been used to refer to participants. The acronym IP, for interview participant, and a number have been used to identify interview participants (i.e., IP #1, IP #2, IP #3, IP #4).

Transcription, Coding, and Data Analysis

Surveys

Analysis of the survey data began with the printing of each individual survey which was used to conduct an initial review of the data in order to identify preliminary themes. These initial themes were then used to create codes. Coding was conducted by reviewing each survey and highlighting prominent quotes. This process allowed me to identify specific reoccurring themes that emerged throughout the data. Surveys were reviewed a total of 5 times to refine relevant codes and themes.

In-Depth Expert Interviews

Analysis of the interview data followed a similar formula as the analysis of the survey data. It began with transcribing digital recordings of interviews with service providers. I listened carefully to all digital recordings and transcribed each interview, word for word, using Microsoft Word. Once transcription was complete, the transcribed interviews were printed and reviewed. After a preliminary review of the data, a relevant classification system was created to help organize the interview data in order to identify overarching themes and generate codes. I completed a coding phase by going through each interview and highlighting prominent quotes. I continued by sorting chunks of data into general themes and sub-themes. I examined each of the chunks of data and their corresponding themes/subthemes once more to refine themes/subthemes and make final revisions.

Data Analysis and Major Themes

Data analysis yielded two major themes: Power and Social Control and Fatphobia. The first theme, Power and Social Control, draws attention to the hierarchies and power relations involved in eating disorder discourse and treatment. It also highlights the models used to understand eating disorders and the diagnostic criteria used to treat eating disorders, and how each of these things contributes to a culture of inaccessibility. The second major theme, Fatphobia, represents the rampant fear and intolerance of not only fatness, but also of difference, in medicine, research, and society at large.

Subthemes have also been identified and include normalization, restriction, inaccessibility, and interpersonal relations. Sub-themes and relationships between themes were examined to construct one over-arching theme that cuts across all the data that has been termed “One Size Fails All”. In other words, the data shows that much of what we know about eating disorders (what they are, who they affect, how they are treated, underlying causes) is unrepresentative and insufficient.

Positioning the Participants – Demographics

Before diving into an in-depth analysis, it is important to acknowledge and explore the unique identities and positionalities of each participant. Survey participants were asked to complete a demographic questionnaire which included questions that explored:

a) Age
b) Gender identity
c) Sexual identity
d) Racial identity
e) Ethnicity
f) Citizenship
g) Location within Nova Scotia
h) Highest level of education
i) Employment status

j) Relationship status

k) Children/dependents

l) Income

m) Religion

To participate in the study, participants were required to be between the ages 18 and 30. Ages ranged from 18 to 27, with 54% (14) of participants falling within their mid-twenties. Next, participants were asked to disclose their gender identity. The study was particularly interested in the experiences of self-identified women and/or non-binary folks. Therefore, all participants fell somewhere along this spectrum, with 72% (19) identifying as female, 8% (2) identifying as women, 8% (2) identifying as she/her, 8% (2) identifying as non-binary, and 4% (1) identifying as femme non-binary. Participants were then asked to describe their sexual identity. Forty-six percent (12) of participants identified as straight/heterosexual, 26% (7) identified as bisexual, 12% (3) identified as lesbian, and 8% (2) identified as unknown/unsure. It appears that some participants misunderstood the question as 8% (2) of participants indicated that their sexual identity is “female**”.**

Next, participants were asked to share their racial identity. Seventy-six percent (20) of participants identified as white/Caucasian, 4% (1) identified as Indigenous, 4% identified as African Nova Scotian (1), and 4% (1) identified as mixed-race. Another 4% (1) of participants described their identity as “Hispanic”. It should be noted that the women and gender studies discipline views this as a colonial term. Therefore, I have opted to use the term Latinx to describe this participant instead. It appears that some participants misunderstood the question as 4% (1) responded “conservative”, while another 4% (1) responded “N/A”. Participants were then asked to share their ethnicity. Some described their ethnicity as Canadian, European Canadian, British-

Canadian, Irish, and Cuban. Others described it using physical characteristics such as race (Caucasian/white, Indigenous, white and Indian/South Asian, African Nova Scotian). When asked to share details of one's citizenship, 100% (26) of participants indicated that they are Canadian.

Participants were required to be current residents of Nova Scotia to participate in the study. Most participants, 65% (17) reported that they reside within the Cape Breton Regional Municipality. The remaining number of participants, 35% (9), reside on the mainland of Nova Scotia (Halifax, Dartmouth, Wolfville, Annapolis Valley). Next, participants reported on their highest level of education, with 85% (22) of participants having some type of post-secondary education (post-secondary, college, university, bachelor's degree, post bachelor's degree, master's degree) and 15% (4) having completed up to high school. The following question assessed employment status. Seventy-three percent (19) of participants reported being employed (part-time, full-time, self-employed), 19% (5) reported being unemployed, while the remaining 8% (2) reported that they are students.

When asked to share their relationship status, Fifty-eight percent (15) of participants reported being in some type of relationship (taken, in a committed/long-term relationship, in a relationship, engaged) while 42% (11) reported being single. Participants were then asked to disclose whether or not they had any dependents. Ninety-two percent (24) of participants reported that they do not have any dependents. Eight% (2) percent of participants reported that they do have dependents, one being a parent of two children, and another being a guardian for their younger sister. Next, participants reported on their annual household income. Nine-teen percent (5) of participants reported earning a household income of $20,000 or less a year, another 19% (5) reported earning $20,000 to $30,000 a year, 23% (6) reported earning $30,000 to

$40,000 a year, 8% (2) reported earning $40,000 to $50,000 a year, and 27% (7) reported earning $60,000 or more annually. The final 4% (1) of participants did not respond.

The final question of the demographic questionnaire asked participants to report their religion (if applicable). Responses ranged from Christian (4%, 1), to Catholic (12%, 3), to Agnostic (4%, 1), to Atheist (4%, 4). Forty-six percent (2) of participants did not respond and 8% (4) of participants indicated that it is not applicable/they do not have a religion. Finally, 4% (1) responded with "Cape Breton Regional Municipality) and it appears that they did not understand the question. A summary of each participant's demographics can be found in Appendix A.2.

While interview participants were not directly asked to share information on their own positionality/social location, the topic did arise in some discussions. Additionally, each participant had information pertaining to positionality on their online professional profiles (such as their preferred pronouns). Of the four interview participants, three identified as cisgender women and one identified as queer non-binary. All four interview participants were white. Other factors such as sexuality, ethnicity, age, and religion, were not discussed. Questions surrounding each participant's education and training were asked and have been summarized below:

Table 3.1: Interview Participant (N=4) Training and Frameworks

Designation	Education	Type of Practice	Frameworks
Psychologists Dieticians	Graduate degree in Clinical Psychology Bachelor of Science in Nutrition	Private practice Public health Community-based organizations	Dominant psychology frameworks used: • Cognitive Behavioural Therapy • Dialectical Behaviour Therapy Less common frameworks used: • Intersectional Feminism • Fat Liberation • Health at Every Size • Intuitive Eating • Anti-Oppressive

Based on each participant's professional designation and work in private practice, it is assumed that they each fall within the middle to middle-upper class. Each participant comes from different educational and professional backgrounds, but they have all performed eating disorder related treatment and intervention. It has become clear that not asking interview participants direct questions surrounding positionality is a major limitation to this study. Service providers are not objective, detached bodies within their clinical/therapeutic relationships. Their own social location shapes their experiences as service providers, similar to how patients' social locations influence their experience within the therapeutic setting and their experience with eating disorders more broadly. It is impossible to fully understand the intricacies of therapeutic relationships or assess their effectiveness without taking both sides of the relationship into account.

Although this section has simply described participant demographics, it is a critical step in the research process. A true intersectional feminist analysis cannot be conducted without acknowledging how each participant's unique identity positions them within the research context. Further, it is important to be transparent about whose voices are being represented within this study. Participants in this study predominantly identified as women/female, straight/heterosexual, white/caucasian, middle-class, and were in their mid-twenties. From this, it can be observed that participant demographics largely resemble the stereotypical imagine of someone with an eating disorder. I must acknowledge that this unrepresentative sample may present the same dilemmas that I have attempted to critique throughout the entirety of this thesis. Moreover, I must consider why my research mostly attracted participants from these dominant social groups. While there are obvious limitations due to the severe lack of representation in participant demographics, there is an opportunity to analyze and unpack this in a meaningful way. This information will be explored, analyzed, and unpacked from an intersectional feminist lens in more detail in the following chapter.

Chapter 4: “You Should Probably Lose Weight”: From Normalizing Eating Disorders to Pathologizing Fatness

In this chapter, I employ an intersectional feminist theoretical framework to analyze and unpack current discourse surrounding eating disorders. This was done by drawing attention to the systemic, institutional, and social relational factors that impact the lived experience of self-identified women with eating disorders in Nova Scotia by offering an analysis of the responses offered by participants. The overarching theme of this chapter is “You Should Probably Lose Weight”: From Normalizing Eating Disorders to Pathologizing Fatness and features participant responses that fall within this theme. More particularly, the analysis draws on the body of literature discussed in Chapter 2 to situate the findings within a broader context. This chapter explores how the social construction of the body exerts a degree of disciplinary power and uses this power to govern thoughts, attitudes, and behaviours. Specifically, it draws attention to how dominant discourses surrounding eating disorders perpetuate and sustain a culture of consumption, restriction, and intolerance. This chapter is broken down into subthemes/sections to provide a clear and concise analysis of the data.

“That’s a skinny girl’s problem”: Constructing and Contesting the Fat Body

As discussed in the literature review, Morris (1999), Hankivsky and Christoffersen (2008), and Hankivsky et al. (2010) discuss the degree of normalized expectations that we are bombarded with daily, especially in relation to health research. They emphasize that representations, or differences, have become homogenized in order to create a culture of western assimilation. In particular, they draw attention to the traditional foci of Canadian health research on women and how this research tends to essentialize the category of woman. As a reminder, they state that:

> the traditional foci of Canadian health research on women tends to essentialize the category of women (that is, assumes that all women, regardless of age, cultural background, geographical location, socioeconomic status, religion, sexual orientation and other categories of difference, share exactly the same experiences, views, and priorities), and further, gives too much primacy to gender over other key determinants and does not adequately address the interactions among all determinants of health. Consequently, the issues and priorities of many vulnerable women, including members of ethnic, racial, and linguistic minorities, [Indigenous] women, low-income women, lesbians, and women with disabilities are usually excluded from mainstream women's health research (Hankivsky et al., 2010, p. 1).

Therefore, difference is tolerated to an extent. Mostly, however, those who vary too far from this homogenized category of difference face ostracization, lack of representation, and ultimately oppression. One category of difference that was frequently mentioned by both survey and interview participants is those who occupy fat bodies. While the Body Positivity and Fat Acceptance movements have become increasingly popular, there remains a lack of representation of fat bodies in healthcare, research, and media. Further, there is a hierarchy of desirability based on where one carries fat. In order to make leaps and bounds, representation needs to extend much further past the norm.

This lack of representation is especially prominent in eating disorder related healthcare. Participants discussed experiences of lack of representation and fatphobia and how they lead to barriers in help-seeking situations. SP #29 stated "my weight [is a barrier]. Plus sized individuals are just 'getting healthier,'" while SP #35 said "being plus sized, it sometimes feels hard to be taken seriously." SP #32 did not disclose being plus-sized, but they did disclose that "not fitting the physical stereotype of someone with an ED" has been a major barrier. Similarly, SP #36 stated that "BMI prevented me from accessing serious medical intervention because I was never considered underweight, even when starving myself." There has been an almost gatekeeping of eating disorders, especially in medical and other help-seeking situations. Jutel (2009) explains that the "link between health and beauty is neither simply historical, nor limited to lay perspectives and advertising. How an individual looks when he or she presents for medical consultation is likely to have a strong influence on the diagnostic process" (p. 65).

This idea that fat people are "just getting healthier," as reported by participants, runs rampant within medical and clinical communities. It perpetuates another unfounded belief: that being fat and being unhealthy are synonymous and, in turn, that being thin and healthy are synonymous. How someone looks does not paint a full picture of how healthy someone truly is. On the official website of the world-renowned Mayo Clinic[1] (*About Mayo Clinic – About Us*, 2022), they claim that obesity "isn't just a cosmetic concern." They continue by stating that "it's a medical problem that increases the risk of other diseases and health problems."

This section from the Mayo Clinic is followed by a segment of text that discusses the improvements associated with weight loss: "The good news is that even modest weight loss can improve or prevent the health problems associated with obesity" (AMC, 2022). Their so-called solutions to obesity involve a healthier diet, an increase in physical activity, and behaviour changes that aid in weight loss. They conclude by informing website viewers that "prescription medications and weight-loss procedures are additional options for treating obesity." This is an example of how fatness is pathologized. When one of the world's largest medical facilities deems fatness a "complex disease" that requires intervention and openly platforms anti-fat rhetoric, credibility and acceptability is given to fatphobia. Further, it creates a barrier for those seeking help and indirectly promotes body related issues.

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[1] The Mayo Clinic is a private, non-profit, healthcare organization and academic medical centre that focuses on integrated healthcare, group practices, hospitals, and programs in biomedical research and education. It is comprised of three locations, one in Minnesota, one in Arizona, and another in Florida (*About Mayo Clinic – About Us*, 2022).

While participants with lived experience of an eating disorder have pointed out how fatphobia influences help-seeking experiences, it should be noted that service providers working in this field have also acknowledged this problem. IP #1, a registered clinical psychologist, expressed great frustration with how fat people are viewed and treated in medical/clinical settings. When asked if there are certain groups who are less likely to be diagnosed or seek help, IP #1 said:

> People who are fatter frankly. Their doctors reinforce it by saying “you don't like yourself” or “you're feeling depressed” and they don't ask about their eating, how they relate to their body, or how they've been traumatized by the medical system. They just tell them, “You should probably lose weight.” So, I find they take a lot longer to get into my office, have a hard time believing me, and have a hard time asking for help from their doctors.

This quote displays the gravity involved when medical practitioners and/or other service providers do not incorporate fat acceptance into their practices. As Zola (1983) and Jutel (2009) have pointed out, medicine is not neutral or objective. Rather, it is steeped in cultural values. Moreover, the context and environment in which healing takes place is an incredibly important component of the healing itself. This participant’s response demonstrates the damage that can occur when a safe, inclusive approach and environment is not provided. IP #1 continues by sharing:

> It’s really tricky, because for eating disorders we’re doing a lot of consultation and coordination of treatment with doctors because there's such a medical component to treatment. So, they take a while to come in and to tell me and they often don't think that they actually have one, even though they're restricting every day. They're like, “that's a skinny girl’s problem” …So their whole life, they think that they're supposed to be starving themselves and their body is the problem. And that isn't true. But people who are fat are treated less and discriminated against. It's a really hard battle.

The work of LaMarre, Rice, and Jankowski (2017) discusses how fat people’s stories are continuously omitted from literature that details the success of eating disorder prevention. Moreover, they assert that obesity prevention needs to be challenged as it vilifies fatness and creates the erasure of fat bodies. Because fat bodies are often omitted from these conversations, it is no surprise that many people end up feeling like eating disorders are “a skinny girl’s problem”. Medical professionals, such as general practitioners and family doctors, are thought of as legitimate figures of authority when it comes to matters related to the body. When these authority figures are the very people exclaiming that fat people need to lose weight, it justifies fatphobia and reinforces patients’ beliefs that the size and shape of their body is a problem that needs to be solved. Moreover, this individualism and personal blame diminishes the ways in which fatphobia is a systemic issue.

Another service provider, IP #3, who is a registered dietician, shared similar observations in her practice:

> People living in bigger bodies are less likely to be diagnosed and receive care. I had an assessment with a client, she's a nurse and she said to me, “I was overweight and undernourished.” I think individuals in bigger bodies can sometimes get missed, because how can they have an eating disorder? They're not small, right? I would say that they’re less likely to be diagnosed, but also maybe less likely to go get help and reach out and say, “I'm struggling with my eating”. Because they've also been told to diet a lot of times by people in their life, by friends, family, partners, healthcare workers. And so, I think sometimes their story, their narrative gets diminished and gets dismissed. I would say probably lived experience in a bigger body may impact someone reaching out or someone recognizing that they have disordered eating.

This quote exemplifies how social relational factors, such as our environment and those we interact with, can uphold a culture of fatphobia. Family doctors, in particular, are often an initial point of contact for those hoping to pursue professional help. If it is these very doctors that are spewing anti-fat rhetoric, patients are at risk of being harmed and are unlikely to continue seeking help. However, when someone is surrounded by friends, family, partners, peers, and others who are also making fatphobic comments, it is likely that they will never pursue professional help.

SP #36 who shared that the BMI prevented them from accessing professional help because they were never considered underweight shared that this issue was further compounded due to their queer identity and other mental illness diagnoses. They shared:

> Stigma and lack of education have made it difficult for me to pursue doctors as I experience imposter syndrome with my disorder and am scared of being told it's not real. I have several other mental illness diagnoses, and am queer, which adds to my fear and anxiety when it comes to any sort of care.

This highlights the importance of acknowledging and creating space for differently positioned people and their intersectional identities, particularly within the medical community. Burke et al. (2020) discuss how disease risk (in relation to eating disorders) may increase when an individual occupies two (or more) high-risk identities, when compared to each identity in isolation. In SP #36's account, their queer identity in combination with their multiple mental illness diagnoses may place them at a higher risk and influence their lived history with an eating disorder. All of the isms and phobias, such as racism, sexism, classism, fatphobia, transphobia, homophobia, xenophobia, are a part of our cultural landscape and exist within these institutions. In fact, they are a part of the very framework that these institutions have been built upon. Therefore, it is essential that we employ models of care that thoroughly consider how the multiplicities of people's identities impact their lived realities, including eating disorders. I conclude that without taking an intersectional approach to healthcare, individuals are less likely to receive adequate and relevant care and are also at great risk of being harmed by their service providers and the medical community at large. Alternatively, individuals may opt to refrain from engaging in help-seeking as a protective measure, as can be observed in the case of SP #36.

"I don't restrict, I'm fat": The Normalization of Restriction

Restriction plays a major role in many eating disorder related experiences in a variety of different ways. For those who have experiences resembling anorexia nervosa, food restriction may be a symptom of their disorder. In fact, 73% (19) survey participants reported engaging in some form of restriction when asked to disclose what eating disorder symptoms they experience on a day-to-day basis:

Table 3.2: Survey Participant Symptoms

Participant	Quote
SP #20	"restrictive guilt"
SP #21	"struggling to eat or not eating"
SP #24	"fasting and excessive exercise"
SP #25	"not allowing myself to eat"
SP #26	"feeling a sense of accomplishment for making it past a certain hour of the day without eating"
SP #28	"forgetting to eat for hours or days at a time"
SP #29	"using lack of food as punishment"
SP#33	"I still only eat one meal a day before bed"
SP #36	"not eating enough"

Restriction through the means of purging after binge eating is another experience reported by participants: "purging anything over my set limit for the day" (SP #23), "shame/guilt/fear of eating too much which results in purging" (SP #25), "binging and purging" (SP #40).

When you search the definition of restriction on Google, the definition that best describes it in this context is "the limitation or control of someone or something, or the state of being limited or restricted" (Google, n.d.). The use of the word control to describe restriction is incredibly interesting yet unsurprising. This definition can be explored in relation to the concept of disciplinary power as introduced by Foucault (1977). Although there is often no physical entity who is constantly present and directly governing our food intake, an overarching social control is very much present and plays a huge role in our consumption and, therefore, our restriction. Food intake has become something that requires monitoring. If we consume more than what is deemed normal or appropriate, there is often shame and guilt associated with it.

Restriction and consumption cannot be addressed without acknowledging the fatphobia that is inherent within this discourse. There is a social belief that restriction has been reserved for thin individuals. IP #3 shared an anecdote about clients who do not believe that they engage in restriction because of their size:

> I've heard a lot of clients ask about restriction who will say, "well, no, I don't restrict, I'm fat." And then I'm like, okay, but you're not eating enough during the day. You actually are restricting; you're not getting enough.

This quote emphasizes the degree to which the experiences of people occupying fat bodies have been invalidated and delegitimized. It is a serious concern when individuals cannot recognize the harm being caused because they have been gaslit into believing that the size of their body makes it impossible to engage in practices such as restricting.

In general, restriction is something that is tolerated and accepted. However, there are sometimes exceptions when those who are engaging in it are very thin. When a fat person restricts, it is typically viewed as them trying to better themselves. A major contributor to this problem is that healthy has become too closely associated with desirability. People are constantly using healthiness as an excuse to engage in fatphobia. Wright (2009) draws attention to the guidelines imposed for managing our bodies, which include moral implications for how people should look and act. Bodies, especially deviant bodies, are constantly under surveillance "under contemporary, Western, neoliberal capitalism" (LaMarre, et al., 2017, p. 250). Fat bodies are particularly and unfairly susceptible to this constant surveillance.

For example, fat celebrities are often shamed for celebrating their bodies because it allegedly promotes an unhealthy lifestyle and encourages obesity. Singer Lizzo, for example, is constantly criticized for glorifying obesity and an unhealthy lifestyle simply because she exists in a fat body. However, some folks (from celebrities all the way to my own peers) constantly engage in practices that are potentially harmful to the body, such as cosmetic procedures (breast implants, lip injections, Botox, liposuction) or performance enhancing supplements (steroids), that are not given the same degree of criticism that fatness is given. Although health is supposedly at the forefront of these fatphobic beliefs, it is clear it has much more to do with desirability than it does health. Moreover, I assert that healthiness is not something anyone owes to anyone else. Fat people who choose to engage in an unhealthy lifestyle (whatever that may mean) are just as deserving of acceptance, happiness, love, and ultimately life as anyone else. Fatness is not a moral failure.

This feeds into the degree to which engaging in harmful restrictive practices has become normalized. IP #2 a registered psychologist, shared:

> I think we've really normalized disordered eating, especially with the rise of health influencers, healthy eating, and all of that BS. People are normalizing things like the keto diet, or intermittent fasting. And as I always tell my clients, intermittent fasting is a diet culture word for restriction. And that's not good. I think there's a lot of normalization of that.

The Keto diet, for example, has become so normalized that many restaurants have opted to include Keto options on their menus. A locally owned pizza shop in Dartmouth, Nova Scotia for example has a section of their menu/website dedicated to Keto pizzas. Restaurants are quite literally creating space for glorified eating disorders. There are other practices that have become so ingrained within Western culture that they are no longer considered diets such as vegetarianism and veganism. IP #4 shared similar thoughts around the pervasiveness of diet culture and the mediums in which it presents:

> Diet culture is so accepted and it's really easy to push these restrictive eating patterns under the rug. Or blame it on, for example, one that I see all the time is vegan[ism], like following a vegan or vegetarian [diet]…that would often be one of the biggest red flags that I would see…there's a big drive for plant-based diets, so that's really easy to just kind of fall between the cracks. Diet culture and restrictive eating is a big one. And then, it's

> not a diagnostic criterion, but orthorexia[2] would be another one that also I feel really falls into that clean eating or eating whole foods and that type of lifestyle. Even weight loss is so normalized and celebrated. And nobody asks how a person really has lost the weight…For folks with eating disorders who have experienced weight loss, they get celebrated for having their weight loss, and then it just kind of grows legs and snowballs.

Although plant-based/health-food diets are not inherently eating disorders, any type of diet that requires restriction and monitoring of food intake creates increased risk of developing problematic food related thoughts and behaviours. There is also often a degree of morality and superiority associated with plant-based, clean, and whole food diets in the Settler Global North. Engaging in these diets is also largely unaffordable and inaccessible. However, it is this very inaccessibility that attributes a sense of exclusivity to being able to purchase health food products. These plant-based, clean, healthy diets also further perpetuate fatphobia as they are exclusively associated with thin individuals who are well off. It is critical to note, however, that I am approaching this analysis in the context of diet culture and capitalism. There are political, cultural, and/or religious aspects of engaging in vegetarianism/veganism that are elided when they are only associated with eating disorders.

This promotion of diet culture goes much deeper than the promotion of fad diets. Under a capitalist regime, it is impossible to escape the persistent inundation of products that are designed up help us “love” ourselves. These products often target our bodies and appearance. IP #1 provided a noteworthy analysis of this:

> We have multi billionaire industries, but I don't think humans have a good concept of what money really means. But that means billions of dollars are being made off of hating ourselves and our bodies for “self-improvement”. It’s really normalized to be on a diet, normalized to have New Year's resolutions of getting back into the gym, or fixing yourself by doing clean eating.

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[2] “Orthorexia is a term that describes an obsession with eating healthy food. It comes from the Greek words ortho, mean “correct”, and orexis, meaning ‘appetite’” (*What is Orthorexia Nervosa?,* 2021).

Capitalism has us trapped in a vicious cycle: We are bombarded with capitalist messaging that encourages us to hate ourselves. We then engage with capitalism by purchasing what it is selling in the hopes that we will feel accepted and loved. Unfortunately, this only feeds the capitalist beast, making it stronger and strengthening its grip on us. Hesse-Biber's (2007) previously discussed examples of the extreme measures people will take to modify their bodies in order to appear more desirable exemplifies the power of oppressive systems. To recount, she mentions everything from tinted contacts to self-tanning products, all the way to diet pills to address the extent people are willing to go to achieve the perfect body.

Although product advertisements often emphasize self-love and feeling good about oneself, capitalism relies on us hating ourselves to turn a profit. Tsouluhas (1999) discusses the concept of an "internalized disciplinarian" which she describes as the consumption of the disciplinary practices of femininity. It is this internalized disciplinarian that capitalism depends on to keep its motor running. Even movements that have been created to contest the capitalist agenda have been co-opted and taken advantage of. Take the body positivity movement for example, as discussed by IP #1:

> Even the conversations about body positivity are sometimes being weaponized and being used incorrectly. And there's been a lot of interesting discourse to see where that movement is going. I'm definitely no expert to speak on this, but I think body positivity has been co-opted by companies to make money. Aerie is a great example of that. I do love the diversity in their models and I do think that's a very positive change. But the whole body positivity is "come spend money here and we'll make you feel better about yourself". It's really hard discourse because I see a lot of thin bodies being mostly liked still within those kinds of posts online, which it's not like I don't want those folks to love themselves. It's just, can we please center fat people? Have more conversations about fat liberation? It's still overall better. But I just think it's being used with a capitalist agenda at this point.

The body positivity movement's origins can be traced back to the 1960s with the beginning of Fat Activism and Black Civil Rights movements. Unfortunately, the movement has strayed far from its roots and is being co-opted by those who have been centered throughout history. It is not uncommon to see young, straight, thin, cisgender, white women posting provocative photos online with the caption "#BodyPositivity." This is a far cry from where the movement began and only further harms those who the movement was originally created by and for. When it comes to companies such as Aerie, it is positive to see increased representation within their media and marketing. However, they are marketing off and relying on the exclusion of certain demographics of people to increase their clientele and therefore increase profit. While it would be nice to consider this a shift in the right direction, the ongoing harm this causes cannot be ignored.

This can be circled back to the discussion of restriction. While restriction is largely thought of as limiting food intake in the context of eating disorders, this co-opting of and exclusion from movements is a sort of forced restriction that differently positioned people are forced to endure. Fat people are consistently excluded from spaces, even those that have specifically been created by and for them. This exclusion is even more extreme for those who are further marginalized due to race, class, gender, sexuality, ability, and other social experiences and locations. The social control that is held over fat bodies and other marginalized bodies creates restricted access to the conversations and spaces that allow for real change to occur.

Take white fragility and white guilt for example. White discomfort co-opts and refocuses discourse to prioritize white folks' needs and further distracts from the oppression experienced by racialized people (DiAngelo, 2018; Parasram, 2019). I propose that this co-opting and refocusing applies not only to relationships between white and racialized people, but can be extended to any and all environments, contexts, relationships, and conversations that involve an imbalance of privilege and marginalization. When the spaces that have been created to dismantle these power structures are being co-opted and taken over by the oppressor, it leaves little space for those truly being affected to have a voice.

“It’s a Minefield”: The Body and Social Media

Many survey participants expressed how social media negatively impacts their eating disorder. With the prominence of social media, diet culture and its related capitalist agenda is more pervasive than ever. Platforms such as Instagram have become a breeding ground for frequent promotion of diet culture and social comparison. Participants shared that social media “make[s] me feel the most guilty” (SP #1), “ha[s] had a significant impact on my eating disorder” (SP #2), “creates pressure on ‘the perfect body’” (SP #9), “h[as] a negative impact (constant posing, photo editing software, promotion of ideal body types)” (SP #12), “is the biggest influence with my disorder, I’m constantly comparing myself to others” (SP #14), “is a minefield. I feel I can navigate the comments in real life fairly well, but the visuals on social media and in marketing have a heavy impact” (SP #17), and “affects me, I have to go off of it sometimes. I compare myself to other women and wish I looked like them” (SP #24). SP #26 stated that:

> I also specifically avoid many social media platforms like Instagram and beauty influencers that promote unhealthy/unrealistic standards of beauty. In general, I find that keeping only body positive influences in my environment have allowed me the space to build up myself-confidence while building better habits.

Social media’s degree of accessibility makes it difficult to escape. We live in a world where we are constantly plugged in, constantly connected to one another. This also means that we are constantly exposed to the dominant culture and its values that are reproduced through the media. On applications such as Instagram, people are constantly sharing images of themselves. With the prominence of beauty filters, photo editing applications, posing, camera angles, good lighting, and much more, the line between what is real and what is not has become blurred. Although social comparison is not new, social media has created a whole new danger. The presence of these features results in people comparing themselves to versions of others that do not actually exist. This is especially apparent in instances where photo enhancements are not so obvious.

Participants' examples of how social media has impacted their wellbeing demonstrates the severity of its affects. Ultimately, social media is a medium for disciplinary power (Foucault, 1977), making it almost inescapable. While it presents in many ways, it is especially present through mass surveillance and social categorization. Although there is a degree of choice in what we post online, there is also a degree of social pressure to stay connected and fit in. Moreover, the desire to be validated by likes, comments, and messages is a strong driving force behind our choice to post online. By sharing parts of ourselves online, we are constantly under the surveillance of one another. In her discussion of the relationship between disciplinary power and the body, Hesse-Biber (2007, p. 45) posits that the "natural body" gets lost in the pursuit of western beauty's latest trends. It can be argued that social media has made this even more prominent as we are now able to completely alter our appearance without making any physical changes to our body. This makes the natural body appear more and more unnatural and abnormal, likely causing increasing amounts of stress, insecurity, dysmorphia, and dysphoria toward our own natural bodies.

Not only is Instagram plastered with heavily edited and filtered posts of people appearing to have the ideal body, but it also serves as a major marketing platform. Recent updates to the app allow companies to sell their products directly through the app itself. Individuals have used this to their advantage as well to pursue entrepreneurial projects. Multilevel marketing schemes became particularly popular and were often centered around weight loss and beauty related products. SP#11 wrote the following in their survey:

> Seeing posts on social media from women in my family who are trapped in MLMs is triggering because they treat "fatness" as a consequence of personal actions, rather than as a result of genetics. They claim that their products will cure digestion issues or things like IBS (therefore implying that people with these issues are suffering because they don't care enough to find a solution themselves).

It is extremely difficult to constantly be overburdened by major corporations looking to turn a profit. It is even more difficult to be bombarded with this content by your own family and peers. This demonstrates the reach that disciplinary power has. Its impact is so strong that people are feeling its influence through their own loved ones, who are likely unknowingly reproducing this social control.

Social media has also had a profound influence on discourse surrounding eating disorders and how they continue to be stigmatized and normalized. Because we live in a world in which we are constantly plugged in, it is extremely difficult to escape the constant promotion of diet culture and beauty ideals. Further, social media in general, but especially Instagram, is a place where we are expected to share only the best versions of ourselves and our lives. Therefore, it is seen as taboo for someone to use their platform as a medium for open and honest dialogue surrounding issues such as eating disorders. We are constantly under the scrutiny of one another in the virtual world and many individuals will do their best to avoid sharing parts of themselves that they believe will result in even more judgement. An interesting theme that emerged was the duality of normalization and discourse surrounding eating disorders. Eating disorders are common as it has been deemed acceptable to do virtually whatever it takes to achieve what society has deemed the ideal body. But despite its pervasiveness, admitting you have a problem, or, what's more, openly discussing your problem with other people (especially online), has been deemed inappropriate or taboo.

To summarize, engaging in eating disorder related behaviours is accepted and even encouraged, but openly discussing these behaviours has become heavily stigmatized. In terms of specific examples of normalization, many participants reported that their experiences were "never seen as a problem" and that they were not taken seriously. When asked about what barriers have been involved in help-seeking situations, one participant indicated that they were not "being taken serious." They continued "My doctor was never concerned about my fluctuating weight, or sudden/fast loss or increase of weight in short periods of time or obsessing over the gym or how many calories I would eat." In contrast, however, IP #2 shared their thoughts on eating disorders and how they:

> Do think they've been somewhat normalized in a healthy way, or in an adaptive way, in that there is more awareness, there's more education about it. I think even early on in my career, when I talk to people and say, "oh, I want to work with eating disorders", there was such a limited understanding about that. Whereas now, when I'm working with folks, most people have an understanding that there's bulimia and binge eating. But they don't tend to understand the nuances of binge purge subtype or other specified feeding and eating disorders or things like pica. But people do have like, more of a baseline knowledge. So, in that way, it's kind of been normalized education wise, which I guess is a good thing. But yeah, I find the behaviors are kind of like minimized in very unhelpful way.

This participant's perspective demonstrates that progress is being made in the areas of acknowledging that eating disorders do exist and are very prominent and that people are starting to have a basic understanding of what they are. However, this "healthy normalization" does not account for or help explain how eating disorders are, large in part, a product of oppressive power systems or how the social categories in which we belong to need to be acknowledged to fully understand people's experiences.

Tsouluhas (1999) summarizes how eating disorders are a symptom of disciplinary power, or as mentioned above, oppressive power systems, and how they are often a result of backlash against women's liberation. Participants' narratives above can clearly be supported by Tsouluhas' work demonstrating the intersecting systems of patriarchy, capitalism and racism which produce these experiences and effects. It should be noted that this is not only true of women but is very true of anyone occupying marginalized positionalities. Patriarchy, capitalism, and colonialism work to reinforce one another to ensure that this disciplinary power continues its reign. Eating disorders are clearly an example of how these complex systems assert their dominance and maintain power.

Chapter 5: "The BMI requirement is stupid": Definitions and Diagnoses

In the previous chapter, I discussed the concept of disciplinary power and how it pertains to eating disorders. In this chapter, I explore how disciplinary power becomes institutional. This means examining law, policy, academia, medicine, and other institutions and how power is exerted and distributed throughout them, specifically in relation to eating disorders. While all institutions play a role, significant attention was given to educational, clinical, and medical institutions and how they create and reproduce injustice towards those with lived experience with eating disorders.

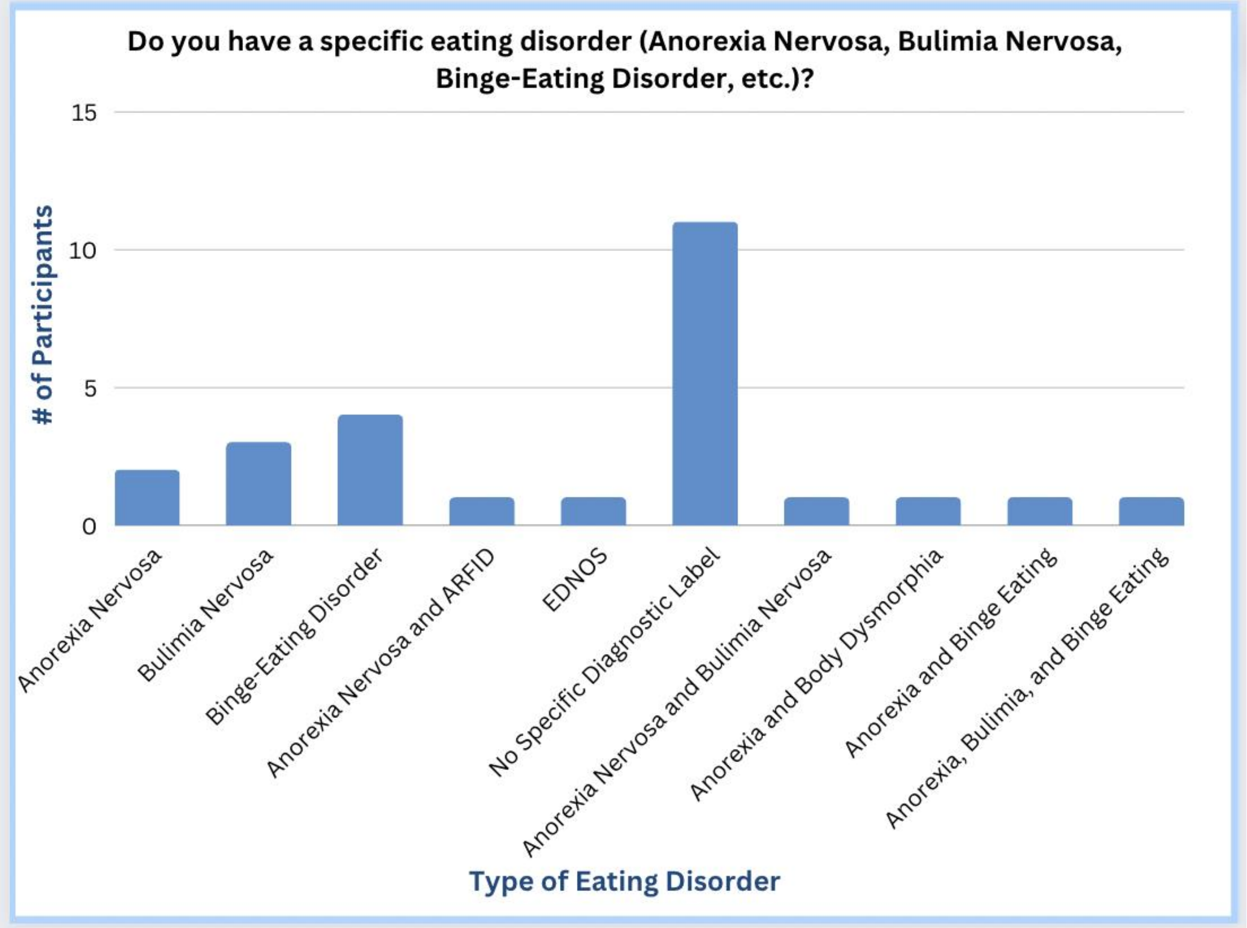
Clinical and medical approaches are among the most common approaches to understanding and treating eating disorders. In fact, receiving a diagnosis is done through clinical and medical institutions. This means seeing a professional with the designated authority to diagnose, such as a physician, psychologist, or psychiatrist. While there are many other professionals who offer treatment of eating disorders, there are few who can give an official diagnosis. As stated in the literature review, eating disorders are classified as psychological conditions that encompass physical/medical components. Psychology, as a discipline, and its taxonomic and diagnostic manual, the DSM-5, serve as the primary legitimate resource and respondent. The DSM-5 provides an in-depth definition of eating disorders and how they present symptomatically from a medical/psychological point of view. According to the DSM-5, there are eight categories of eating disorders: Pica, Rumination Disorder, Avoidant/Restrictive Food Intake Disorder, Anorexia Nervosa (Restricting type, Binge-Eating/Purging type), Bulimia Nervosa, Binge-Eating Disorder, Other Specified Feeding or Eating Disorder, and Unspecified Feeding or Eating Disorder (American Psychiatric Association, 2013). This chapter will foreground lived experiences with eating disorders by exploring participants' thoughts, behaviours, and attitudes and positioning them against the dominant discourse; specifically, regarding how eating disorders are defined, diagnosed, and treated, and how service providers are educated and trained.

Diagnosing the Socially Constructed Body

Survey participants were asked to disclose if they had a specific eating disorder and if they received a medical diagnosis or made a self-diagnosis. Informal diagnosis was common amongst participants. Thirty-eight percent (10) of participants had made a self-diagnosis while 19% (5) of participants reported only having been partially diagnosed (i.e., "some have been self-diagnosed…others have been formally diagnosed" – SP #36). Another 19% (5) of participants indicated that they had received a formal diagnosis, while 19% (5) did not respond to this question. It is interesting to note that a large portion of participants had not received a formal diagnosis from a healthcare provider. As discussed by participants in the previous chapter, those occupying fat bodies are often not taken seriously in eating disorder related help-seeking situations. The conclusion that I draw from this is that there are likely many individuals who seek to be diagnosed and receive help, but perhaps get overlooked because they don't fit the stereotypical image of someone who experiences an eating disorder. Further, the awareness that people who do not fit the norm are often overlooked, ignored, and invalidated by healthcare professionals likely discourages many others from attempting to seek help at all.

In terms of specific disorders, responses ranged from anorexia nervosa (27%, 7) to bulimia nervosa (19%, 5), to binge-eating disorder (23%, 6), to ARFID (avoidant/restrictive food intake disorder) (4%, 1), to EDNOS (eating disorder not otherwise specified) (4%, 1), some of which are a combination of the previously mentioned disorders. Forty-two percent (11) of participants described their symptoms and experiences without providing a specific label. The following chart provides a general summary of eating disorders reported by survey participants:

Figure 5.1: Summary of Specific Diagnoses of Survey Participants



Only 38% (10) of survey participants reported having experienced one individual category of disorder. The remaining 42% (11) shared that they have either experienced symptoms of two or more eating disorders or did not provide a specific label for their experiences. This begs the question, are these diagnostic labels painting a true picture of lived experiences with eating disorders? Based on participant experiences, diagnostic criteria do not reasonably take the complexities of people's lived experiences of eating disorders into consideration.

Interview participants were similarly asked to describe what their typical client with an eating disorder looks like regarding most common eating disorders and how they tend to present. IP #2 shared that her typical client fits the stereotypical image of someone with an eating disorder: young/university-aged, cisgender, woman, and heterosexual. With regard to specific disorders and symptoms, she shared that:

> [I]t's pretty common for folks to fluctuate over their disordered eating experience with how the symptoms present, typically starting with dieting, or over exercise…starting with unhealthy dieting behavior, moving into more typical anorexia, symptoms of restriction and over exercise, then sometimes slipping into more BP [binge purge] type symptoms where they can't maintain the restrictions and then they're binging and purging. They could develop bulimia for a time and switch back. I find that it's very fluid throughout the lifespan in terms of how they present…the most common thing I see would fall under the eating disorder not otherwise specified, or that other specified feeding and eating disorder would be the most common because of that symptom dance that people tend to do.

IP #2 describes a spectrum of experiences that do not necessarily fit neatly within a single category of eating disorder. There appears to be a degree of fluidity, interaction, and multiplicity in the experiences of her clients. IP #2 shared that her clientele largely comes from a young, university-aged, cisgender, woman, and heterosexual demographic, yet their experiences cannot be summed up with a simple diagnostic label. If those coming from very similarly positioned social locations have a wide array of varying experiences, one can only imagine how varying and diverse the experiences of very differently positioned social locations would be.

Registered dietician, IP #3, described a similar degree of fluidity in her clients:

> I see a lot of diet/binge folks, folks that struggle with chronic dieting, or have dieted or have had weight fluctuations. I probably see more clients that struggle with that – under eating, dieting, trying to eat less, clean eating[3], food rules, and then binge eating or loss

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[3] Harvard School of Public Health describes clean eating generally as eating "foods that are as close to their natural state as possible, maybe organic, and most likely with minimal use of any chemical additives and preservatives. A clean diet may include whole fruits, vegetables, lean proteins, whole grains, and healthy fats while limiting highly processed snacks and other packaged foods with added

> of control eating after that. Or cycling between that… And I do have a few clients that would fit, at the lack of this awful description, atypical anorexia, who would demonstrate more restrictive eating habits, whether their weight is truly low or weight suppressed, but this under eating may or may not be paired up with a relationship with activity…With binge eating disorder you're not supposed to be compensating in any way for these binges. But in my observational experiences, most individuals with binge eating disorder are compensating whether they know it or not by just under eating or trying to fix their binge the next day.

IP #3 uses interesting language when discussing Binge Eating Disorder. By stating "With binge eating disorder you're not supposed to be compensating in any way," the misconception that eating disorders are *supposed to* look a certain way is upheld. I do not believe it was IP #3's intention to perpetuate this idea. Thus, it demonstrates the pervasiveness of diagnostic criteria. Further, it exposes the essentialist mindset that specific eating disorders are experienced in very fixed, unchanging, and generalizable ways.

Just as the category of women has continuously been essentialized in Canadian health research (Hankivsky et al., 2010), I assert that categories of eating disorders have become essentialized too. Essentialist thinking is maintained through the belief that specific eating disorders, such as binge eating disorder, are experienced in the same way by all people, regardless of positionality. In fact, the diagnostic labels and criteria that currently exist may not be representative whatsoever for those occupying any social location other than that of those who fit the stereotypical image of someone who experiences eating disorders.

IP #3 continued this discussion by explaining the ways in which eating disorders are perpetuated and normalized through diet culture rhetoric and behaviours:

> I would say restrictive, clean eating, food rules, diet rules, most of them result in loss of control eating or feeling really out of control around food. Dieting is so prevalent. I see the trickle-down effect of individuals trying to eat cleaner and cleaner and cleaner and

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sugar and salt. It may also be associated with terms like plant-based, grass-fed, sugar-free, or gluten-free. In summary, clean eating seemingly promotes health and wellness" (*Clean Eating,* 2022).

> then it kind of gets away from them…For folks that struggle with the diet/binge or diet/loss of control or feeling really out of control around food, I would say most of that would be the women that I see that are 25+, 25 to 30 to 35 I tend to see a lot of that…whereas I see a bit more restrict/exercise in that university population with some binge eating. But I would say individuals who have dieted for 10 years tend to be around 35 and older. For the younger population, I it's not dieting in the same sense of Weight Watchers, it's more clean eating. I see that healthy, healthy, healthy eating, don't eat anything bad. It's this relationship with food that's chaos. Whereas before, it was traditional dieting.

From this quote, I observed that specific symptoms and behaviours such as dieting, binging, restricting, and clean eating, appear to be more common than specific diagnosable disorders. When referring to the work of Jordan (2011), we are reminded that the current system for diagnosing eating disorders requires strict criteria to be met in a clear-cut, checklist fashion. If the client does not experience the specific symptoms outlined by the diagnosing system, they do not meet the criteria for an eating disorder diagnosis. Flanagan, Davidson, and Strauss (2007) advocate for the incorporation of client subjective data in the development of diagnostic criteria of mental disorders. Ultimately, they argue that this shift can occur without major disruptions to reliability, validity, structure, or conceptualization of mental illness. Further, they assert that subjective experiences can be incorporated into the DSM to provide clinicians with a more well-rounded understanding of patient experiences. Increased inclusion of qualitative research serves as a valid method for obtaining a more in-depth understanding of lived experience with mental disorders.

Flanagan et al. (2007) also highlight the possibility and accessibility of incorporating person-centered approaches to mental disorders. While this is a step in the right direction, a common miscalculation is the inclination to cause as little disruption as possible. The reassurance that clinicians would not need to learn new structures or conceptualizations of mental illness and that the DSM would continue to have a significant role in the therapeutic process does not leave space for the radical change that is so desperately needed within clinical settings. It has become increasingly clear that the DSM, diagnostic criteria, and many therapeutic practices have been developed through a lens that is rooted in colonialism, capitalism, and patriarchy. In order to really revolutionize how we understand and treat eating disorders, we need to consider how these existing methods and resources perpetuate harm and toxicity and further compound mental health disorders. Moreover, we must consider the possibility of complete reconceptualization of mental disorders, diagnostic criteria, and treatment if we are to create a system that truly serves those who are a part of it. If help-seeking environments are only further perpetuating harm, drastic change is necessary.

The rigidity of diagnostic categories makes it difficult for those who fall outside the diagnostic norm to be seen as having eating disorders. I propose that there are two reasons this may be true. The first reason is that the nature of the lived experience of eating disorders often differs from the diagnostic descriptions. Second, is that the experience of eating disorders in relation to people occupying different, intersecting social locations can vary greatly based on how they experience privilege and marginalization. Failure to consider the holistic nature of lived experiences with eating disorders further alienates, invalidates, and perpetuates harm against differently positioned bodies. This point is further supported by reports from registered dietician, IP #4 regarding atypical anorexia nervosa:

> I see a full spectrum of things; I see a lot of atypical anorexia nervosa. That would be the main one. I often see general disordered eating patterns, patterns that do not meet diagnostic criteria. The atypical anorexia nervosa folks that I would have seen are those whose BMI isn't underweight. These are the ones that are the most dangerous really because they fit that societal norm or mold a little bit more. They can fly under the radar for longer and end up presenting sicker because they've been malnourished for so long. They're sick from a from a mental health state as well. I have quite a few binge eating clients as well. Maybe not textbook definition of binge eating disorder, but a loose version…Then like I mentioned, disordered eating patterns, where people need a little bit

> of guidance and myth busting in regard to diet culture, and of course, help with body image conversations and stuff like that.

IP #4 shared that atypical anorexia is characterized by a BMI that is not considered underweight. The use of the BMI scale as a measure of the degree of severity of anorexia nervosa creates cause for concern. Justin and Jette (2022) share that critical obesity scholars have theorized that the BMI “operates as a biopolitical tool that is fundamental to modern governance and the contemporary stigmatization of fatness” (p. 608) because it “regularizes and disciplines bodies at the population and individual level” (Evans & Colls, 2009, p.1075). This outdated method of measurement likely results in the exclusion of large numbers of people from getting the help they need, simply because their BMI is not considered low enough to receive a diagnosis and care.

While atypical anorexia is a category of the disorder that does not have the BMI requirement, if it is necessary to create an atypical version of a particular disorder, perhaps that should be taken as an indication that said disorder is not truly representative of lived experiences. While atypical anorexia was described as one of the more common disorders observed by IP #4, she described a significant degree of disordered eating patterns that do not necessarily fit into one single category of disorder. As previously discussed, the use of the BMI as an indicator of health is largely controversial and inaccurate as it operates as a biopolitical tool that stigmatizes and polices bodies in medical practice (Hatch, 2016; Justin & Jette, 2022). There is a sense of morality that has been ascribed to the appearance of health and physical fitness. However, I assert that how we look and how we choose to nourish our bodies should not be a determinant of how we are treated or how much value we have in society.

The final interview participant, IP #1’s report of their clients and common ED behaviours/experiences differed most significantly from that of the other interview participants. They shared that:

> There are three camps that I usually see. One is people who are loosely neurodivergent, and/or people who have ADHD [Attention-Deficit/Hyperactivity disorder], and/or people who have ASD [autism spectrum disorder]. All three of them usually have bulimia nervosa, that's the norm. I find people with eating disorders with ASD use it more to gain a sense of control and to try to regulate their emotions, and to try to get a sense of how they can make themselves better so people stay and don't hurt them, which often is because they were hurt. The next camp is people with gender dysphoria. There is a large percentage of people that I see who have a lot of underlying trauma as well, but it's usually to mask and manage dysphoria. The last camp is what you'll typically see, the typical narrative of a cisgendered woman with usually a lot of complex trauma. Childhood sexual abuse is the most common that I see there and the disorder is being used to mask all of that pain.

IP#1's discussion of their clients draws attention to the variety of underlying mechanisms that can impact a person's relationship with food and their body. While it is true that insecurity and social comparison are a root cause for many individuals' food and body related challenges, it is crucial that we acknowledge the varying degree of factors that can be at play. The three camps of participants mentioned above all appear to be heavily impacted by social-relational factors. A commonality between all three camps is that their disorders stem from a desire to be considered socially acceptable and an attempt to move through a world that was not necessarily designed for their needs. Research has indicated that eating disorders are sometimes used as a body modification tactic for transgender and non-binary individuals who experience body dissatisfaction and gender dysphoria (Duffy et al., 2016; Muhlheim, 2020). Research has also indicated that 20% - 30% of adults with eating disorders have autism and that 20% of women with eating disorders demonstrate high levels of autistic traits (Solmi et al., 2020).

What the research often fails to consider is that there are trans non-binary folks who have autism and experience an eating disorder. Moreover, there are poor, Black, fat, bisexual, trans non-binary folks with mobility issues who have been victims of sexual abuse and also have an eating disorder. As humans, we are diverse, intersectional beings who occupy many different social locations. We can simultaneously be privileged (i.e., straight) and marginalized (i.e., Indigenous). Therefore, the complexities of each of our identities must always be factored into understanding our lived experiences. The people in the three groups mentioned by IP #1 are also differently positioned people. It is possible for a client who has autism to also be transgender and have been a victim of sexual abuse. Occupying one marginalized positionality does not render someone exempt from experiencing another. In fact, it can often be a contributing factor as to why someone may experience multiple marginalized positionalities and lived experiences. Our identities intersect and interact with one another and cannot be viewed from an individualist and universalist lens. In order to truly understand lived experiences with eating disorders and provide nuanced, adequate care, acknowledging these multiplicities and complexities is crucial.

Defining Eating Disorders: Lived Experience vs. Diagnostic Criteria

The experiences reported by survey and interview participants do not necessarily reflect a pattern of diagnosable conditions that can be found in the DSM-5. Rather, they highlight a spectrum of disordered behaviours and attitudes surrounding eating and body image. Further, they shed light on the variety of underlying mechanisms that contribute to the development and maintenance of eating disorders. This is especially apparent in IP #1's recount of their experience working with clients with ASD, ADHD, and gender dysphoria. While it is important to address the more commonplace contributors to eating disorders, there is a significant need for more discourse surrounding these less familiar factors. IP #1 expanded upon this and discussed that:

> Disordered eating more broadly affects everyone. In research about 1/5 of people with an eating disorder have autism. For people with autism or who are neurodivergent, rates of eating disorders are really high because they're trying to control and make sense of their body, they're trying to understand their interceptive cues and things like that. Queer people, specifically trans people, are often overlooked. I have noticed a lot of them have eating disorders, often to mask or manage gender dysphoria. They don't want their body to look too big or too womanly, they restrict so that they don't have a period or don't have their body shape a certain way. It's a lot more common than people realize. That's not really talked about in the literature, and definitely not in training. But in general, a cold

> cut rule of who is most likely to be diagnosed? Who's most likely to come into my office? It's probably a cisgender woman.

Those who fall outside the normative standard of what someone with an eating disorder can and should be, are often omitted from these conversations. This is true on both systemic and institutional levels as these omissions can be felt within academia, research, training, and treatment. This discrepancy between who is researched, diagnosed, and treated and who is not creates tension within service providers. More specifically, there are tensions within service providers between recognizing who is omitted and reproducing omissions within their practice. IP #1 addressed this by acknowledging the cruciality of critiquing the institutions in which they work:

> We've got to be critical of the research, of how we're being trained, and who gets to be included in research. Researchers, as they're studying new protocols, they're looking for a clean cut, no comorbidities, people without really complex trauma, which is actually not the norm with eating disorders. They think they're representing the norm when they're not. Clinicians are trained to think "they're just trying to control their emotions and their body and need to hate their body and that's why they're doing it." And more often than not, an eating disorder is a distraction. They're more likely to have other issues going on underneath it, like gender dysphoria, like autism, like ADHD, and more often trauma. But if we don't look at the why, we can't really help them get through it.

Any person who exists within the margins of society is at risk of being overlooked by these institutions. Despite social awareness, good intentions, and a large degree of care and concern, it is not possible to be fully ethical while working within power systems that create injustice and reproduce harm. Service providers are servants of the disciplinary power of the institutions in which they work. Although there are efforts made to push the boundaries and provide radical, nuanced care by some, there are sets of rules that must be followed for one to maintain their career. This can create tensions within service providers who recognize the inequities and unethical practices involved in their line of work but must continue to follow the optimal model (Foucault et al., 2009) that has been set forth by medical institutions in which they work.

Although it has its shortcomings, it is important to address that there is value in diagnostic criteria. The DSM-5 provides standards for diagnoses, treatment, and research and provides therapeutic guidance for mental health professionals (Fritscher, 2020). But although these strengths exist, they do not compensate for the harm they create and reproduce both in the short and long term. If the definitions and diagnostic criteria of eating disorders in the DSM-5 do not reflect lived experience, how are those with lived experience defining their experiences? Survey participants were asked to describe their personal definition of what an eating disorder is. A summary of key words from participant definitions has been provided in the word cloud below:

Figure 5.2: Summary of Survey Participant Definitions of Eating Disorders

While responses varied, not a single participant regurgitated the material found in the DSM-5. Rather, they describe eating disorders more generally as an unhealthy relationship with food, weight, body image, and exercise.

Seventy-six percent (20) of survey participants are white, 88% (23) of participants identify as female/woman, 46% (12) are straight/heterosexual, and 76% (20) are white/European. Therefore, there is a significant number of participants who occupy one or multiple positions of power and fit the norm of who is typically understood to have an eating disorder. However, the fact that differently positioned participants shared similar views of what an eating disorder is provides hope that participant definitions are more widely generalizable than those provided in the DSM. The vagueness of participant definitions is likely what makes it so generalizable. But by having a looser definition of what eating disorders are, there creates more space for individualized, subjective care based on each individual person's lived experience. Further, participant definitions incorporate a more intersectional definition of eating disorders by referencing the relationships and mechanics involved in experiencing an eating disorder (i.e., the interacting relationships between weight, body image, food, and exercise).

Survey participants were also asked to share any eating disorder symptoms they tend to experience on a day-to-day basis. Symptoms were categorized into four major categories: Restrictive behaviours, mental/emotional distress, physical symptoms, and consumption related behaviours. Restrictive behaviours include things such as food restriction, struggling to eat, fasting, starvation, forgetting to eat, limiting variety of foods eaten, avoiding food, food aversion, purging, excessive exercise, using hunger as a reward, and calorie counting. Seventy-three percent (19) of participants indicated that they engage in some form of restrictive behaviours. Mental/Emotional distress consists of stress, breakdowns, mood swings, anxiety, disordered thinking, invasive thinking, guilt, shame, fear, self-criticism, Body Dysmorphia, poor body image, body checking, scale checking, suicidal thoughts, constantly thinking about food, and low self-worth. Eighteen participants reported experiences with mental/emotional distress. Physical symptoms include symptoms such as migraines, unintentional vomiting, stomach issues, growth of excess body hair, constantly cold, lethargy, dizziness, significant weight loss, heart arrhythmia, acne, insomnia, and thinning of hair and was reported by four participants. Finally, consumption related behaviours included bingeing, using food as comfort, hiding food, lack of control, and using food as punishment and was experienced by seven participants.

The definitions and symptoms provided by participants draw attention to the rigid, narrow, and exclusionary nature of diagnostic criteria resulting in a lack of relevance. IP #2 critiqued the DSM-5 by stating:

> The criteria for eating disorders are so rigid and not helpful. The BMI requirement is stupid and should be removed. If you look at the DSM for bulimia, it needs to be three times over three months. If someone's purging twice a week for two months, that technically meets the diagnostic criteria for other specified feeding and eating disorder. So, in that case, they're not diagnosed with one of the “go to” eating disorders.

While there is some overlap between what participants shared and what is stated in the DSM-5, it appears that no participant would be deemed clinically diagnosable based on their definitions and symptoms. This begs the question: If food and body related struggles fail to meet diagnostic criteria, how are those who are struggling expected to receive adequate intervention and care? The medicalization of lived experiences takes up space and leaves little room for understanding the diversity and complexities involved in having an eating disorder. Further, it delegitimizes and invalidates the lived experiences that do not align with the medical model of what an eating disorder is.

In addition, therein lies an issue with pathologizing behaviours and emotions that are a response to socially constructed systems. Medicalization and its disregard of social process "enables contemporary society to ignore the extent to which the processes of socialization itself produces many of the behaviors and emotions that are now labeled disorders" (McGrath, 2009, p. 420). If people are experiencing body dissatisfaction because they are being influenced to hate their bodies through the disciplinary power of capitalism, then capitalism needs to be critiqued, interrogated, and dismantled for people to experience a healthy relationship with their bodies. This is true of any and all power systems including patriarchy and colonialism. Eating disorders are largely a social justice issue and need to be treated, understood, and intervened as such. For a discipline that focuses so heavily on avoiding and critiquing bias, western psychological/psychiatric thought routinely fails to account for its own biases and reproduction of westernized norms and ideals.

Another danger created by diagnostic criteria, specifically in treatment settings, is the pathologizing of normal behaviours and ways of being. While there are several examples of this, fatness has been a prime target. As mentioned in Chapter 2, obesity was included in past editions of the DSM as a mental disorder. Medical institutions have been used to "oppress people of size" and "convey disapproval and censure" as "most people are quite willing to support the stereotype of fatness signifying ill health" (Rothblum & Solovay, 2009, p. 72). By ignoring social processes and systems and how they perpetuate harm only further exacerbates these issues. By emphasizing subjective experiences, space is created to provide nuanced, personalized care. This is especially important for marginalized groups of people. There are many diverse categories of people that are failed by clinical and medical communities when it comes to eating disorders and receiving adequate care. Acknowledging that clients are the experts of their own experiences provides clients with a degree of validation and autonomy. How these experiences are shaped by race, class, gender, sexuality, migration, religion, and other locations and identities is best understood by the individual experiencing them themselves.

Pathological labels and diagnostic criteria have been designed based off a very specific protype or model. For eating disorders, this model is a young, white, middle class, cisgender woman. Therefore, the assessments and criteria being derived from this model fail to acknowledge each person's intersectional positionalities. Attributing labels designed to name and summarize the experiences of this very specific group of people to those who fall outside it is a recipe for harm. Further, a plethora of different symptoms and experiences could exist, but potentially have not been discovered by the medical/clinical community because its focus has been so narrowly focused on a very specific demographic. Not only is this not helpful, but it is harmful and minimizes and invalidates the experiences of people who are struggling. If the way eating disorders are experienced has changed dramatically since the implementation of diagnostic criteria and the DSM, should our methods for treating them not change dramatically as well?

Survey Participants on Seeking Help

So, what do those who are struggling have to say regarding their experiences in help seeking situations? Survey participants were asked to describe whether or not they had accessed eating disorder related intervention services or treatment such as an eating disorder clinic, therapists, peer mentors, group support, and other services. Some participants have accessed eating disorder specific resources while others have received more general mental health related help that did not focus on their eating disorder. In total, fifteen participants reported accessing some form of intervention. Ten participants reported that they have not accessed any resources, and the remaining one did not respond. For those who have accessed eating disorder related intervention, they were asked to identify the type(s) of service/treatment, indicate if it was helpful, and discuss why or why not. Responses varied with ten of participants having accessed private counselling (therapist, psychologist, social worker), two having accessed community-based support (psychologist, peer mentor, support groups), and one having accessed a full treatment team (therapist, dietician, pediatrician). Thirteen participants did not respond or indicated that the question was not applicable.

From participant responses, it is clear that there are resources out there that are currently working. Of the participants who reported that they have accessed resources, 15% (4) responded that they were helpful, 15% (4) responded they were somewhat helpful, and 8% (2) responded that they were not helpful. The remaining 62% percent (16) of participants did not respond or indicated that the question was not applicable. For example, SP #24 stated that seeing a therapist helped them identify "why I feel the need to purge and makes me identify it," while SP #27 shared that discussing the topic of self-worth with a private counsellor was helpful as they "touched on how my feelings about food are a result of other issues… It was helpful because I was given tips on how to retrain my brain into realizing food was a need, and not a reward."

Others expressed that "Talking to other people about how they have overcome their disorder helped me the most" (SP #33) and "I worked with a private psychotherapist through cognitive behavioural therapy and dialectical behaviour therapy, I also had a peer mentor, attended group peer support groups. No medical doctors ever involved. I think these things all helped greatly" (SP #36). Finally, two others revealed that "I had a treatment team. A therapist, a dietitian, and a paediatrician that I would see every week. I personally didn't think they were the most helpful. I got most of my help online. Through helpful YouTube videos and a recovery coach I zoomed with.” (SP #44) and “I have used psychology services (with a social worker) …I was also directed to an external resource (CCI Information Packs on Overcoming Disordered Eating) that I found extremely helpful to better managing my eating/health through self-monitoring and cognitive behavioural therapy” (SP #45). Despite these helpful resources, many participants did not seek help or received inadequate, or even harmful, intervention when they pursued eating disorder related intervention.

After exploring recommendations made by survey participants, I draw attention to recommendations that have been made by academics within the field. Specifically in relation to assessment and diagnoses, Barrera and Jordan (2011) discuss the importance of utilizing dimensional assessments due to the rigidity that is inherent to diagnostic criteria. It also draws attention to the lack of client subjectivity that is involved when assessing clients. Giving more weight to the subjective experiences of those living with eating disorders, and other mental illnesses more generally, seems like an incredibly obvious and underutilized resource.

There has been a lengthy discussion of the many factors contributing to the development and maintenance of eating disorders, and the inadequate treatment and diagnoses involved in eating disorder intervention. However, one factor that has not yet been discussed and underpins it all is toxic individualism in westernized cultures. Eating disorders have long been treated as personal battles to overcome. Not enough attention has been given to how these disorders impact us as a collective. Recovery from an individualist perspective can only result in temporary change. Clinical intervention is often necessary in order to create relief. However, this relief is still being created within a colonial, patriarchal, capitalistic system that only further perpetuates the issue. In order to see permanent change, we must act with collective resistance by radicalizing the way we treat eating disorders. Complete eradication of the diversity and complexity of eating disorders may not be possible as it would require the dismantling of power systems that they exist within. What is most important is to build the necessary and accessible resources and frameworks to respond and intervene. I would like to close this chapter with a quote from the Instagram of author, poet, spoken word artist, speaker, educator, humanitarian and social justice activist, Sonya Renee Taylor (2022):

> There is an opportunity to be defiant on a collective scale. And I hope that people are starting to think about how they build coalitions of defiance – coalitions of ungovernability. The only way to combat white male cis-hetero patriarchy is to absolutely refuse to acquiesce. In Mass. In Numbers. To become ungovernable as a collective body. I have such a deep and passionate desire for us to wake up as a collective. For us to begin to defy the order that they demand which solidifies their power.

May we move forward with collective, ungovernable, radical, passionate defiance.

Chapter 6: Interview Participant Reflections and Recommendations

This final analytical chapter is dedicated to exploring interview participants' recommendations for better serving self-identified women with eating disorders in Nova Scotia. It is apparent that there is a significant need for change in diagnostic and help-seeking situations. So, what are service providers for those with lived experience suggesting be done to implement change? The main points to emerge from participant responses involved increased education/knowledge for those with lived experience and service providers, more eating disorder specific training for service providers, increased accessibility to treatment and resources, less stigma, and more community-based treatment/treatment teams. Interview participants provided a number of possible recommendations to better serve a diverse population of people with eating disorders. Each service provider offered in-depth, well-informed recommendations which are discussed below. Three major themes emerged from interview participant responses: 1) Policy, politics, and public education 2) Accessibility and diversifying care, and 3) Learning and unlearning for service providers.

Policy, Politics, and Public Education

The first theme, Policy, politics, and public education is characterized by the degree to which policy, politics, and education influence access to care and knowledge pertaining to eating disorders. IP #2, for example, explained that policy and politics are an unfortunate but necessary component of creating access to care. Those in positions of power who have access to money have the resources to support the type of interventions, knowledge, and care that they deem worthy:

> Policy and politics are unfortunately really important. I use Newfoundland as an example because Newfoundland has really great eating disorder services, especially in St. John's, and that's primarily because a lot of really rich people had daughters with eating disorders. They had a lot of power, and they did a lot of promotion and lobbying with

> governments. Because that's just the way the world works, rich white men and their power. They advocated for more eating disorder treatment and put a ton of money in it. And honestly, for a province that has terrible reputations with health care, I think they have one of the best eating disorder treatment accesses in the country.

While it is positive that Newfoundland has great access to eating disorder services, therein lies danger in rich white men dictating and deeming which resources are acceptable and which are not. As Monzo (2020) shared, capitalism is an enterprise that is both racialized and gendered and operates to guarantee the global domination of a capitalist class that is predominantly white and male. It is unlikely that individuals from this demographic, who are focused on providing their rich white daughters with proper care, are taking the time to consider the needs of a more diverse population.

The quote above highlights the need for more public education as well as improved education. As important as it is to promote and lobby for eating disorder resources, it is equally as important that we do so with honest and accurate information. IP #2 states that:

> There needs to be more public education. With initiatives like Bell Let's talk, it's awesome because we're all talking about mental health. But it's not that helpful if you don't know what you're saying. If we're talking about it, but we're not actually providing accurate information, it can actually do more harm than good.

In addition to providing accurate information, we must also be wary and critical of the information we receive. As previously discussed, medicine has been deemed neutral and objective, which often leads to people overlooking the problematic cultural values that are deeply ingrained in this field (Zola, 1983; Jutel, 2009). The BMI is an excellent example of the harm that is done unto bodies when misinformation is spread. It is crucial that when we are spreading awareness and lobbying for change, that we are not also spreading misinformation that may ultimately cause more harm than good. This also extends to any information we are absorbing. This issue is especially prevalent in nutritional messaging. While it is important to provide our bodies with certain vitamins and nutrients, the degree to which people have been taught to track what and how much food enters their bodies has become obsessive and unhealthy.

Calorie counting, intermittent fasting, and other methods of bodily surveillance have become normalized and embedded in many different sectors of society. School-aged children are not exempt from this bodily surveillance as diet culture presents itself in schools under the guise of health. IP #3 shared her thoughts on this issue:

> If we could stop doing school projects that get kids to calorie count their food and intake, that'd be great. Not everyone needs to track their intake. In fact, very few people if anyone, need to track their intake. If we could also normalize that not all dietitians are going to ask you to go on a diet and lose weight, that there are many dietitians that are going to help you eat enough and eat more and eat well rounded and have a good relationship with food. I also think we need to be really cautious about how we speak about food and nutrition in the school curriculum. Children do not have the critical thinking to be able to articulate and understand and implement nutrition messages when they're young.

Children's relationships with their bodies are incredibly important as it is the body that makes our identities visible (Driscoll 2002; Foucault 1978; Zaslow, 2009); and for many young girls the body *is* the self (Phillips, 2015). Girlhood studies scholars have explored issues surrounding the relationship between sexuality, representation, and the female body (Zaslow, 2009, p. 113). Therefore, how we present topics such as our relationships with our bodies and our relationships between food and our bodies to children needs to be approached delicately, honestly, and responsibly. The passage above draws attention to the extent to which diet culture is infiltrated through school systems and forced upon children at a very young age. When teachers are promoting this ideology, it legitimizes diet culture's claim that what we eat and how much we eat needs constant monitoring. Further, it encourages children to believe that tracking food intake is not only normal but is healthy. This plants the seed in these young minds that there is a preconceived set of rules created to govern our bodies that they must adhere to.

Accessible and Diverse Care

The next theme, Accessible and Diverse Care, explores the need for increased access to services and increased diversity in help-seeking situations. Dieticians, in particular, have been highlighted as having an invaluable role in contributing to eating disorder treatment. Yet few people seem to have access to this type of care. IP #2 states:

> Having more access to dieticians is such an important part of an eating disorder team and something that not everyone has access to, especially in our community mental health programs. We need more eating disorder informed dietitians who are trained well in eating disorders and are more available. We talk a lot about increasing access to mental health services, and when you have an eating disorder, a dietitian is a mental health service.

There are many reasons why access to dieticians is limited. These reasons include a discrepancy between the number of people requiring services and the number of service providers available, the cost associated with accessing dietetic services (especially in private practice), and a lack of regard given to dieticians by other service providers in this field of work (i.e., gender practitioners, psychologists, and psychiatrists). However, access to dietetic services is crucial for many individuals attempting to recover from eating disorders. Not only is increased access to dieticians critical, but increased access to differently positioned dieticians across ages, cultures, and ethnicities is especially important.

The need for increased diversity does not only pertain to dieticians. Rather, it pertains to all service providers present in help-seeking environments. There needs to be diversity across age, gender, culture, race, ethnicity, sexuality, gender identity, racial identity, and lived experience. IP #4 discussed the importance of having diversity amongst service providers:

> I think, even as a practitioner, there needs to be more people who are part of these diverse populations. Because I'm a cisgender female practitioner, a lot of people may not find that they can relate to me as a provider. I think that this is big all across the board, because there really aren't very many folks in minority groups who are providers for eating disorders or mental health care in general.

White service providers must be cautious when providing care to marginalized clients. When working with racialized clients, for example, white service providers must be careful not to centre their own feelings and experiences as it is very possible for white service providers to experience feelings of white guilt or/and white saviour when engaging with racialized clients. I draw on the work of DiAngelo (2018) and Parasram (2019) and assert that feelings of white guilt in service providers may lead to co-opting and refocusing the dialogue to prioritize their own white cultural settler needs which further distracts from the oppression experienced by the racialized clients.

Within client-clinician relationships, service providers occupy a position of power in the sense that they are the so-called experts offering knowledge and support to vulnerable persons. When these service providers occupy other positions of power, such as being white, straight, cisgender, able-bodied, and financially well-off, an even greater divide and imbalance of power is created. If people do not see themselves represented in help-seeking environments, it creates more barriers and potential harm. This is why it is important for those with lived experience to see themselves represented in therapeutic settings; not only as those suffering, but as those providing care as well.

In terms of those suffering, however, there continues to be a lack of diversity in those being represented as well. Interview participants concluded that the subset of individuals that they’re treating is not representative of who is truly struggling or who is at the highest risk. IP # states:

> When we see the typical subset of folks that we're serving, it's not reflective of eating disorders. When you think of the eating disorder poster child, you think young, cisgender, straight, white, female, middle class. That is not totally reflective. That image leaves a lot of people out who don't identify with that description and leaves people feeling misunderstood.

How we conceptualize our own bodies and the bodies of others is heavily influenced by binary criteria and normative standards of what a healthy and productive body is believed to be (LaMarre et al., 2017). The existence of these normative standards leads to the exclusion of those who do not fit them. While conversations around a lack of representation in therapeutic settings have begun to emerge, we need to continue to unpack why this is the case. We need to interrogate these institutions and explore why they continue to exclude certain demographics of people. Why are we continuing to see a disproportionate number of young, cisgender, straight, white, female, middle class persons in these therapeutic settings when we know there is a much more diverse population of people suffering?

Some service providers did report seeing a wider degree of diversity than others. For example, IP #1 shares:

> There is a diversity of clients who struggle with eating disorders. I see a bit of a diversity in my practice, but I still only see mostly white women. I see diversity in body size and in diagnosis or struggle. But I don't see as much diversity in terms of diagnosis or struggle as is out there. I don't see as many people who binge and purge, I don't see as many people who are not female. There's a lot of people that I don't see that I know are struggling.

While some service providers do see a range of diversity in their practice, it appears the degree of diversity only extends so far. It should also be noted that, of all four interview participants, IP #1 was the only participant who did not identify as a cisgender woman. Rather, they shared that they identify as queer non-binary. Interestingly, it was IP #1 who appeared to see the most diversity in their practice. This supports the idea that more representation amongst service providers creates space for more diversity amongst clientele.

Ultimately, there needs to be a shift in how we visualize and conceptualize those who experience eating disorders. There is no particular image we can attribute to eating disorders because they are complex disorders that can, and do, affect people of all social locations. Until there is widespread acceptance that these disorders do not discriminate, we will continue to let certain people fall between the cracks. It is possible to provide assistance to people striving to develop a healthier relationship with their body in ways that do not prioritize the manifestation of symptomatology (Gotovac, LaMarre, & LaFreniere, 2020) or the ability to meet the stereotypes of who someone with an eating disorder may be. IP #3 expands on this by stating:

> We need to normalize that eating disorders don't have a look and validate people's distress over food. That would better serve a diverse population. There are lots of individuals that feel like they don't fit the mold of someone with disordered eating or an eating disorder. They end up suffering a lot longer before getting treatment or suffer in silence a lot more. We have individuals who maybe don't have health care. We have individuals that don't have a good understanding of eating disorders, disordered eating, weight stigma, Health at Every Size, weight loss, and lack of evidence to support indicators of health. We need to normalize accessing support for when your eating doesn't feel okay and it causes chaos, and it feels distressing.

Not only do we need to revolutionize how we visualize those with lived experience, but we must also be open-minded to how and when care is provided. Whether someone has a clinically diagnosable eating disorder based on the DSM-5 or someone simply feels distress over eating, both scenarios warrant the need for attention and care. By validating people’s concerns, especially early on, a lot of trauma and suffering can potentially be avoided.

Learning and Unlearning for Service Providers

An important theme to emerge from in-depth expert interviews with service providers is having access to increased/specialized training opportunities. As previously mentioned, Becker et al. (2003) argue that there are disparities in psychiatric diagnoses and access to care based on ethnicity that can lead to (1) poor fit of psychiatric diagnostic categories with ethnically diverse explanatory models and presentations of illness; (2) differential help seeking patterns for illness; and (3) clinician error or bias. While Becker et al. (2003) make this argument on the basis of ethnicity, I propose that these disparities exist for a wide array of marginalized people, as well as people who do not fit the eating disorder poster child image. This exposes the need for increased/specialized training opportunities for service providers.

More specifically, there is significant need for more specialized training for those who are the first point of contact for those seeking eating disorder related help/intervention. Those on the frontline making that initial contact have to opportunity to really make a difference and provide a foundation for someone to receive the care they need. On the other hand, if not approached correctly, these initial points of contact could result in a number of people slipping through the cracks. For example, IP #3 said:

> It would be excellent to have better training in the ER for when clients do present with disordered. When they're at a medical facility and being told to just eat more and go home, it's not helpful. If we could have different screening, or if someone does present to the ER with low potassium and vomiting, etc, could they be connected with the eating disorder program at that time? Could they have a list of community supports for people? Can they at least start those conversations of support? I think sometimes it goes super amazing and clients get hooked up with the services they need. But other times people fall through the cracks when there was an opportunity to make a connection with a program or their family doctor and get the ball rolling.

If this initial point of contact does not provide the client with a sense of hope and leaves them feeling invalidated and misunderstood, it is unlikely that they will feel motivated to continue seeking help.

In the excerpt above, IP #3 used emergency rooms as an example of where/who might be the initial point of contact for someone seeking help for their eating disorder. While this may be the case, there is a wide variety of people who may find themselves in this position. Whether it be a friend, a parent, a sibling, a guidance counselor, a social worker, or a psychologist, this initial contact has the potential power to shape how the person suffering moves forward. IP #2 used general practitioners and teachers as an example of who might be that initial point of contact:

> I think training folks who see people more frequently like general practitioners or teachers. Folks who interact with people early on in their eating disorder experiences, especially folks who are less commonly diagnosed. Training them for screeners, what to look for, giving psychoeducation to patients about eating disorders. It's really important to ensure that everyone gets that access and service providers are trained against these biases. For example, Black people can get eating disorders, no one seems to understand that.

Specialized training such as screening processes and psychoeducation for patients are examples of measures that can be taken up front to help ensure that clients receive the care they need. LaMarre, Rice, and Jankowski (2017) discuss how eating disorder prevention and intervention methods must be socially just if they are to be effective for and embracing of all people's bodies and bodily experiences, especially for marginalized people. Further, as IP #2 mentions, service providers acknowledging and understanding their own biases is a critical component of providing safe, effective, and socially just healthcare. Despite what academia often states, it is impossible to be completely free of bias. This is unfortunately true for all service providers. At least by acknowledging and understanding one's own biases, the possibility of harm is reduced.

The final, and arguably the most important theme of this section, is the ability and willingness for service providers to unlearn the harmful narratives that are present in western academia and medicine; narratives that would have been instrumental to their training and education. IP #1 explains this beautifully by stating:

> Folks need to own their role in it and unlearn a lot. If you don't actually see Health at Every Size, and you don't actually see that our bodies are worthy of love and connection and physical contact and fucking food, then you need to do your own unlearning. I don't think we tell clinicians or doctors enough of that. We need to look at stereotypes as well. We need to expand a lot more. We need to have people do their own learning and stop reinforcing stereotypes and cater your treatment to the person and recognize your own positionality.

It is not possible for service providers to provide safe and equitable care to a diverse population of people with eating disorders without acknowledging their own positionality. Further, attention must be brought to how service providers' positionalities influence the therapeutic environment and relationship. The HAES approach, for example, prioritizes self-acceptance and engagement in healthy day-to-day practices (Rothblum & Solovay, 2009) and encourages service providers to look past and dispel the harmful stereotypes and their own biases associated with fatness and eating disorders. In fact, there is much to be learned in reflecting upon what the relationship between service providers and people with lived experience should look like. A revelation that presented itself throughout this research is the dynamics and intricacies of the client-clinician relationship and how these relationships have been constructed. This revelation will be discussed in more detail in the following chapter under the section *Contributions and Implications*.

I end this chapter by explicitly stating the following recommendations based on each of the subthemes discussed in this chapter for better serving those with lived experience of an eating disorder in Nova Scotia:

1. Policy, Politics, and Public Education:
    a. Increased financial support for eating disorder intervention and care
    b. More honest and accurate public education and nutritional messaging surrounding eating disorders (especially when presenting this material to children)
    c. Increased diversity in positions of power/decision-making roles in terms of eating disorder related policies, financial support, education, etc.

2. Accessible and Diverse Care
    a. Increased access to services, resources, and a variety of different service providers (i.e., access to a treatment team that includes service providers from different fields such as social workers, dieticians, psychologists, general practitioners)
    b. Increased diversity in help-seeking situations, such as: Differently positioned service providers and service providers with lived experience of an eating disorder)
    c. More diversity in how we visualize and conceptualize who experiences eating disorders
    d. Access to support and resources for those who may not have clinically diagnosable eating disorders but who still struggle

3. Learning and Unlearning for Service Providers
    a. Increased/specialized training opportunities for service providers, especially those at the first point of contact (such as general practitioners and teachers)

b. Ability and willingness for service providers to unlearn harmful narratives and practices that are intrinsic to western academia and medicine; decolonizing their minds and their practices
c. Ability for service providers acknowledge and consider how their own positionalities influence the therapeutic environment; Service providers must acknowledge and understand their own biases

CHAPTER 7: Conclusions, Contributions, and Implications

This thesis explores how eating disorders are conceptualized, understood, treated, and experienced by self-identified women in Nova Scotia. I argue that dominant eating disorder discourse, as presented through a medical and psychological lens, fails to acknowledge the multiplicities of different social locations and how these social locations influence the understanding, experience, and intervention of eating disorders. An intersectional feminist analysis was employed to explore the following questions:

1. What impact has dominant eating disorder discourse had on our understanding of eating disorders and related interventions?
2. How have economic, political, and social factors affected patterns of eating disorders within the Canadian context?
3. How can an intersectional feminist framework provide a nuanced way of understanding eating disorders and the way they are treated?

A qualitative approach was taken in order to create space for participants to share details surrounding their own unique lived experiences with eating disorders. This study involved surveying self-identified women with eating disorders and interviewing service providers for those experiencing eating disorders to gain a well-rounded perspective of these experiences within Nova Scotia. A total of 26 survey participants and four interview participants were recruited to participate in the study.

This research supported the hypothesis that medical and psychological approaches to understanding and treating eating disorders do not adequately represent lived experiences. In fact, these approaches are likely to perpetuate harm as they do not incorporate a social justice lens despite how crucial its incorporation is. Survey and interview participants shared the belief that diet culture's pervasiveness is especially prominent within the field of medicine. Differently positioned bodies, whether they be racialized bodies, queer bodies, fat bodies, or disabled bodies, often fall through the cracks in help-seeking situations as they do not fit the stereotypical image of what someone with an eating disorder looks like. Fat bodies have been highlighted by participants as being particularly vulnerable due to widespread fatphobia within the field of medicine. Some survey participants shared how they had been failed by medical professionals as they were invalidated and not believed when seeking help. Interview participants supported this by sharing that client's themselves did not believe they had an eating disorder because they occupy a fat body.

Discontentment with how eating disorders are defined and diagnosed was another major theme to emerge from this study. Interview participants shared the belief that how eating disorders are currently being defined is much too rigid and does not adequately or accurately capture lived experiences. When asked to provide their own personal definition of eating disorders, not a single survey participant regurgitated the DSM-5 definitions and diagnostic criteria. Rather, they shared more generalized definitions largely characterized by an unhealthy relationship with food and their bodies. The rigidness of the DSM-5 diagnostic criteria is very exclusionary and discriminatory and prevents many people who are struggling from receiving proper care.

Fortunately, this research made space for service providers to provide recommendations for how the population of folks with eating disorders in Nova Scotia can be better served. Three major themes emerged from interview participant responses: 1) Policy, politics, and public education 2) Accessibility and diversifying care, and 3) Learning and unlearning for service providers. In summary, responses involved increased education/knowledge for those with lived experience and service providers (especially medical doctors), more eating disorder specific training for service providers, increased accessibility to treatment and resources, less stigma, and more community-based treatment/treatment teams.

Overall, this study draws attention to the degree to which dominant power systems continue to exert their power over our bodies. Colonialism, capitalism, and patriarchy work together to create a norm to which we are expected to confirm. Those unable to do so risk being ostracized, discriminated against, and abused. In addition to the explicit forms of violence and harm being committed against othered bodies, there is an even larger degree of implicit harm being done through systemic and institutional violence. These power systems contribute to the creation of eating disorders, and yet we continue to rely on these systems to provide us with the education and tools to remedy the very problems they have created. Further, the comments and critiques to emerge from this study have been made by feminist scholars, critical race scholars, and fat studies scholars for decades; this begs the question: why does the existing discourse persist despite decades of critique? To summarize in the words of Audre Lorde (1984, p. 2), “the master’s tools will never dismantle the master’s house.” We must work toward nuanced ways of rectifying this problem without reinforcing the harm that is and continues to be created.

Contributions

This research produces a range of contributions and implications that are relevant to the academy, healthcare professionals, community advocates and supports, and those with lived experience with eating disorders. More specifically, the research critiques our current understanding of eating disorders in self-identified young women by contributing nuanced theoretical and methodological understandings of eating disorders through an intersectional feminist lens. The research can also be used to identify which services/supports are currently working to aid those with eating disorders, what is not working, and what is missing/needed.

As stated previously, much of what we know about eating disorders come from psychological and medical theoretical frameworks. These perspectives offer very rigid and scientific ways of understanding eating disorders and fail to account for the multiplicity of socio-geo-political factors that contribute to and affect people with eating disorders. In fact, according to Walsh and Malson (2010):

> A range of dominant cultural norms and values concerning femininity, bodies, identities and so forth are implicated in the production of 'eating disordered' subjectivities and practices. Yet, despite [this]… there has to date been considerably less critical feminist attention given to the ways in which 'eating disordered' girls and women are constituted in discourses circulating amongst and articulated by the general public (p. 530).

The current study aims to distance itself from these dominant theories to make space for new ways of understanding this complex issue. By employing an intersectional feminist lens, we can begin to understand that eating disorders are much more than a mental health issue - they are products of a colonial, patriarchal, capitalist world and must be acknowledged as such.

Another important contribution of this research is its goal to identify resources and supports for individuals with lived experience of an eating disorder on global, national, provincial, and community levels. The current study aimed to identify what resources and supports currently exist and for whom, as well as how effective and accessible they are. Reflections and recommendations provided by participants reinforce the previously discussed idea that there are many tensions that exist within service providers. All four interview participants shared that more education and training is necessary for other service providers and medical professionals. This increased education and training also needs to include acknowledging one's own biases, putting a stop to reinforcing stereotypes, and unlearning harmful western ideals. There was also a consensus that there needs to be more and more comprehensive education for the general public, especially for those struggling. Further, they all concluded that there is a severe lack of diversity and lack of adequate care for diverse populations in help-seeking situations.

By identifying this, we are able to discover what is missing and may be needed to fill these gaps. However, attention must be given to the barriers involved in accessing treatment due to the COVID-19 pandemic. The current crises that the world is in have made it much more challenging to reach people with eating disorders because of the redirection of public attention to managing COVID-19 and redeployment of healthcare providers to COVID-19 related clinical care (Weissman et al., 2020). Finally, it was also important to identify what has not been working for differently positioned self-identified young women. For example, some participants shared that pre-existing resources have not been entirely effective. In fact, others have even been identified as harmful. By having a clearer understanding of this, we can better move forward in creating resources, supports, advocacy, and spaces that are safe, accessible, and helpful.

One final strength of this research is my insider position as a person with lived experience of an eating disorder. As a researcher, there are many benefits to being in this position. To begin, my lived experience has fueled me with a passion to conduct meaningful research with a unique standpoint bring forth relevant methods and analysis. I have a strong desire to learn with and about others who struggle with similar issues. Studying a community that I am a part of places me in a somewhat vulnerable position, which hopefully allowed participants to feel comfortable and safe throughout the research process. My personal experience has also equipped me with the sensitivity for and consideration of people with eating disorders. I am more aware of potential triggers and have a larger capacity for empathy and care. It should be acknowledged, however, that my insider position may also create ethical dilemmas and limitations. Collins (1999) notes the importance of acknowledging the power relations involved in the creation of outsider-within locations. She argues that there are different mechanisms, such as different group histories, involved in arriving at outsider-within positions. Although my research focuses on a group of individuals with something in common (having lived experience with an eating disorder), it is crucial that I acknowledge that no two experiences will be the same. The trajectory that each participant's life has followed, particularly their social location and where they fall on the hierarchy of power, has a significant influence on how their eating disorder presents and how it is experienced.

Limitations and Ethical Dilemmas

There are various limitations and ethical dilemmas involved in this research that should be noted. As mentioned in the section above, being an insider of the community of people with eating disorders can be cause for some concern. I must acknowledge my power within the space and organization of the research. Although I am a member of the community being studied, being the researcher places me in a position of power. It is possible that some participants may have felt uncomfortable speaking and disclosing personal information to someone who also has an eating disorder due to shame, guilt, and a spectrum of other emotions. However, it can also be true of people who do not have eating disorders. My identity as a white, cisgender, able-bodied, straight-passing person puts me in a position of power as well. By acknowledging and understanding the complexities of the position of power that I am in, I strived to create space for the voices of others to be amplified.

Next, attention must be drawn to the participants of the study. Participants with eating disorders are part of a vulnerable community. It is possible that the research topic may have been triggering. Therefore, it was crucial that survey questions were framed in a way that allowed participants to feel comfortable and safe. Service providers shared that their line of work functions largely from Eurocentric theories and methods. Therefore, it is unsurprising that a large portion of their clientele are members of privileged communities. For example, it is predominantly white, cisgender, middle-upper class women that seek treatment. Service providers shared that this was true of their own clientele, hence this is why it is crucial that demographics are taken into account in a more relevant manner. Burke et al. (2020) highlight the importance of investigating eating disorders through an intersectional lens as it "is needed to determine which intersecting identities confer highest risk, through which mechanisms, and how EDs may present differently by group" (p. 1608). Another shortcoming of this research in relation to intersectionality was the failure to adequately explore the intersection of (dis)ability. Exploring the plethora of intersections that exist has proven to be challenging. The unfortunate truth is that there is limited time and space when completing a master's thesis. However, the intersection of (dis)ability is equally as important and deserving of inclusion as each of the other intersections that have been included. Future research should be dedicated to examining this intersection with increased awareness and care.

Finally, the COVID-19 pandemic has caused several limitations in itself. Because of the COVID-19 restrictions that had been in place in Nova Scotia throughout the duration of this study, it was uncertain how data would have been collected. It was my hope that in-person interviews would have taken place. However, for the safety of myself and my participants, virtual interviews via Zoom were deemed most appropriate. Further, service providers saw an exponential increase in demand throughout the COVID-19 pandemic. Therefore, finding service providers who were available and had the capacity to participate was a challenge.

Implications for Future Research

Two major implications emerged throughout the course of this research: 1) service provider positionality, and 2) temporality and spatiality. As discussed in Chapter 6, taking client demographics into account is a crucial component within the therapeutic process. However, the current study also revealed the need to further unpack service provider identities. As much as client positionality influences lived experiences with eating disorders/within therapeutic settings, service provider positionality plays an equally important role. Service providers have been led to believe that they must be objective, neutral bodies. However, the relationship between service provider and client is dialogical and multifaceted. The interaction itself is the knowledge and informs the support that is needed.

Service providers and researchers cannot be neutral bodies when engaging in this kind of work. We need to move forward by encouraging service providers to move away from being neutral. Service providers need to give themselves permission to really engage and feel and take risks. It is important that we challenge policies and recognize how these boundaries have been solidified by oppressive power systems. Ultimately, we need to reconsider how we conceive these relationships by shifting away from the idea of providing a service and moving toward the idea of providing care. It should not be taboo or inappropriate for service providers to care about their clients. By examining and reframing these relationships, more space is created for healing.

This thesis cannot be concluded without discussing the significance of temporality and spatiality. When and where people exist, in space and time, has a major impact on the relevance of the services and supports they require. Socio-geo-political context is an essential component in determining the needs of people with eating disorders. For example, the needs of someone who existed during the 1930s Great Depression is likely very different than the needs of someone who exists today. Further, the needs of someone currently residing in Afghanistan is likely very different than the needs of someone currently residing in Canada. Time and location play a major role in how experiences are framed and what interventions are necessary – this is at the core of intersectionality. This thesis itself is not exempt from the relevance of temporality and spatiality.

Final Researcher Reflections

The current study highlights social and political complexities involved in the development and experience of eating disorders. Dominant eating disorder discourse often reproduces patriarchal, colonial, and capitalist values within a limited Eurocentric framework and practice, causing harm to an already vulnerable population. Dominant society profits off of insecurities and body-shaming, a fact that psychological perspectives fail to acknowledge.

An intersectional feminist approach significantly contributes to expanding, creating, re-evaluating, and responding to omissions and silences that are pivotal to understanding and challenging the destructive social and political narratives at play within and across discourses of eating disorders. Collins (2019) posits that intersectionality cannot be used in its truest sense without incorporating a social justice lens. She asserts that it is a way of being, not just a framework. Therefore, before concluding this thesis, it is important that readers are aware that there is no checklist for applying an intersectional feminist framework to eating disorder research. There is no step-by-step guide that outlines how to employ a way of being to one’s research. Intersectionality cannot be reduced to a simple framework. It is rich with complexity and requires a depth of work to be done to ensure it is done safely and honestly.

Participant responses have provided invaluable insight into the lived realities of eating disorder experiences among self-identified women and non-binary folks in Nova Scotia. However, it would be irresponsible if I did not acknowledge the lack of diversity in participant demographics. The data clearly advocates for a nuanced understanding and approach to eating disorder discourse and intervention; one that is rooted in fat acceptance, increased access to funding and resources, and inclusive and honest discourse about eating disorders (especially online and in the media). While this is a step in the right direction, it in itself is not enough. Most participants in this study occupy privileged positionalities and fit the norm of those whose voices and experiences are typically centered in eating disorder discourse, treatment, and research. To get a true sense of the work that needs to be done we must provide a platform for and centre the voices of marginalized people. It would be negligible and unethical to advocate for the needs of differently positioned people without having their input and centering their voices and experiences. On the other hand, we must also be cautious not to place the burden of responsibility on such folks either as that can lead to increased harm.

This study has been conducted with participants who mostly occupy privileged positionalities. And yet, it is clear that current approaches to eating disorder discourse and intervention do not serve this population despite the privileges they may have. Because of this, I pose the following question: Why are we continuing to use certain language and methods around eating disorders when it is not providing adequate support to most people? Further, it has the capacity to lead to increased harm. If some of the most privileged people are feeling failed by current approaches to eating disorders, then one can only imagine how much harm is being inflicted upon marginalized folks and their bodies. Ultimately, I advocate for eating disorder approaches that are intersectional and prioritize anti-colonialism. While I hope my research can be used as a resource to advocate for eating disorder discourse and intervention that is intersectional, decolonial, and employs a social justice lens, it is only one small contribution to the immeasurable amount of work that has been and needs to be done.

As a student of the Women and Gender Studies discipline and a person with an eating disorder, I am scholarly responsible to uncover alternative ways of understanding eating disorders and their contributing factors. Rather than simply reproducing what currently exists, I hope to call attention to the intersections of race, class, gender, sexuality, ability, citizenship, and age and how they interact with one another to contribute to the development and experience of eating disorders for self-identifying young women. Using an intersectional approach requires a shift, both conceptually and methodologically, but “will provide further avenues of research to create and/or adapt prevention and treatment to higher-risk groups (Burke et al., 2020, p. 1608). Throughout my degree, I have been exposed to new ways of seeing and critiquing the environments in which we live in and plan to apply this knowledge to my research. I am dedicated to exposing the hegemonic narratives surrounding the body and how it is perceived as well as uncovering nuanced revelations about how to think through this topic.

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APPENDIX A.1: Survey Participant Demographics

Participant	Age	Gender Identity	Sexual Identity	Racial Identity	Ethnicity	Canadian Citizen?	Location
P20	24	Woman	Heterosexual	White	Caucasian	Yes	Cape Breton
P21	26	Female	Straight	Caucasian	White	Yes	Dartmouth / Cape Breton
P22	25	Female	Bisexual	White	White	Yes	Halifax
P23	26	Female	Unsure	White		Yes	Halifax
P24	25	Female	Heterosexual	White	Canadian	Yes	Cape Breton
P25	25	Female	Lesbian	White/ Caucasian	White European	Yes	Sydney
P26	24	woman	bisexual	African Nova Scotian	African Nova Scotian	yes	Cape Breton
P27	22	Female	Female	Indigenous	Indigenous	Yes	Cape Breton
P28	24	Female	Straight	White	European Canadian	Yes	Annapolis Valley
P29	23	Female	Unknown	White		Yes	Sydney
P30	21	Female	Bisexual	White	Canadian	Yes	CBRM
P31	26	Female	Bisexual	Caucasian	Caucasian	Yes	Cape Breton
P32	22	Female	Lesbian	White	Canadian	Yes	Cape Breton
P33	25	Female	Heterosexual	White		Yes	Cape Breton
P34	21	Female	Straight	Conservative	Caucasian	Yes	Cape Breton
P35	25	Female	Straight	NA	Caucasian	Yes	Cape Breton
P36	27	Non-Binary	Lesbian	white		Yes	Cape Breton
P37	27	She/her	Straight	Caucasian		Yes	Cape Breton
P38	20	Female	Straight	Caucasian	Irish	Yes	Wolfville
P39	24	Female	Bisexual	White	British-Canadian	Yes	Cape Breton
P40	24	Female	Straight	White	White	Yes	Halifax
P41	27	femme non-binary	bisexual	white	Canadian	yes	Halifax
P42	26	Female	Straight	White	White	Yes	Cape Breton

P43	20	Female	Heterosexual	Hispanic	Cuban	Yes	Dartmouth
P44	18	She/her	Female	Caucasian		Yes	Cape Breton
P45	23	Non-binary	Bisexual	Mixed-race	White and South Asian	Yes	Halifax

Participant	Level of Education	Employment Status	Relationship Status	Children/ Dependents?	Annual Household Income	Religion
P20	College	Employed	In a relationship	No	$40,000 - $50,000	Catholic
P21	University	Employed	In a relationship	No	Above $60,000	
P22	Undergrad	Unemployed	Single	No	Less than $20,000	
P23	Private college	Employed	Single	No	Less than $20,000	
P24	Post-secondary	Full time	Relationship	No	$20,000 - $30,000	
P25	Post Degree Bachelors	Employed full time	Engaged	No	Above $60,000	Atheist
P26	high school	full time employment	single	no	$20,000 - $30,000	
P27	Undergraduate degree	Employed	In a long-term relationship	No	$30,000 - $40,000	
P28	Two bachelor’s degrees	Preservice teacher	In a relationship	No	Less than $20,000	Catholic
P29	Post-secondary	Employed full time	In a relationship	No		N/A
P30	Bachelor of Arts- in progress	Unemployed	In a relationship	No	$30,000 - $40,000	
P31	Bachelor’s degree	Full time, permanent	Engaged	No	Above $60,000	N/A
P32	High school	Full time	Committed relationship	No	$30,000 - $40,000	Agnostic
P33	Masters	Full time	Engaged	No	Above $60,000	
P34	High school completed, attending university	Unemployed	Single	No	Above $60,000	Atheist
P35	High school	Employed	Single	No	$30,000 - $40,000	NA

P36	2 bachelor's degrees	part time employed and self employed	single	no	$30,000 - $40,000	none
P37	College	Employed	Taken	No	$40,000 - $50,000	
P38	Currently in a bachelor program	Part time	Single	No	$20,000 - $30,000	
P39	BA	Full time permanent	Single	No	$30,000 - $40,000	
P40	Bachelor's - completed; Master's - in-progress	Student	In a relationship	No	$20,000 - $30,000	Atheist
P41	BA	Unemployed	single	no	Less than $20,000	
P42	Current PN student	Student	In a relationship	Yes 2 children	$20,000 - $30,000	Catholic
P43	University	Unemployed	Single	Yes, a younger sister	Above $60,000	Christianity
P44	High school	Self employed	In a relationship	No	Above $60,000	
P45	Bachelor's degree	Part-time employment	Single	No	Less than $20,000	Atheist

APPENDIX A.2: Interview Recruitment Script for Service Providers

My name is Gabrielle Smith, and I am a graduate student in the Master of Arts in Women and Gender Studies Program at Saint Mary's University. I am conducting a research project called

Reconceptualizing Eating Disorder Through an Intersectional Feminist Lens for my master's thesis under the supervision of Dr. Benita Bunjun. The purpose of the study is to examine the real, unique, and diverse experiences of self-identified women with eating disorders and how these experiences are framed and understood. This research will use an intersectional feminist analysis to examine the multiple experiences of self-identified young women with eating disorders and the current discourse surrounding these disorders. Further, this research hopes to identify the symptoms and effects that individuals with eating disorders have experienced, and how these symptoms and effects have influenced social/personal life and institutional relations.

Please consider participating in an interview in which you will be asked to share general thematic trends based on clients who self-identify as women while removing all personal identifiers. Questions surrounding observations of clients' behaviours and experiences with eating disorders will be asked.

Participation will require approximately 1 hour of your time and will be held at a location of your choice (at your place of employment, in a private room on the Saint Mary's University campus, online via Zoom, etc.).

If you are interested in participating in this study, please contact me at gabsmith97@hotmail.com to arrange a meeting time.

If you have any questions about me or my project, please contact me at the email address provided above.

If you know anyone who may be interested in participating in this study, please give them a copy of this information.

Thank-you in advance for considering my request,

Gabrielle Smith
MA WGST Candidate, Saint Mary's University

Supervisor: Dr. Benita Bunjun
Saint Mary's University, Department of Social Justice and Community Studies/Graduate Program in Women and Gender Studies
Phone: 902-496-8161
Email: benita.bunjun@smu.ca

APPENDIX A.3: Survey Recruitment Script

My name is Gabrielle Smith, and I am a graduate student in the Master of Arts in Women and Gender Studies Program at Saint Mary's University. I am conducting a research project called

Reconceptualizing Eating Disorder Through an Intersectional Feminist Lens for my master's thesis under the supervision of Dr. Benita Bunjun. The purpose of the study is to examine the real, unique, and diverse experiences of self-identified women with eating disorders and how these experiences are framed and understood. This research will use an intersectional feminist analysis to examine the multiple experiences of self-identified young women with eating disorders and the current discourse surrounding these disorders. Further, this research hopes to identify the symptoms and effects that individuals with eating disorders have experienced, and how these symptoms and effects have influenced social/personal life and institutional relations.

I am in search of individuals to participate in an online survey in which they will be asked to complete a short, anonymous, open-ended, online survey that should take approximately twenty minutes of their time. The survey will use a qualitative format as it will allow participants to describe their experiences using their own words. Survey questions will consist of a short demographic questionnaire and open-ended questions to give space for participants to share their experiences accurately and comfortably. Surveys will be completely anonymous.

Participant criteria: Survey participants must self-identify as women and have lived experience with an eating disorder (medically diagnosed or self-diagnosed)

If you are interested in participating in this study, please click the link below to access the online survey.

insert survey link

If you have any questions about me or my project, please contact me by email at gabsmith97@hotmail.com

If you know anyone who may be interested in participating in this study, please give them a copy of this information.

Thank-you in advance for considering my request,

Gabrielle Smith
MA WGST Candidate, Saint Mary's University

Supervisor: Dr. Benita Bunjun
Saint Mary's University, Department of Social Justice and Community Studies/Graduate Program in Women and Gender Studies
Phone: 902-496-8161
Email: benita.bunjun@smu.ca

APPENDIX A.4: INFORMED CONSENT FORM – INTERVIEWS

Informed Consent Form

Date:
Study Name: Reconceptualizing Eating Disorder Through an Intersectional Feminist Lens
Researcher: *Gabrielle Smith, Saint Mary's University, gabsmith97@hotmail.com, 902-217-2200*
Supervisor: *Dr. Benita Bunjun, Saint Mary's University, Social Justice and Community Studies, benita.bunjun@smu.ca, 902-496-8161*

Purpose of the Research: The research will examine the real and unique experiences of self-identified women with eating disorders and how these experiences are framed and understood. It will use an intersectional feminist analysis to examine the experiences of self-identified young women with eating disorders and the current discourse surrounding these disorders. Further, this research hopes to identify the symptoms and effects that individuals with eating disorders have experienced, and how these symptoms and effects have influenced social/personal life and institutional relations. Finally, the study will examine the multiplicities of different social locations and how these social locations influence the understanding, experience, and intervention of eating disorders.

What You Will Be Asked to Do in the Research. All in-person interviews will follow provincial COVID-19 protocols (such as wearing a mask, social distancing, and sanitizing). Questions surrounding observations of clients' behaviours and experiences with eating disorders will be asked. Each interview will take approximately an hour to complete. Interviewees will be promised confidentiality with their comments and a pseudonym will be used to refer to the participant during the analysis.

Risks and Discomforts: We do not foresee any risks or discomfort from your participation in the research.

Benefits of the Research and Benefits to You: This research will produce a range of contributions and implications that are relevant to the academy, healthcare professionals, community advocates and supports, and those with lived experience of eating disorders. More specifically, the research will critique our current understanding of eating disorders in young women by contributing nuanced theoretical and methodological understandings of eating disorders through an intersectional feminist lens. The research will also be used to identify which services/supports are currently working to aid those with eating disorders what is not working, and what is missing/needed.

Voluntary Participation: Your participation in the study is completely voluntary and you may choose to stop participating at any time.

Withdrawal from the Study: You can stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers or any other group associated with this project. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality: All information you supply during the research will be held in confidence. Your name will not appear in any report or publication of the research. Pseudonyms will be used, and personal identifiers will be removed. Your data will be safely stored in a locked facility and only the researcher and supervisor will have access to this information.

Questions About the Research? If you have questions about the research in general or about your role in the study, please feel free to contact myself, Gabrielle Smith, by email (gabsmith97@hotmail.com).

This research has been reviewed and cleared by the Saint Mary's University Research Ethics Board. If you have any questions or concerns about ethical matters, you may contact the Saint Mary's University Research Ethics Board at ethics@smu.ca or (902) 420-5728

Legal Rights and Signatures:
I *(fill in your name here)*, consent to participate in *(insert study name here)* conducted by *Gabrielle Smith*. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature ______________________ **Date** ____________________
Participant
Signature ______________________ **Date** ____________________
Principal Investigator

APPENDIX A.5: INFORMED CONSENT FORM – SURVEYS

Informed Consent Form

Study Name: Reconceptualizing Eating Disorder Through an Intersectional Feminist Lens
Researcher: *Gabrielle Smith, Saint Mary's University, gabsmith97@hotmail.com, 902-217-2200*
Supervisor: *Dr. Benita Bunjun, Saint Mary's University, Social Justice and Community Studies, benita.bunjun@smu.ca, 902-496-8161*

Purpose of the Research: The research will examine the real and unique experiences of self-identified women with eating disorders and how these experiences are framed and understood. It will use an intersectional feminist analysis to examine the experiences of self-identified young women with eating disorders and the current discourse surrounding these disorders. Further, this research hopes to identify the symptoms and effects that individuals with eating disorders have experienced, and how these symptoms and effects have influenced social/personal life and institutional relations. Finally, the study will examine the multiplicities of different social locations and how these social locations influence the understanding, experience, and intervention of eating disorders.

Your Role: This is a short, anonymous, open-ended survey that should take approximately twenty minutes of your time. The survey uses a qualitative format to allow you to describe your experiences using your own words. Survey questions will consist of a short demographic questionnaire and open-ended questions to give space for you to share your experiences accurately and comfortably. Surveys will be completely anonymous.

Participant criteria: Survey participants must self-identify as women and have lived experience with an eating disorder (medically diagnosed or self-diagnosed)

Confidentiality: All information you supply during the research will be held in confidence. Your name will not appear in any report or publication of the research. Your data will be safely stored in a locked facility and only the researcher and supervisor will have access to this information.

Voluntary Participation: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Once you have submitted your survey it is not possible to withdraw your data as we have no means of identifying your particular responses.

Risks: The survey questions inquire about potentially sensitive issues (e.g. eating disorders), and so emotional discomfort may be experienced. Before you begin, it is important to note: (a) the survey is completely anonymous (b) an overview of what the survey will entail has been provided, (c) you are free to exit the survey at any time, as well as refuse to answer any questions, (d) open-ended questions have been used to allow you to respond in a way that makes you feel most comfortable, (e) a list of available resources has been provided below

Resources:
- Nova Scotia Mental Health Crisis Hotline, 1-888-429-8167
- Crisis Text Line, www.crisistextline.ca or text 686868 via SMS
- Eating Disorders Nova Scotia, info@eatingdisordersns.ca or 902-229-8436

- Eating disorder therapists in Nova Scotia, https://www.psychologytoday.com/ca/therapists/eating-disorders/ns/halifax
- eMentalHealth, https://www.ementalhealth.ca/Nova-Scotia/All-Mental-Health-Resources/index.php?m=heading&ID=2

Questions About the Research? If you have questions about the research in general or about your role in the study, please feel free to contact myself, Gabrielle Smith, by email (gabsmith97@hotmail.com). This research has been reviewed and cleared by the Saint Mary's University Research Ethics Board. If you have any questions or concerns about ethical matters, you may contact the Saint Mary's University Research Ethics Board at ethics@smu.ca or (902) 420-5728

By clicking the button below, you acknowledge:

- Your participation in the study is voluntary.
- You are 18 years of age.
- You are aware that you may choose to terminate your participation at any time for any reason.

APPENDIX A.6: Participant Survey

Demographic Questionnaire:

1. How old are you?
2. What is your gender identity?
3. What is your sexual identity?
4. What is your race?
5. What is your ethnicity?
6. Are you a Canadian Citizen? (If no, where do you have citizenship?)/Where is your home located?
7. Which part of Nova Scotia do you currently live in?
8. What is your highest level of education?
9. What is your current employment status?
10. What is your relationship status?
11. Do you have any children or dependents?
12. Which income group does your household fall under?
    - Less than $20,000
    - $21,000 – $30,000
    - $31,000 to $40,000
    - $41,000 to $50,000
    - $51,000 to $60,000
    - Above $60,000
13. If applicable, please specify your religion.
14. What is your first language?

Eating Disorder Questionnaire

1. What eating disorder symptoms do you tend to experience on a day-to-day basis?
2. Do you have a specific eating disorder (Anorexia Nervosa, Bulimia Nervosa, Binge-Eating Disorder, etc.)?
3. How long have you been experiencing an eating disorder?
4. Has the COVID-19 pandemic impacted your eating disorder? If so, how? Are your symptoms better or worse?
5. Has isolation impacted your eating disorder? In what ways?
6. Has the COVID-19 pandemic affected your access to food? Have you experienced food scarcity? Do you have more access to food than prior to the pandemic?
7. How has the COVID-19 pandemic affected your recovery? What does recovery mean to you?
8. Has the COVID-19 pandemic affected your access to resources/services? Has it affected when and how you access these resources/services?
9. Do you think the services currently being offered to those with eating disorders during the COVID-19 pandemic are adequate?
10. What improvements can be made to help support those with eating disorders during the COVID-19 pandemic?

APPENDIX A.7: Participant Feedback Form

Purpose of the Research: The research will examine the real and unique experiences of self-identified women with eating disorders and how these experiences are framed and understood. It will use an intersectional feminist analysis to examine the experiences of self-identified young women with eating disorders and the current discourse surrounding these disorders. Further, this research hopes to identify the symptoms and effects that individuals with eating disorders have experienced, and how these symptoms and effects have influenced social/personal life and institutional relations. Finally, the study will examine the multiplicities of different social locations and how these social locations influence the understanding, experience, and intervention of eating disorders.

Data: Confidentiality of the data will be maintained by ensuring that all personal identifiers are removed and that only the primary researchers (myself and my supervisor) will have access to the data. Additionally, the data will be kept in a locked drawer and password protected on a computer hard drive. Themes will be coded by identifying chunks of data into general themes and sub-themes as they relate to the overall research questions. I will employ Rennie's (2000) Grounded Theory approach to identify common themes running across the surveys and interviews, as well as relationships/patterns among resulting themes, and descriptive statistics will be calculated for the survey data. Due to the exploratory nature of qualitative inquiry, it is difficult to predict what outcomes may be discovered through the study. In fact, good qualitative research typically produces unexpected and new insights that the researcher did not originally expect to find. Whereas quantitative analyses deductively generate a hypothesis that is tested, qualitative analyses collect data and inductively attempt to makes sense of the information/generate a new theory/visual model of themes that emerges from the data that has been collected.

Based on your experience participating in the study, please provide any feedback you have for the research team in the space provided below:

Student Researcher: Gabrielle Smith
Saint Mary's University, MA in Women and Gender Studies Candidate
Phone: 902-217-2200
Email: gabsmith97@hotmail.com

Supervisor: Dr. Benita Bunjun
Saint Mary's University, Department of Social Justice and Community Studies/Graduate Program in Women and Gender Studies
Phone: 902-496-8161
Email: benita.bunjun@smu.ca

Resources:
Nova Scotia Mental Health Crisis Hotline, 1-888-429-8167
Crisis Text Line, www.crisistextline.ca or text 686868 via SMS

Eating Disorders Nova Scotia, info@eatingdisordersns.ca or 902-229-8436
Eating disorder therapists in Nova Scotia,
https://www.psychologytoday.com/ca/therapists/eating-disorders/ns/halifax
eMentalHealth, https://www.ementalhealth.ca/Nova-Scotia/All-Mental-Health-Resources/index.php?m=heading&ID=2

APPENDIX A.8: In-Depth Expert Interview Questions

1. What demographics do most of your clients fit into? Race? Gender? Age? Sexuality? Class? Religion? Please give a general picture of your clients across gender, age, class, and race.

2. How widespread do you think eating disorders are in Nova Scotia?

    a. Do you think some people are more likely than others to experience eating disorders?
    b. To what extent do you think eating disorders have become normalized in our community and society at large?

3. Can you give a description of what your typical client with an eating disorder looks like?
    a. What specific eating disorders are most common amongst your cliental?
    b. How do these disorders tend to present?

4. Did you observe major changes in eating disorder behaviours and patterns during the COVID-19 pandemic?
    a. Did symptoms lessen or worsen?
    b. Did relapse occur?

5. Did any of your clients contract COVID-19?
    a. If so, how did this impact their disorder?
    b. How did it impact recovery?

6. Has the demand for services increased during the COVID-19 pandemic?
    a. Did clients need more support?
    b. Did new people request your services?

7. How effective and accessible do you think current eating disorder resources are?
    a. What is working well?
    b. What needs to be improved?

8. What suggestions would you give to decrease or prevent eating disorder pathology during the COVID-19 pandemic?