Exploring the Narratives of People with Lived Experiences of Eating-Related Distress and their Stories of Recovery

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Abstract

A significant portion of the eating disorder literature prioritises a clinical perspective informed by diagnostic classification and clinical markers of recovery. Yet, research into the perspectives of people's lived experiences provides very different accounts of eating-related distress and personal recovery. The personal recovery model privileges lived experiences, where symptom remission is not necessary to recover/y, but instead "recovery in" as opposed to "recovery from" is better aligned. Broad qualitative analyses cite factors in alignment with the recovery model; however, these studies often abstract from the daily, lived recoveries.

In this study, I examined the narratives of recovery among 15 adults with lived experiences of eating-related distress. Specifically, those who self-identified challenges related to food, weight, body shape, and/or exercise, and identified as doing better currently relative to one's own past experiences. A day in the life questioning approach allowed for a micro-contextualised view of recovery, exploring what it means to be "in" or "enacting" recovery across daily practices. A narrative analysis was conducted which attuned to complex social, cultural, and relational contexts, grounded within a social constructivist epistemological approach. Narratives included: Re-Appraising Body, Image and Identity, Neutrality and Nourishment, Routine and Structure, and Media and #Recovery. Participants formed intentional daily practices in recovery, largely described as an active process requiring continued re-appraisal. Daily practices centered around energy, function, pleasure, accomplishment, comfort, control, self-development, visibility, and routine. Participants described alignment, resistance, and opposition to master narratives and sociocultural prescriptions on recovery, offering a counter narrative to the clinician and researcher recovery perspectives that have traditionally dominated the literature and guided service provision to date. Overall, these multi-layered narratives align with critical feminist perspectives and may importantly inform evidence-based practice from the "inside out".

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"Ehara taku toa i te toa takitahi, engari he toa takitini"

Success is not the work of an individual, but the work of many

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Chapter One. Introduction

Terms and Perspectives

Terms and perspectives inform the way in which experiences are understood, expressed, and constructed, both on an individual and societal level. The way individuals describe their experiences are largely shaped by the categories that form and inform experiences, and the narratives or discourses that surround such constructs. What constitutes eating-related distress, and similarly, what is defined as recovery from such distress, is an area of contention across practice and research (Grilo et al., 2008; Wade & Lock, 2020; Whitley & Drake, 2010; Wonderlich et al., 2007). Understandings of recovery are influenced by the lens and language through which recovery is understood, the perspectives that are given space, and the sociocultural and political contexts in which recovery occurs. While there are varying definitions and perspectives on recovery, there is no clear consensus on what recovery is. Recovery is a multifaceted construct. I position myself in this research with a desire to understand such complexities, particularly, exploring clinical and personal recovery perspectives through individual meaning making. With an over-arching aim to understand daily practices of recovery, this renders the question; how does a person know if they are practicing recovery within a context where differing perspectives lead to a complex experience it itself.

Clinical research often explores eating-related distress through the lens and language of "eating disorders" and "clinical recovery", framing experiences within a diagnostic perspective with an emphasis on *psychopathology*, *illness*, and *disorder* (e.g., Bardone-Cone et al., 2010; Tomba et al., 2019). In contrast, research encompassing the perspectives of people's lived experiences provides very different accounts of eating-related distress and recovery (e.g., Dawson et al., 2014, 2018; Hay & Cho, 2013; LaMarre & Rice, 2016, 2021; Patching & Lawler, 2009). Language typically used when framing experiences within a

personal recovery framework are more person-centred, defined by the *person* and their *individual experiences* (D'Abundo & Chally, 2004; LaMarre & Rice, 2016, 2021). Consequently, language and labels may have different meanings for different individuals (Frank, 2005; Slof-Op't et al., 2019). Some may reject the language used within a clinical approach, some may find meaning within it, while others may view recovery as a blend of both perspectives. Perhaps, some may reject the concept entirely. In line with a social constructivist approach, the categories and concepts that provide a framework for meaning making are provided by the language that is used. Thus, it is important to hold in mind the range of terms and perspectives and consider who holds the power when defining such experiences. It is important to consider the implications of such languaging for the person experiencing the distress, both across practice and research (Frank, 2005). This chapter discusses these issues and explains the terms and perspectives that will be used in this research for eating-related distress and recovery.

It is important I begin by positioning myself within my research, allowing the reader to understand my "why" for exploring this space. I am a young woman and Doctor of Clinical Psychology trainee raised in New Zealand at the intersect between two worlds: a western world of knowing and living, and a more distant world in which I identify of Sri Lankan descent. Although I do not come from a place of lived experience of eating-related distress, I hold lived experiences within an ethnic minority group, understanding what it may be like to not be "here nor there", influenced by both systemic racism and acculturation. I hold unique insight into these two different worlds and wish for greater representation of ethnic minorities and diverse perspectives across research, treatment, and practice.

In line with my purpose, values and beliefs, my professional and research interests lie in understanding and supporting *people* beyond the situational circumstance that may *label* someone as "disordered" or "unwell". This understanding and interest in this area stems from

my residential work experience in child, youth, and adult mental health and addictions settings in Ōtepoti (Dunedin) and Tāmaki Makaurau (Auckland). Across both work experience and my clinical training, I have supported several people struggling with complex eating, weight, and body image difficulties. I observed that it was often the day-to-day practices that impacted on a person's sense of independence, self-esteem, and resilience, all contributing towards self-defined well-being and recovery. For example, the connection and sense of discovery elicited when a young person learns to cook, is given a safe space to talk, to eat, express creativity, or learns life skills such as reading the clock or riding a bus. It was these small, yet significant day-to-day activities that the clients/service-users often reflected on at their "graduation" as key moments within their recovery journeys. It is these daily practices I am most interested in hearing about from those with lived experiences of eating-related distress and recovery. As I am not able to witness these micro-moments of recovery first-hand, I am interested in the processes deemed most important to them, by them. In line with the notion of everyday life, daily practices are interpreted as subjectively meaningful and presented as reality. From this perspective, this research holds focus on a person's recovery rooted within a wider contextual lens, situating both distress and recovery within social and relational contexts. Extending beyond clinical parameters into wider possibilities, daily practices may illustrate how recovery is *enacted*, as opposed to achieved or reached. I believe recovery possibilities lie within an understanding of how a person is situated across contexts, where a wide-lens orientation opens greater scope for understanding recovery.

Eating-Related Distress

Eating-related distress will be used as an umbrella term in this research, to encompass a problematic or challenging relationship/s with food, weight, body shape, and/or exercise. Drawing from a critical post-structuralist perspective, this term broadly encompasses a range

of distress that may include any form of disordered eating, regardless of diagnosis (Malson & Burns, 2009; Patching & Lawler, 2009). Although some people may identify within a diagnostic framework, keeping the language broad encourages a focus on meaning making and knowledge from those who do not have or reject the idea of diagnosis, yet self-define a problematic or challenging relationship with food, weight, body shape, and/or exercise. By using this definition, I aim to be inclusive in generating findings beyond the diagnostic perspectives from which eating-related distress has largely been clinically defined to date.

Recovery

Over the last twenty years, the concept of recovery has become increasingly influential as a key concept in mental health service development and practice. Despite this, recovery remains poorly defined across the literature and clinical space. While recovery is considered the "end point" for clinical interventions aimed at addressing disordered eating and body image, a poorly defined concept suggests that the "end point" may not be as straight forward, linear, or standardised, as the term suggests (Bardone-Cone et al., 2010; LaMarre et al., 2015). Lacking consensus on its definition there are divergent perspectives on the development and maintenance of eating-related distress. This subsequently influences the perspectives through which recovery is understood, measured and/or explored, across both quantitative and qualitative research (Bachner-Melman et al., 2018; Howell & Voronka, 2012; Noordenbos, 2011). For example, in a study by Noordenbos (2011), ex-patients and therapists were asked to select recovery criteria from a list that they viewed as important for recovery from an eating disorder. While ex-patients and therapists agreed upon most of the same criteria for recovery, having enough sleep was identified as a relevant construct within recovery by 83% of patients, yet only 38% of therapists rated this as important. This examples one of many differences in perspective between therapist and patient, suggesting

that what might be important to those journeying recovery, may not always match therapist recovery goals. Similarly, while clinical criteria identified the return of menstruation as an indicator of recovery, 50% of the ex-patients in this study rated regular menstruation as the least important criteria to them. Noordenbos (2011) and others before this (and since then), note a lack of clear, consistent, and measurable definition of recovery.

As different people represent various positions, purposes and perspectives, different definitions exist based upon the stakeholder and the orientation (Bowlby et al., 2015; LaMarre et al., 2022; Musolino et al., 2016; Noordenbos, 2011; Noordenbos & Seubring, 2006). I am less interested in which definition holds the absolute truth, aligning with a social constructivist view that there is no objective truth. Instead, I am interested in exploring the experiences and constructions of eating distress and recovery through story. A social constructivist approach overall takes a critical stance towards taken for granted knowledge, critically examining how one may interpret and understand the world through meaning making. By holding this stance, what is most important within this project is grounding an overall definition in alignment with the personal recovery model, and critically engaging with the assumptions of recovery perspectives that have traditionally dominated the literature and guided service provision to date.

The personal recovery model is embedded within the history of the personal recovery movement. Since the mid 1900's, early advocacy efforts of those who have since referred to themselves as consumers/*tangata whaiora* of mental health services, ex-patients, and/or survivors[1], have challenged the system by privileging knowledge gained through personal experience over clinical knowledge (Ahmed et al., 2012; Chamberlin, 1978). The personal recovery model was fueled by consumers'/survivors' views that traditional systems of recovery fostered disability, alienation, oppression, and marginalisation, and that a social

[1] People with mental distress use various terms and languaging to refer to themselves such as these

transformation was necessary to deal with the pervasive stigmatisation and exclusion experienced by those with mental illness (Frese et al., 2009; Jacobson & Curtis, 2000). During the second half of the 20th century, widespread de-institutionalisation of the mental health system occurred across most of the western world, including New Zealand. It was through de-institutionalisation that the development of psychotropic medication was introduced to reduce the economic burden of government funded mental health hospitals, with the view that treating those within the community would be more effective (Talbott, 2004). Albeit a potential positive step, mental health services were still criticised for lacking a cohesive and effective strategy to provide community support (Test, 1984). This continued to inadvertently perpetuate the idea that people living with mental distress faced a lifetime of medicated symptom management, reinforcing the idea that recovery was not possible (Mead & Copeland, 2000). It was against this backdrop that service users and advocates fought to promote an alternative version of "mental illness", one that transcended symptom relief and focused on supporting people to live a satisfying and meaningful life, despite/amidst distress.

It was these significant events that reflect the period of the "recovery movement", an era in which the "personal recovery model" was born (Anthony, 1993). The underlying philosophy of personal recovery is that people living with mental distress deserve more than just symptom relief (Anthony, 1993). Mental illness is viewed as only one aspect of the whole person, where a sense of fulfillment and meaning is possible, despite the presence of symptoms (Anthony, 1993; Davidson & McGlashan, 1997). Since the beginning of the recovery movement, empowerment, self-direction and choice have been core tenets to the model (Chamberlin, 1978; Mead & Copeland, 2000). The recovery model privileges knowledge gained through personal experience, where symptom remission and normal functioning are not necessary to recover/y but instead, a "recovery in" as opposed to "recovery from" orientation is better aligned.

The national mental health strategy; *Blueprint for Mental Health Services in New Zealand* (Mental Health Commission, 1998), loosely defines recovery as "living well in the presence or absence of one's mental illness" (p.1), emphasising hope, social and personal responsibility. In its updated edition; *Blueprint II: Improving Mental Health and Well-Being for all New Zealanders* (Mental Health Commission, 2012), recovery is defined as "living well in the community with natural supports" (Mental Health Commission, 2012, p. 47). These definitions align with Anthony's (1993) articulation of recovery as *"*a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and roles. It is a way of living a satisfying, hopeful and contributing life even within limitations caused by the illness". Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness*"* (Anthony, 1993, p. 527). This project engaged with the tenets of the personal recovery model through participants' self-identification of recovery and specific focus on daily practices that enact a broader representation of living well in the presence or absence of distress. More specifically, recovery was broadly described as doing better currently than in the past, relative to one's own personal experiences of distress. While this broad definition of recovery was used as a starting point in this study, it was specifically participant's own self-identified recovery that I was most interested in, rooted within each individual's own experience.

Chapter Two. Eating-Related Distress and Recovery

In this chapter, I situate my research both in its broader contexts and the existing body of literature. I begin by exploring and critiquing what is known about eating-related distress, before moving to a discussion and critique on eating-related distress recovery specifically. The dominant diagnostic discourse is introduced, where one psychiatric classification system is explored (DSM-5) and critiqued. I analyse the definition of eating distress within a diagnostic perspective, exploring estimated prevalence rates, linguistic considerations, and the merits and critiques of such a classification system. From here, the discussion shifts towards a contextualised discussion of eating-related distress, engaging with the critical feminist literature in line with the orientation of this research. A contextualised approach is centred around an understanding of sociocultural, political, and economic contexts, beginning with contemporary western contexts of beauty and thinness. As eating-related distress is known to transcend across all ages, ethnicities, cultures, sexual orientations, and genders, a discussion on the gendered, raced, and classed assumptions and impossibilities generated from the misconception that eating distress only affects young, white, middle-class, females, is also discussed (Musolino et al., 2016; Thompson, 1994). Lastly, cross-cultural literature illuminates a broader interpretation of eating-related distress beyond western models of understanding. Within this, eating behaviours may be understood to serve a purpose of care and control, in response to pain and trauma for example, instead of simply being tied to a preoccupation with weight and body shape.

In the second part of this chapter, I explore the perspectives of recovery, critiquing the clinical model before reorienting discussion towards the personal recovery model. The personal recovery model is influential in both this chapter and my research. Implementation of this paradigm shift across mental health services, particularly in New Zealand, is reviewed, highlighting the gaps in translating policy to practice. From here, qualitative recovery studies

will outline how the personal recovery model has been taken up among the eating disorder literature specifically. Shifting the narrative from a clinical recovery model to the accounts of those who have experienced/or are experiencing personal recovery is of key importance. By the end of this chapter, the rationale will be clear for the need to elicit a rich understanding of situated lived experiences of recovery among those with experiences of eating-related distress in New Zealand.

Lastly, eating-related distress and recovery is contextualised within a New Zealand context, considering the indigenous people of the land; Māori as tangata whenua[2]. A discussion on the current socio-political and economic context highlights the influences of COVID-19 within a New Zealand context, impacting how people navigate recovering within this fraught time and context.

Understanding Eating-Related Distress

Our world is saturated with messages about ideals surrounding bodies and eating practices, where this material may have significant impact on a person's ability to feel at peace in their own body. People's challenging experiences and relationships with their bodies, weights, shapes and/or eating highlights the importance of exploring what this may be like; more specifically, what constitutes eating-related distress. What is known about eating-related distress depends largely upon the perspective explored. While I am not interested in coming to a consensus on a dominant perspective, I acknowledge there is merit in engaging with multiple perspectives to supplement the traditional diagnostic understandings predominant across practice and research (Brinchmann et al., 2022; Wade & Lock, 2020). Understanding eating-related distress through the dominant diagnostic model will be

[2] Māori as Tangata Whenua can be directly translated to "people of the land", referring to Māori people as the indigenous people of Aotearoa, New Zealand.

critiqued and analysed in relation to a critical feminist perspective, where there is a greater focus on contextualising distress, in line with the direction of this research.

Critiquing Diagnostic Definitions of Eating-Related Distress

Eating-related distress categorisation occurs across multiple diagnostic approaches and classification systems. There is no consensus on the best way of classifying eating-related distress, reflected by iterations of psychiatric classifications, such as the DSM (Ferreday, 2012; Ison & Kent, 2010). Unclear diagnostic boundaries makes it difficult to differentiate between unusual patterns of eating from clinically significant distress, thus creating further ambiguity on what is defined as an "eating disorder" (Fairburn & Bohn, 2005; Polivy & Herman, 1987). For example, Other Specified Feeding and Eating Disorder (OSFED) comprises 40-60% of all ED diagnoses (Galmiche et al., 2019; Stice et al., 2013); where unclear delineations between diagnoses has led to a proliferation of OSFED diagnoses (Forbush et al., 2018). Homogenising varied experiences of distress into a discrete category may possibly leave individuals in a state of diagnostic uncertainty (Garfinkel et al., 1995; Thomas et al., 2009). Given the nature of such a classification system, however, it is not uncommon to see high rates of diagnostic "crossover" or co-morbidity across diagnostic categories (Eddy et al., 2008; Mortimer, 2019; Peat et al., 2009). Within a diagnostic approach, little space is given to the individual to be the narrator of their story and labeler of their own experiences.

The DSM classification system takes a biomedical perspective to defining, describing, and categorising the way distress is framed and understood, primarily generated from western research (La Roche et al., 2015; Thakker & Ward, 1998). Diagnostic practices are based in biomedicine, the dominant model of disease that applies biological principles to clinical practice (Engel, 2012). A biomedical perspective describes a state of health defined

in the absence of illness (Deacon, 2013). I will be engaging with diagnostic discourses, while this is rooted within the perspectives of biomedicine, I am specifically exploring concepts of distress classification. Diagnostic classification systems are based on meeting a threshold of symptoms that determine whether criteria are met for a disorder. A major limitation lies in the subjective nature of clinical judgement, determining whose distress is deemed "severe enough" to meet diagnostic classification (Hoek, 2006; Santomauro et al., 2021). With the need to broaden the approach to illness to include psychosocial factors, diagnostic classification includes clinical severity based on the impact symptoms have on functioning across one or more life domains. The DSM-5 defines an "eating disorder" as the "persistent disturbance of eating or eating-related behaviour that results in an altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning" (American Psychiatric Association, 2013, p. 329). Diagnoses under this umbrella term in the DSM-5 encompass anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), other specified feeding and eating disorder (OSFED), pica, rumination disorder, and avoidant/restrictive food intake disorder (ARFID). In the DSM-5, AN is characterised by a "restriction of energy intake relative to requirements, leading to a significantly low body weight that is motivated by an exaggerated concern about body weight and shape", while BN describes "recurrent episodes of binge eating with extreme compensatory behaviours such as vomiting, laxative misuse, over-exercise, and/or fasting" (American Psychiatric Association, 2013, pp. 382, 387).

The overall lack of diagnostic clarity suggests that the line between pathological and non-pathological eating is not as clear as the DSM may suggest (Keel et al., 2011; Thomas et al., 2009). Research has found substantial crossover between eating disorder categories. For example, 20-50% of individuals with AN will develop BN over time (Bulik et al., 1997; Tozzi et al., 2005), with 40-50% of individuals diagnosed with an eating disorder at baseline,

"migrating" in the first five years to a different diagnosis (Stice et al., 2013). If a person with OSFED who has a history of AN and BN was told that they have had three psychiatric disorders, two of which they have recovered from but are presently not "fully recovered" according to DSM-5 criteria, they may react with scepticism, confusion, and possibly hopelessness. The commonality of subtype migration suggests that diagnoses may not be neatly partitioned or approached in the same way medical conditions are. This poses the question whether diagnostic categories are indeed the best way to understand the varying levels of distress people experience, and whether eating distress can be divided into binary categories as suggested by the distinction of "pathological" versus "non-pathological" (Malson & Burns, 2009).

While the DSM classification system has some limitations, including those noted above, it can pose some merit for guiding clinical assessment and intervention. The benefits of a diagnosis include specialised funding and support, a framework in which to view an array of "symptoms", and a sense of categorisation that may offer relief to individuals who find comfort in knowing their experience fits into a known and researched framework of distress (Forbush et al., 2018; Herman et al., 2014). However, others may not find the same sense of support from a diagnosis, and it may not be as simple as reducing experiences to fit within a dichotomous diagnostic approach (Keski-Rahkonen & Tozzi, 2005; Lester, 2007). Perhaps there is more nuance to experiences that extend beyond a diagnostic/non-diagnostic categorisation system.

Diagnostic categorisation also invites opinion and certain stereotypes that may impact how a person feels about receiving or being framed within such diagnoses. Studies examining public opinion reveal that the public tend to hold more negative attitudes about certain symptoms; socially rejecting and stigmatising purging behaviours that are characteristic of BN, while viewing symptoms of AN as "normal" (Roehrig & McLean, 2010). Perhaps,

normal refers to the way restrictive practices are somewhat accepted or even praised in a diet-culture context. Often, AN and BN are constructed in hierarchical opposition to one another, based on assumptions about normative femininities where AN is regarded positively as a successful desire towards the pursuit of thinness, whilst BN is positioned as undesirable in contrast (Burns, 2004; Mortimer, 2019). The moral value implied by these two diagnostic categories alone suggest that certain stereotypes exist among society and may be experienced through such categorisation.

It is likely that people's meaning making of diagnosis span the spectrum from pro to anti-diagnoses and includes all the shades of grey in between. While I hoped to include all perspectives in my research, I specifically aimed to hear from those who are often missed in research and practice, or those who may be omitted because they do not fit neatly into a category. I envisioned the people who are unable to access support that requires a diagnosis based upon systemic and/or structural barriers, or the people who are marginalised in society and do not feel that research would account for their lived reality or understand their sociocultural context. Where individuals do not meet or identify with diagnostic criteria yet still identify their patterns of eating to be a problem to them, the focus must be re-oriented to the person's constructed meanings of distress and expression for well-matched support.

Critiquing Prevalence Estimates

Prevalence estimates are collected in order to get a sense of how common eating-related distress is among the general population in order to meet population health needs from a resource perspective (Smink et al., 2012). Prevalence estimates, however, may be inadequate, outdated, and marked by several limitations. On the whole, epidemiological research is not often collected for eating disorders, and when it is, certain disorders are often omitted (Santomauro et al., 2021). For example, a review by Hoek (2003) did not include

data on participants with an EDNOS diagnosis (now termed OSFED), due to the limited epidemiological information available for this category across the literature. This not only translates to less information on OSFED, but also creates a context in which OSFED may be considered “less important” to understand than other disorders. Anorexia is given greater research priority and funding which in turn may communicate a hierarchy of importance that extends beyond research into clinical and sociocultural spaces. A hierarchical structure across diagnoses communicates unhelpful messages to those whose version of distress is not recognised in research or practice. It is also important to note that, like this review, most prevalence estimates are vastly outdated by over 10 years, particularly in New Zealand (Hoek, 2006; Hudson et al., 2007; Oakley-Browne et al., 2006; Smink et al., 2012). Outdated estimates may reflect an underestimation of true distress among the general population, marginalising or missing certain groups of people altogether.

A synthesis of 135 epidemiological studies collated prevalence estimates between 2009 and 2021 with the sampled population inclusive of developed western countries (Hay et al., 2023). This study observed a lifetime prevalence rate between 0.6% and 2.2% for AN, 1.9% among females and 0.6% among males for BN (Galmiche et al., 2019), and 1.9% for BED. Reported prevalence rates have increased among both males and females particularly for BN and BED (Hay et al., 2023), however, prevalence rates remain double among females than among males (Kessler et al., 2013). Since updating diagnostic criteria through the DSM-5, the removal of amenorrhea has increased sensitivity for detecting male AN (Call et al., 2013; Dahlgren et al., 2018). Where there is a much smaller evidence base for OSFED compared to AN, findings reflect significant variation across OSFED community prevalence studies (Hay et al., 2023). One study using DSM-4 criteria suggests that the prevalence of EDNOS among adults in the United States is 4.8% and 4.6% among adolescents (Le Grange et al., 2012). Findings indicate that eating disorders appear more prevalent among adolescents

and young people, particularly among young women (Le Grange et al., 2021). These findings support earlier research where rates for AN were found to be highest for females in the 15-19 age group, comprising approximately 40% of all identified cases (Hoek, 2003). More recent research suggests that people identifying as LGBTQIA+ are six times more likely to have an eating disorder, compared to the general male population (Watson, Adjei, et al., 2017).

The New Zealand Mental Health Survey (*Te Rau Hinengaro*) found that half of those who met criteria for AN developed distress before the age of 19, with increased prevalence rates in females compared to males and frequent co-morbidity with anxiety and depression (Oakley-Browne et al., 2006). A lifetime prevalence of 0.6% for AN and 1.3% for BN has been reported using a general population sample. These findings, however, are limited by the age of the data and an older classification system (DSM-4) at the time of data collection, where diagnostic categorisation and cut-offs have since been revised in the DSM-5. According to the New Zealand Mental Health Survey (*Te Rau Hinengaro,* 2006), eating disorders are at least as common in Māori as non-Māori, and in some cases higher (particularly BED and BN). However, to date, there is very little research focusing on eating-related distress among Māori (Clark et al., 2023; Lacey et al., 2020), as research has predominantly included a New Zealand European/Pākehā population. Lacey et al. (2020) suggest that Māori do not receive treatment in specialist services at a level proportionate to prevalence rates. They hypothesise the unmet need to be linked to systemic bias and factors related to deprivation, reduced access, shame, and secrecy leading to low help-seeking. More recent research by Clark and colleagues (2023) explored Māori experiences of accessing treatment for eating disorders, identifying both systemic and social barriers. Systemic barriers included the idiosyncratic use of assessment methods, inaccessible service locations, and limited inpatient beds. Social barriers included those identified in previous research (Lacey et al., 2020) as well as the idea that support networks can act as both an enabler and barrier to

accessing support (Clark et al., 2023). Although Māori are not the focus of this research, it is important to highlight such findings and limitations, recognising Māori as tangata whenua (the people of the land of New Zealand).

While prevalence rates hold merit for understanding eating-related distress to some degree, limitations exist when considering who is missed from this count. For example, those who may not fit within a diagnostic category, those who do not seek help, or those who get missed due to aforementioned barriers to recognition including not fitting stereotypes. The gender disparity in reported prevalence rates suggests the proportion of males may be an underestimation of the true distress in the population (Strother et al., 2012). People from diverse backgrounds are often neglected from prevalence data altogether, further reinforcing cultural stereotypes (Cheng et al., 2019). Treatment non-seekers most frequently endorsed barriers such as financial difficulties, followed by not believing others could help, feelings of shame, fear of being labelled and discriminated against. These omissions and occlusions in turn may lead to unclear and inconsistent rates, overlooking distress that does not fit within a diagnostic lens, thus underestimating the true level of both population distress. These are the understandings and perspectives that are not accounted for when a diagnostic or clinical lens is applied to understanding eating-related distress.

While diagnosis certainly has its importance and place, I believe it does not capture a person's *contextualised state of living.* Extending beyond these parameters, a broader perspective is considered. To do this, a situated analysis of self-defined eating-related distress is required in line with a social constructivist epistemology, where probing beyond diagnostic categorisation is a key element of my approach. This research aligns with a feminist-informed orientation towards both eating-related distress and recovery.

Contextualising Eating-Related Distress within Critical Feminist Perspectives

While a diagnostic perspective, more specifically, the DSM classification, has merit as discussed above, many critical feminist scholars question its use. Linguistic critiques point to the differences between a diagnostic perspective and a feminist perspective where language use offers different meanings. By unpacking diagnostics, many critique the language around the term“ eating disorder” which may imply pathology located within the individual (Malson & Burns, 2009). Thompson (1994) points out potential issues with this term, similarly, suggesting that the term “eating disorder” categorises the problem as an individual pathology with little recognition of the social inequalities underlying the person’s context. Some alter the use of the term by changing the order and emphasis of speech, doing so by adding a slash (eating dis/orders) or parentheses to eating (dis) orders, while others reject the term altogether. Others opt for terms such as “eating issues”, “eating distress”, or “eating problems”, reflecting a range of experiences beyond diagnostic classification (LaMarre et al., 2022).

Early literature may also be critiqued for its exclusive focus on gender (predominantly female) at the exclusion of race and sexuality, overlooking the cultural variation and complexity of eating-related distress across diverse people and experiences (Thompson, 1994). Despite this, it is known that eating-related distress is experienced by all genders, ages, and sexualities, inclusive of people of colour and ethnic minorities (Jones & Malson, 2013; MacDonald, 2011; Rinaldi et al., 2016; Root et al., 1986). How are people within minority groups meant to feel safe and understood in a world where societal structures impact on visibility? While this view cannot be generalised to all minorities, for those who experience marginalisation, it makes me question how this may in turn impact the meaning-making of both eating-related distress and recovery. A discussion on contemporary contexts of beauty, cross-cultural perspectives, and sexuality will provide a contextualised discussion

and integration of feminist perspectives on eating-related distress. To understand eating distress, feminists argue that the culture itself must be subject to analysis and critique and that underlying oppressive normative assumptions be exposed (Allan, 2005).

Within this sociocultural context, research has pointed to key influences on eating-related distress such as the internalisation of the thin-ideal, diet culture, eating and exercise practices, and weight stigma (Polivy & Herman, 2004). At a broader level, living within a western, neo-liberal societal context imposes its own challenges for people living in a body. Constrained and conflicted by contemporary views on beauty, weight, and body shape, makes nourishing one's physical and mental well-being a challenge (Gotovac et al., 2020; Hancock et al., 2000). Feminist perspectives articulate disordered eating as a social epidemic that stems from gendered oppression and unrealistic beauty standards among western capitalist cultures (Malson & Burns, 2009). This includes the social roles, expectations, and understandings of sexuality interlinked with personal agency. These cultural norms and gender roles are long entrenched and continue to provide a context for understanding women's preoccupation with thinness and their pursuit towards beauty that exists today (Rodin et al., 1984). A post feminist perspective on the other hand describes embodied self-monitoring, discipline and transformation as freely chosen rather than culturally demanded which also has a significant impact on how contemporary women come to understand body image (Riley et al., 2023).

Understanding contemporary culture is important, where studies point to the influence imposed by the thin ideal of beauty and its empirical link to the development of eating-related distress (Aparicio-Martinez et al., 2019; Batista et al., 2018; Marks et al., 2020). To understand the current context of thin pursuit, an explanation is first rooted in history. From the 1960's, thinness was equated with attractiveness whilst larger bodies held opposite connotations and deep stigmatisation. The landscape around body image ideals today, is ever-

changing. People seem to face a wider variety of body image prescriptions beyond the pursuit of thinness alone, facing additional pressure to conform to the image of "health", "fitness", and "wellness" (Betz & Ramsey, 2017; Griffiths et al., 2018; Raggatt et al., 2018). Particularly prominent is a direction towards "fitspiration", reflecting a "strong is the new skinny" notion (Boepple et al., 2016), alongside ideals that promote curves (Ahern et al., 2011) and athleticism (Simpson & Mazzeo, 2017). Post feminism ideas position a weight, health, worth disciplinary lens through its construction of femininity as a bodily practice requiring self-surveillance and improvement (Riley et al., 2019). Within a post-feminist lens, fitspiration draws on a subject position that centers athletic ideal as a form of discipline and transformation towards health (Riley et al., 2019). Neoliberal healthism constructs health through self-control, choice, and responsibility (Riley et al., 2019). As social media becomes further embedded in lifestyle practices, digital influence strengthens master narratives around bodies, health, fitness and beauty (Camacho-Miñano et al., 2019). This power can be considered disciplinary as people internalise such master narratives and discipline themselves accordingly. With several incongruent body-ideals circulating in our society, it is no wonder body dissatisfaction is increasing within a sociocultural backdrop that fosters social impossibilities and prescriptions around bodies (e.g., the perfect body, the bikini body, the post-partum body). Post feminism views on eating distress adds further contradictions and complications through a complex set of intersecting discourses. For example, the scrutiny of women's bodies is both oppressive, but also located within a discourse of care.

While prescriptions exist for thin bodies, similarly, discourses around living in a larger body circulate through forms of weight bias. Weight stigma (also known as weight bias/fat-phobia) refers to the view that larger bodies are systematically devalued and criticised based on based on body weight alone (Tomiyama et al., 2018). Persisting as a pervasive form of discrimination, weight stigma presents at an individual, interpersonal,

institutional, and societal level, therefore is relevant to a contextual understanding of eating-related distress and recovery (McEntee et al., 2023; Puhl & Heuer, 2009). One widely understood example of thinking about bodies and health is the "obesity epidemic"; where under such discourses that align with healthism master narratives, larger bodies are devalued and assumptions are made about health and worth based on weight (Rice, 2015; Saguy & Ward, 2011). Master narratives are culturally dominant prescriptions that can be regarded as appropriate ways to experience and behave in the world, determined by society at large (Thorne & McLean, 2003). When we explore cultural discourses on what it means to be "healthy", "well" or even "beautiful", it is important to orientate ourselves to the master narratives that circulate in our society (Rich, 2018). Applying this concept when exploring eating-related distress, master narratives may inform a person's view and care towards their body (Halse et al., 2009), based on instructions that circulate in society. In alignment with a social constructivist view, distress is culturally and historically specific, thus, products of social and economic arrangements prevailing in the culture at the time (Burr, 1995).

Weight stigma has been reported across healthcare from framework to practice. Examples include unsupported weight classifications guiding diagnosis (McEntee et al., 2023; Sim et al., 2010), where people in larger bodies are less likely to receive a diagnosis and experience a longer wait time before receiving treatment (Lebow et al., 2015). Similarly, "looking thin" often defines the dialogue between clinician and patient, where the concerns of a "typical" patient are often sorted based on bodily dimensions than level of distress (Malson et al., 2004). This reinforces the misconception that eating-related distress is primarily a pursuit for thinness and may overlook people in larger bodies, minimising and marginalising one's experiences based on body weight alone (Polivy & Herman, 2004; Puhl et al., 2014). This notion does not accommodate for varied experiences of distress, reinforcing stereotypical assumptions, overlooking and over-simplifying the complexity of a

person and their life circumstances. I believe this to be inherently problematic, as it not only reinforces weight stigma, but poses another level of societal impossibility for those navigating recovery. Some treatment providers have even been found to hold fatphobic attitudes themselves (McEntee et al., 2023). Despite the need for greater weight inclusive care, there is also a sense of resistance within this sociocultural climate (McEntee et al., 2023). This suggests to me that master narratives continue to strongly inform the way bodies are viewed, where sociocultural meanings around thinness continue to be valued, and such implicit biases are left unchallenged.

The intricacies of race, class, and sexuality, specifically, encourage us to rethink demeaning assumptions about white middle-class femininity and to broaden our views on distress among diverse populations. It was once thought that people of colour were "protected" against the development of eating-related distress based upon cultural beliefs around beauty (Root, 1990). Protection was thought to occur through the appreciation of a physiologically "healthy" body size with less emphasis on physical appearance, in contrast to Western culture where thinness was valued and accepted as physically superior, to that of a larger body (Root, 1990; Warren et al., 2005; Wildes et al., 2001). Although some studies have found that people of colour are less susceptible to eating disorders and that one's cultural context may offer "protection" to some degree (Gordon et al., 2010), other studies suggest greater similarities among ethnic groups and their western counterparts (Grabe & Hyde, 2006). Individuals across diverse ethnic groups are subject to the same standards of beauty present within the dominant culture, particularly where the culture of origin is devalued by the dominant culture e.g., African Americans living in the United States of America (Cheng et al., 2017; Cheng, 2014; Root, 1990).

Mainstream cultural beauty ideals may be especially oppressive for women of colour, as appearance standards favour those with lighter skin, a certain hair colour and texture, lip

size, and body configuration. These societal beauty standards are largely rooted within patriarchal structures and continue to influence gendered roles and responsibilities (Davis, 2018; Harris & Kuba, 1997; Latu, 2020). This raises the question: in what ways do these sociocultural forces cohere to generate barriers to recoveries, particularly for ethnic minorities living within a western society who may not be centred within eating related research, yet alone, society in itself? The #BlackLivesMatter movement, as an example, offers insight into the current societal and cultural inequities in the world, where people face on-going discrimination and marginalisation based on race alone. I believe it is imperative that situated research is conducted to better understand the sociocultural context in which recovery takes place, particularly appreciating the complexities and challenges for recovery among those identifying outside dominant cultural groups.

Understanding cross-cultural literature illuminates a broader, transcultural interpretation of eating-related distress. A few studies have challenged the causal role of western beauty ideals in the development of eating disorders, highlighting the purpose of care eating-related distress affords beyond shape and weight alone. The growing cross-cultural literature has pointed to westernisation, or acculturation as major risk factors for the development of eating distress. A greater understanding for the role of power hierarchies, cultural and gender role responsibilities may explain diverse presentations across diverse people (Becker et al., 2010; Podar & Allik, 2009; Rodrigues, 2017). While the phenomenon of westernisation contributes to understandings of eating distress among Asian populations, more recent attention has been given to the multifaceted cultural transformations driven by industrialisation and urbanisation (Pike & Dunne, 2015; Van Son et al., 2006). These transformations include shifts in population demographics, food supply, traditional family structure, gender roles, and global economies, contributing to a deeper understanding of eating-related distress among Asian populations (Pike & Dunne, 2015).

A subset of people who present with all the symptoms of AN except for the abnormal fear of fat or weight gain, provide difficulty in determining and detecting eating disorders cross-culturally. For instance, Hsu et al. (1993) found that among a sample of 70 women with anorexia in Hong Kong, 58.6% did not exhibit fear of fatness throughout their illness, instead, reported physical problems as opposed to weight and shape concerns. A similar result was found in a sample of Singaporean schoolgirls: 60% of the sample reported no conscious fear of becoming fat (Tian, 1994), a term classified by Lee (1993) as "non-fat-phobic". These studies suggest that the diagnostic criteria for AN is not best matched to the experiences of all ethnicities, where in this instance, these participants would not meet clinical criteria despite distress. Perhaps, manifestation through physical symptoms is culturally normative and requires greater understanding. Steiger (1995) argues that an over reliance on weight preoccupation risks being ethnocentric and misses the universal power of food refusal as an attempt to free oneself from the control of others. In line with a situated feminist understanding of distress, changed eating patterns more often begin as solutions to problems, than problems themselves (Thompson, 1994). This notion has been documented across several non-western populations (Davis & Yager, 1992; Pike & Borovoy, 2004; Tian, 1994). These studies point to another limitation of the diagnostic perspective, which may miss or overlook diverse manifestations of distress.

Thinness itself may not be a central objective for those struggling with eating-related distress, but instead, be better represented by a fear of loss of control, understood within a transcultural context (Katzman & Lee, 1997). To focus on contextual variables that may lead to clinical interventions, Katzman and Lee (1997) suggested organising eating disorders as a problem of disconnection, transition, and oppression, as opposed to being tied simplistically to dieting and weight. The importance of parental and peer influences, particularly in relation to autonomy conflicts, control, and identity stressors, has been increasingly more central to

this understanding (Pike & Dunne, 2015). Pike and Borovoy (2004) found that Japanese women subjectively experienced thinness as an attempt to resist the demands associated with mature adult relationships, for example, master narratives for female roles such as motherhood. It has been thought that restriction is a way of articulating female autonomy, to reclaim personal agency and resolve ambivalent demands, particularly among South Asian women where autonomy is devalued (Littlewood, 1995). How resistance plays out in a person's story appears to be important within a transcultural context, where women may find voice and agency through such behaviours. Anorexia, for example, has been positioned by feminists as a form of resistance to the oppression women face based on gendered power differentials (Katzman & Lee., 1997). Faced by contradictory cultural pressures, starvation can be interpreted as an attempt to reject gendered femininity and the expectations that come with womanhood (Orbach, 2018).

The critical feminist literature offers rich understandings of eating distress situated within socio-political, cultural, and historical contexts; especially in regard to dominant discourses and power distributions as they relate to gender and oppression (Bordo,1993). Feminist approaches are grounded in intersectionality, attending to the structural and systemic factors that contribute to oppression and impact experiences around food, exercise practices and embodied distress (Crenshaw, 1989). Intersectionality highlights various social forces that blend to create unique experiences, acknowledging conditions of privilege and marginalisation within the nuances of human experience (Crenshaw, 1989). From a feminist perspective, oppression results from social categories which involve discrimination, exploitation, and domination of one group over another, where power can be understood between individuals and the social worlds inhabited (Allen, 2005).

Eating behaviours clearly hold different purposes for different people. This is clearly articulated by Lavis (2016), who states "although self-starvation may be clinically framed as

an expression of a lack of self-care, it [… is] a modality of self-care that is simultaneously a response and precarious solution to pain" (p. 68). This way of conceptualising eating-distress has been identified in early work by Thompson (1994) where "eating-disorders" are suggested to begin as a survival strategy for coping with several injustices such as discrimination across race, class, age, religion, and ethnicity, as well as individual pain and trauma. Most people agreed that food served a purpose as a buffer to pain felt from racial trauma and injustice related to sexism and classism (Thompson, 1994). Eating was also described as a way of taking care of oneself in the process of coping with trauma. For some people, sexual abuse has been found to be implicated in the etiology of eating disorders across recent studies (Li et al., 2018; Quilliot et al., 2019). Understanding multilayered contexts is important. Overall, understanding eating problems as a survival strategy shifts the focus and power from an understanding rooted within gendered femininity based upon appearance, to a deeper understanding of the complex intersect between trauma and eating-related distress (Brewerton, 2019; Gur & Keren, 2018).

Heterosexist assumptions have guided research, often excluding the experiences from LGBTQIA+ perspectives. While early research presented lesbian women as "protected" against dominant beauty ideals and eating-related distress (Myers et al., 1999), more recent research suggests that lesbians and heterosexual women are equally likely to experience eating distress (Feldman & Meyer, 2007). Queer woman may internalise both heteronormative beauty standards and that of the dominant ideals of queer women (e.g. the "butch lesbian"), feeling the tension to conform to both ideals (MacDonald, 2011). What is unclear is how these culturally dominant, heteronormative ideas around femininity impact a person's ability to construct a sense of self in their body at the intersect of sexuality and gender (Jones & Malson, 2013). By understanding how body image ideals interlink with identities may contribute to eating-related distress and, in turn, recoveries. However, an over-

emphasis on body image dissonance may not fully reflect the intricacies and complexities of identifying as a sexual minority within a heterosexual context.

Jones and Malson (2013), in their critical feminist exploration of lesbian perspectives on eating disorders, suggest that the process of recognising one's sexuality and "coming out" to others is implicated in the process of distress. Some participants explained their eating disorder as a response to the confusion they felt making sense of their sexuality while others constructed their distress as a response to the stress and uncertainty of not fulfilling heteronormative expectations. Eating distress was framed as a way of escaping heterosexuality, defying traditional heteronormative definitions of femininity (Malson, 1998). Sexual orientation was also positively linked to facilitating eating disorder recovery, where the social and romantic sexual connectedness facilitated by "coming out" was integral to some participants recoveries through a clear sense of identity formation. Sexuality is more nuanced than binary categories may suggest, both implicating distress and facilitating recovery, unique to the individual and the person's contexts.

Overall, eating-related distress among people within the LGBTQIA+ community remains under researched and poorly understood. There has been a tendency across the literature to group participant experiences under labels such as "lesbians" or "homosexual women", categorising and essentially homogenising what is an individual, heterogenous experience (MacDonald, 2011). Further research is needed to explore LGBTQIA+ experiences and perspectives. Not only is there a need for research that includes greater diversity across sexual orientation, research that explores the ways in which sexuality impacts embodiment and gender role expectations is critical to advancing understandings in this area (Striegel-Moore, 1996; Thompson, 1996). The research to date suggests that it may be important to explore how internalised heterosexism may impact a queer person's experience of their bodies and the expression of eating-related distress. This deeper exploration

acknowledges sexuality in its complexity and may have a richer understanding of eating-related distress, rather than simply viewing it as a categorical variable (MacDonald, 2011).

Perhaps, there is merit in blending perspectives (Cuthill, 1991). A clinical framework is essentially a construction of reality for what it means to live with the range of eating-distress defined by the DSM. A construction of eating-distress described in this study situates the reality of living with a challenging relationship with food, eating, shape/weight within an individual's broader contexts. The clinical framework is therefore one construction of a range of ways of understanding what it means to experience eating-related distress. Constructivism specifically discourages foreclosing constructs where this research is led by the meaning-making described by each participant. In alignment with a social constructivist orientation, this study specifically grounds personal understandings and constructions of distress, where reality is subjectively experienced and described based on personal, social, and cultural meanings that influence understandings (Neimeyer & Raskin, 2000).

A recent Australian study aimed to examine the effectiveness of integrating a feminist and clinical perspective through an individually administered blended intervention (Tone et al., 2022). Results suggested this approach to be effective, with participants reporting reductions in eating disorder symptoms, stress, and improvements to recovery as measured by the Recovery Assessment Scale (RAS-DS). The Connecting and Belonging subscale of the RAS-DS extends beyond symptoms; to patient experiences that explored interpersonal relationships, social functioning, and societal participation. What this study suggests is that there is preliminary support for integrating feminist-informed perspectives with individualised clinical interventions, within a community-based setting. In alignment with the findings above, I foreground multiple perspectives to better understand how people make meaning within contexts. Ultimately, I am most interested in subjective meaning making. It is against these backdrops that I suggest a transcultural, feminist interpretation of eating-related

distress is essential to illuminate the broader contexts and varied meanings, attending to these sociocultural challenges and complexities.

The cultural politics surrounding body image and eating has persisted since the 90's, as suggested by Gremillion (1992), where the range of sociocultural influences that are disempowering to people must be explored to better understand eating-related distress. Despite this understanding emerging in the early literature, feminist theories on eating distress is still yet to be taken up fully among dominant frameworks to date (Ferreday, 2012; Holmes et al., 2017; Malson, 1998; Orbach, 1985). This may be due to the emphasis placed on evidence-based practices and a current lack of empirical validation for the value of feminist frameworks within treatment contexts (Heruc et al., 2020; Srebnik & Saltzberg, 1994). However, understanding eating-related distress through a multidimensional lens influenced by biological, psychological, social, and cultural factors, is key to a feminist approach. Eating distress cannot be simply viewed as just eating disturbances and body image problems, but instead must be seen as complex responses to environmental, sociocultural, and political stressors (Katzman & Lee, 1997). I believe by establishing links between eating distress and the range of oppressions and power imbalances that a person faces may invite a more nuanced way to think about precipitating factors within a clinical framework.

Contextualising COVID-19. The rationale for qualitative research exploring distress within sociocultural, political, and economic contexts is even more important within this space and time, given the recent pandemic and its global effects on mental health and well-being (Brown et al., 2020). The COVID-19 pandemic has created a global context that has increased the risk of eating-related distress, increased barriers to accessing support, and decreased protective factors such as interpersonal support (Rodgers et al., 2020). Some of the ways in which eating distress and recoveries may be challenged within this context include

restricted access to in-person care through the pivot towards telehealth, social and functional restriction (eating in a household among others), and exposure to social media messaging around weight gain and exercise prescriptions during lockdown (Brown et al., 2020; Devoe et al., 2023; Rodgers et al., 2020). Furthermore, the stress-triggering effects of the daily news reports, food safety and insecurity, "how to curb emotional eating" advertisements, or the surge in at-home workout challenges, may all inadvertently reinforce eating distress-related cognitions and behaviours (Weissman et al., 2020). These have several implications. The assumption that emotional eating is unwanted and needs to be eliminated positions "emotional eating" as somewhat pathological. It has also been suggested caregiver burden may also increase (Weissman et al., 2020). Collectively, it is important to consider whether these barriers to care and the discourses around eating/weight gain and exercise may not only impose setbacks or constrain the possibilities of recovery for individuals struggling with eating related distress, but also limit a person's ability to feel safe in their own body during this time.

Although long-term impacts of COVID-19 are not fully known at this stage, what is known is the growing impact of eating related distress, both within the general population and among those with pre-existing eating related challenges (Brown et al., 2020). Phillipou and colleagues (2020) aimed to identify changes of eating and exercise behaviours among those with a history of eating distress, and those within the general Australian population. They found that majority of those with a history of eating-related distress reported increased restriction (64.5%), binge eating (35%), purging (19%), and exercise (50%) during the pandemic. Within the general population, an increase in binge eating behaviours (34.6%) were noted. These findings suggest that even in the early stages of the pandemic, those with pre-existing eating distress were reporting changes, possibly reflecting an exacerbation or relapse of symptoms. Within a New Zealand context, the Waikato District Health Board

reported a surge in referrals and acuity of children with eating disorders, causing a strain on outpatient services and their capacity to provide timely care (Hansen et al., 2021). Reports of delays in treatment were cited both locally and internationally (Wong et al., 2023). Exploring the impacts of COVID-19 involves a recognition of its impact on daily living. Simple, yet drastic changes, may make navigating a new routine around working, eating, exercising, and socialising, a challenge. As such, my research gives space to exploring the stories of distress and recovery amongst COVID-19 with a particular focus on the micro-level daily practices that are most important to the individual. A situated understanding, rooted within a person's contexts, is critical. A contextual understanding gives greater agency to the individual who is able to narrate their own experiences (De la Rie et al., 2006), and allows for a richer understanding that is responsive to the nuances.

Understanding Recovery

It is important to reiterate that different stakeholders represent various interests, positions and perspectives on the possibility, utility, and practical use of a consensus definition of eating disorder recovery (Noordenbos, 2011; Noordenbos & Seubring, 2006). When framing recovery for the purpose of this study, it was important for me to ask myself: who defines recovery? What is it like for those experiencing distress first-hand? Are these perspectives and understandings included in research and service provision, and, furthermore, are these perspectives taught and reflected upon clinicians and health professionals alike? How does someone know if they are practicing recovery, and is recovery a state or place to be reached, a process, a blend of both, or something different altogether? If there are varying agreements on the definition of recovery, how do people with lived experiences of distress navigate and orientate towards this concept? These are some of the questions that guide the discussion and critique below.

Critiquing Clinical Definitions of Recovery

Academic and clinical definitions of recovery are often rooted within the dominant biomedical model in which the definition of recovery is largely interlinked within a diagnostic view of distress. Within this, outcome and recovery are often conflated (Berkman et al., 2007; Murray et al., 2018). The definition of recovery traditionally used in mental health services outlines sustained remission and long-term reduction or absence of symptomology accompanied by functional improvement to pre-morbid levels of functioning (Slade et al., 2008). This definition locates the concept of recovery within the clinical model. Despite its understanding as the "end point" of treatment or the desired "outcome" of combatting a challenging relationship with food and eating, the term "recovery" continues to be poorly defined across the literature (Bachner-Melman et al., 2018; Bardone-Cone et al., 2010).

One clinical definition of eating disorder recovery includes a healthy weight standardised by a body mass index (BMI) greater than 18.5, absence of eating disorder behaviours in the past three months, and clinical criteria for an eating disorder to have not been met across the past three months (Bardone-Cone et al., 2010). The latter criterion is typically assessed with the Eating Disorder Examination-Questionnaire (EDE-Q; Fairburn & Beglin, 2008), foregrounding a quantitative lens to recovery comparative to age-matched community norms. It must be noted that the EDE-Q is based on "presumed cisgender men and women and have not intentionally included transgender people" (Nagata et al., 2020, p.1). Therefore, heteronormative constructions around distress inhibit the recognition of eating-related distress among individuals identifying as LGBTQIA+ (Bankoff & Pantalone, 2014; Jones & Malson, 2013; MacDonald, 2011).

From a social constructivist and post-structuralist perspective, the language used to define recovery from a clinical perspective (which requires an *absence* of eating disorder

behaviour and *normative levels* of eating disorder *psychopathology* over a set period) must be critiqued. In alignment with a post structuralist view, meanings carried by language are never fixed, open to question, and constructed between people. The definition by Bardone-Cone and colleagues (2010) raises a number of questions, including what is a *"normative"* level of eating, can this be clearly defined, is there much purpose and need for its normative versus pathological distinction and who requires this definition? Similarly, a specified body mass index cut-off may overlook those with typically, lower BMIs that may be normative to their culture and eating contexts (Gramaglia et al., 2018; Zhang et al., 2018). Within a social context of fatphobia, it may also set too low of a cut-off for those in larger bodies (Harrop et al., 2021), normative to their cultural and familial context. The term *"pre-morbid functioning"* and a desire to reach a state of "*normal functioning*" implies movement towards a category deemed homogenous across individuals, when in fact, "*normal*" is not a real category but instead a socially constructed experience dependent on individual personal factors (Howell & Voronka, 2012). This may also enforce a problematic assumption that pre-morbid functioning is the only state in which an individual may be considered recovered, minimising the experiences of people who may be recovered or recovering despite symptoms and a level of distress (De Vos et al., 2018; Pettersen & Rosenvinge, 2002; Slof-Op't Landt et al., 2019). Research has supported this perspective; for example, Slof'Op't Landt et al. (2019) found that 54% of those with lived experiences self-reported indicators of recovery yet did not meet clinical recovery criteria. Translating this, for those who believe they have recovered or are recovering may feel a sense of hopelessness, met within a system that deems them to be not recovered by clinical definition.

The diagnostic classification system strongly informs the current approach to treatment, invariably informing a clinical lens through which recovery is understood. Through this perspective, recovery is classified in a binary way where symptom remission

determines recovered/unrecovered status. Remission from an eating disorder is based on symptom reduction to normative levels guided by measures, such as the EDE-Q. The term "remission from" implies a process that has been worked through where distress is referred to in past tense, implying recovery as the outcome of treatment. While treatment targets differ based on diagnostic classification, most, if not all treatment programmes tend to have nutrition and/or weight restoration as a primary goal. Within this view, recovery is assumed to be only achieved if weight restoration and the resumption of "normal" eating patterns resume (Bardone-Cone et al., 2010; Rance et al., 2014), in the instances of AN. Similarly, Family Based Treatment models position physical recovery as the primary target in treatment, before psychological needs can be addressed (Chen et al., 2016). These treatment targets and clinical outcome measures reiterate a singular lens in which recovery is understood and approached. Here, physical recovery is viewed as the single most important element to reaching remission, which arguably, may not be as simplistic as suggested.

While quantifying symptoms poses merit for standardisation and provides the ability to track progress across time, this approach limits an understanding of recovery to the outcomes a person can achieve. Outcomes are interpreted based on scores which determine symptom severity and remission. While weight metrics supposedly signal weight recovery, number of days in hospital may signal stage of recovery, yet these metrics only illustrate one way to measure recovery. This approach overlooks daily achievements that that do not fit within such metrics, limiting nuanced understandings and meanings of recovery across diverse people and experiences. Service-user and lived-experience perspectives may extend beyond clinical recovery into meaning making articulated in a person's own words beyond scores and categories. Thus, bringing broader subjective viewpoints into discussion may also better align with a constructivist approach.

Turning to the eating disorder service-user literature, people highlight various perspectives and positions on the usefulness of a clinical approach to recovery. Many report that "medical interventions" were unhelpful, where an exclusive weight focus was experienced negatively. These service users identified a need to address wider issues than food and weight with a greater focus towards coping skills (Bell, 2003). However, some service users described experiencing value in recovery goals set within a clinical framework. A recent qualitative study exploring service user and therapist views on recovery criteria by (McDonald et al., 2021) demonstrated mixed perspectives. Most people agreed that recovery is a journey, not an end state that can be reached within a fixed timeframe or BMI metric. Whereas some felt a multidimensional approach within a clinical framework where criteria that standardised ratings reflective of recovery, relapse, and remission was useful. These findings point to the importance of understanding meaning where everyone's experience of clinical recovery is nuanced. It is about which perspective works best for each individual which can only be determined by the person's first-hand experiences.

The linguistic implications of the term "recovery" also warrants discussion. A key critique of the clinical definition of recovery from mental distress more broadly is that it suggests a homogenous understanding of recovery, covering a "one size fits all" approach to what is experienced as a heterogenous experience unique to each. For example, "*in recovery*" versus "*recovered*" may be understood differently from a clinical standpoint; in contrast, those with lived experiences of distress may prefer other notions such as "*path to healing*" or "*survivorship*", in recognition of such a feat (Bassman, 2001; Costa et al., 2012). Consideration must also be given to the possibility of a mismatch in translation of the word "recovery" cross-linguistically. For example, in a German interview by Slade et al. (2008) translated to English, the word "empowerment" was a direct translation to the word "recovery" in German ("*Genesung"*). By direct translation to the English language,

Genesung refers to *convalescence*, which does not completely translate to the recovery meaning endorsed by the English language. Thus, the possibility of a mismatch in translation from English to diverse languages must also be considered (Slade et al., 2008). It may be possible that for some cultures, the term recovery is not well representing, encapsulating, or matched to the lived experiences.

Viewing recovery as a dichotomous state (recovered or not recovered) and defined by narrow clinical parameters may translate a sense of hopelessness for people who present with varying complexity, diverse experiences, and versions of recovery. These considerations and critiques pose the question: where do people stand in recovery if they do not fit within diagnostic recovery criteria, ascertained based on subjective clinical interpretation of impact on functioning. What does this tell people who strive to be well, what does this tell us about how we treat eating-related distress, and finally, what does this tell us about the elusive concept of "recovery" in itself?

Implementation of the Personal Recovery Model in a New Zealand Context

Following the recovery movement there was an emphasis on transforming the mental health system in line with a broad recovery-orientated approach to mental distress. Some notable countries demonstrating this change include the USA, UK, Canada, Australia and New Zealand (Ahmed et al., 2012). New Zealand's early initiative in understanding the role of social processes associated with recovery in official policy was an important contrast to other countries whose policies still reflected recovery as an individual process (O'Hagan et al., 2012). The recommendations made to increase connectedness with cultural groups such as Māori and Pasifika, ensure service availability to minority groups, and accommodate the views of service users on coping with mental illness, were some examples of this (O'Hagan, 2004). Since the *Blueprint for Mental Health Services in New Zealand* (Commission, 1998),

subsequent policy and framework have reflected a personal recovery orientation (O'Hagan, 2004). Similarly, in 2001, the Mental Health Commission published its *Recovery Competencies for New Zealand Mental Health Workers* to aid in educating service providers under this framework (O'Hagan, 2001).

A key practical implication of the recovery model on mental health service provision has been the proliferation of peer-led interventions and service user consultation, most common within the broader mental health space (Ahmed et al., 2015; Scott et al., 2011). At its very core, peer led interventions are grounded in the privileging of the "lived" experience, the notion that underpins the recovery movement. Peer support has a long history, where individuals share experiences of mental distress with others in similar situations (Mead & MacNeil, 2006). A collaborative relationship built on understanding, validation, and empathy may offer avenues of hope for recovery, beyond messages and possibilities and/or impossibilities around recovery provided by professionals within the clinical realm (Kirkegaard, 2022). Although lived experience roles have been identified as crucial within mental health services, to date, these are often not fully accepted or perceived credible by the wider mental health workforce (Davidson, 2015, Silver & Nemac, 2016).

Despite these policies and the intention of integration, the implementation of recovery-oriented practice is still largely absent from clinical practice. *He Ara Oranga: Report of the Government Enquiry Into Mental Health and Addiction* heard substantial evidence that people and whānau/family want and need their voices to be heard, with a commitment to putting lived experiences and consumers at the centre of the system (Patterson et al., 2018). Strengthening the participation of service users and developing more peer-led interventions were identified as priorities in two recent influential policy guideline documents (Ministry of Health, 2012, 2017). The government inquiry is gradually actioning the recommendations from He Ara Oranga (2018) through Kia Manawanui Aotearoa,

outlining long-term pathways for change. Recent investment has focused on delivering expanded services by increasing access and choice, increasing support for young people, and the launch of extended Māori mental health and addiction services (Ministry of Health, March 2021, Mental Health and Well-Being Quarter Three Update).

It must be noted, peer-led intervention particularly lags within the eating-disorder space and the facilitation of a national, co-designed service transformation with lived experiences front and centre is yet to be delivered. While it may be acknowledged in some service delivery guidelines, it is still yet to be fully practiced (Musolino et al., 2016). Peer support has been trialed among young people specifically, through school-based or online group formats (Ali et al., 2015; McVey et al., 2003). While this is a start, there is a significant gap in peer support access and acceptability among adults eating-related distress, despite extensive adult peer support within the addictions space. This perpetuates the marginalisation faced and supports the stereotype of eating distress as a young person's problem. As a result, adults (and older adults) are left invisible and isolated from age-matched support.

Conceptual Models of Personal Recovery

Several conceptual models have been proposed that offer an understanding of recovery from the perspectives of lived experience. Each model extends beyond the views of clinical recovery in alignment with a personal recovery orientation, where there is a focus on processes of change, rather than defined outcomes. To a large extent, the concept of recovery has been developed out of personal accounts of experiences of general mental health, nonspecific to eating-related distress however (Andresen et al., 2003; Lapsley et al., 2002; Leamy et al., 2011; Mead & Copeland, 2000; Spector-Mersel & Knaifel, 2018). While there is benefit in exploring its more general application to mental distress, none of these models to my knowledge have been applied or inform eating-related distress. Key models include

CHIME (Leamy et al., 2011), *RECOVER*; strategies participants found helpful in recovery, and *HEART;* fundamental processes of change (Lapsley et al., 2002). Core themes of recovery generated from the perspectives of lived experience include hope, autonomy, meaning making, advocacy, peer support, connectedness, identity, and empowerment, to name a few (Andresen et al., 2011; Lapsley et al., 2002; Leamy et al., 2011; Mead & Copeland, 2000). These concepts have been supported by several qualitative studies and include: transitioning from a passive to active sense of self; shifting towards hope from hopelessness and despair; moving from feelings of alienation to discovery; and finally, a sense of connectedness from disconnectedness (Andresen et al., 2011; Glover, 2012; Mead & Copeland, 2000). Where earlier discussions point towards the importance of peer support, these models may deepen such understandings of recovery. Exploring these conceptual models is of value to this research to understand the factors cited as most helpful from a lived experience perspective.

Leamy and colleagues (2011) synthesised common themes of recovery into a conceptual framework given the acronym *CHIME*. Five core recovery processes were identified. Social *connectedness* centres around relationships, being part of a community and support from others. *Hope* and optimism about the future believes in the possibility of recovery and future-based aspirations. *Identity* includes overcoming stigma and rebuilding identity. *Meaning* in life is described through finding meaning in goals, social roles, experiences of distress, and spirituality. Finally, *empowerment* is described as having control over life and personal responsibility for one's wellbeing (Leamy et al., 2011). Several "characteristics" of recovery include recovery as an active, unique process, often non-linear and best described as a gradual journey. Recovery can also be viewed as stages; a process people work through and move between in a non-linear orientation. These ideas largely sit in

opposition to the tenets of a clinical framework, where recovery is positioned as an end state or outcome, a destination to be reached.

Service-users identified three additional themes extending beyond CHIME, broadly validating the framework (Bird et al., 2014). These include the need for practical support to improve material circumstances, issues around misdiagnosis impeding recovery, and the need to take better control over self-management of medication. These additional themes reflect the importance of grounding recovery beyond an individualistic model. Such factors may improve, impact, or impede the process, unique to the individual's context and circumstances. These suggestions reflect the need to take a greater holistic approach, shifting focus to the wider contexts and circumstances inclusive of interpersonal, societal, community, political, and economic perspectives.

There has been very limited research into personal recovery in a New Zealand context specifically. One notable exception to this is a narrative analysis by Lapsley and colleagues (2002) who identified stages of recovery through interviews with forty Māori and non-Māori adults, who considered themselves recovered from mental ill-health. A point of difference from the other studies that focus on process are the three main *stages of recovery* identified. First, a *glimpse of recovery* was described as a few positive changes laying the foundation for the second stage, the *turning point*. During this stage, participants took charge and used help, practiced strategies, and began to undertake significant change, before moving into the final stage labelled *the road to recovery*. A staged approach to recovery resembles some similarities with the clinical model, with the idea that recovery follows a stepwise process, for example, weight restoration before psychological recovery. I draw similarities between these findings and a clinical framework known as the Transtheoretical Stages of Change Model (TTM; Prochaska & DiClemente., 1983), to show how integration could occur. TTM posits that individuals move through six stages of change, where "contemplation" and/or

"preparation" may loosely map onto a glimpse of recovery, "action" being like that of the turning point, and "maintenance" reflecting the road ahead. Lapsley and colleagues (2002) extended their findings through two further frameworks: *RECOVER* and *HEART*. *RECOVER* described strategies participants found helpful such as research and reading, changing circumstances, practicing virtues, and repeating strategies that work. *HEART* described fundamental processes of change such as hope, esteem, agency, relationships, and transitions in identity. The findings of this study, particularly *RECOVER* and *HEART* largely fit with the studies included in the Leamy et al. (2011) review.

Going beyond the individual concepts that define personal recovery, Jacobsen and Greenley (2001) link these concepts with the specific strategies that can be used to facilitate recovery, by recognising the role for both external and internal conditions. Internal conditions refer to the attitudes, experiences, and processes of change of individuals who are recovering. External conditions describe the circumstances, events, policies, and practices that are conducive to recovery, e.g., human rights, a positive culture of healing, and recovery-oriented services. The reciprocal relationship of both conditions is an important element of this model, where recovery itself can be a factor for further transformation within both internal and external conditions. For example, reducing social stigma (external condition) may help reduce the internalised stigma that restricts a person's ability to define their identity (Jacobson & Greenley, 2001). The explicit reference to the influence of environmental factors is specifically relevant to this project which aims to go beyond the internal processes and concepts of change; interlinking internal and external factors through an exploration of recovery situated within and across sociocultural, sociopolitical, and interpersonal contexts.

A recent and notable model that also offers a contextualised person-centred view on eating disorder recovery, is a model recently proposed by Kenny and Lewis (2023). Two foundational tenets of recovery are highlighted: recovery is non-linear and ongoing and there

is no one way to do recovery. This model positions recovery outcomes at the centre of the framework, including clinical criteria such as physical stability, relationship with food, body, exercise, and psychosocial functioning. Extending beyond this, personal recovery markers are included such as quality of life and identity, categorised in the shape of a star to reflect the constellation of changes across recovery. This recovery star is situated within an appreciation for the external and proximal factors that undoubtedly influence recovery to varying degrees for different people. External and proximal factors speak to the contextual nature of recovery pointing to circumstances and personal factors both within and outside a person's control, such as poor medication adherence, time off sick from work, losing a loved one and COVID-19. System level factors differ through the oppression of one or more groups of people, while other groups experience privilege. On a societal level there are disparities across diagnosis and treatment, influenced by fatphobia, racism, white supremacy, even cis-normativity and the marginalisation of neurodiversity. Kenny and Lewis (2023) suggest that by framing one's recovery through such a model, this allows a truly contextualised view on recovery. Being led by the individual and their perspective on recovery (beginning with asking them how they orient and language it), is one way to mitigate systemic tensions on whose stories are included. This view allows for a blended contextualised approach to providing clinical support that also prioritises individual meaning making.

These conceptual models bridge the gap between clinical recovery and personal recovery research and offer important insights into factors of recovery from the perspectives of lived experiences. There is no single measure, definition, or indication of recovery, but instead, many factors and processes of change identified that allow for a more holistic understanding of recovery. Recovery may be a combination of internal conditions, such as identity and hope, while for others, recovery may be deeply influenced by external conditions such as stigma. Recovery may even be understood as a space or place that may never be fully

reached, nor one that may be desired for some. The purpose of personal recovery research is not to demonstrate what recovery is, or isn't, but instead to highlight the array of perspectives that extend beyond clinical parameters. Without this, the absence of such voices inherently prizes professional knowledge and clinical experiences over the knowledge of the lived experience. While the over-arching models of personal recovery offer broad themes and insights, they stop short of a deeper exploration of *lived* recoveries. This requires extending beyond the concepts of hope and autonomy, into the daily practices of recovery situated within time, space, and contexts.

Contextualising Personal Recovery and Eating-Related Distress

Recovery within this time and sociocultural context poses many challenges and unique complexities. Although several studies have explored the personal recovery model in application to mental distress, there is less of a personal recovery orientation within the eating disorder field. A few studies have, however, generated over-arching themes specific to eating disorder recovery. Factors such as the importance of meaningful or supportive relationships, a positive therapeutic relationship (Darcy et al., 2010; Malson et al., 2011; Rorty et al., 1993), hope for recovery, autonomy, and empowerment (Hay & Cho, 2013; Lindgren et al., 2015; Mead & Copeland, 2000), were commonly echoed. More specifically, people in these studies view recovery as a desire for a better life that involves eating comfortably, breaking free from food dominance (Darcy et al., 2010; Pettersen & Rosenvinge, 2002; Rorty et al., 1993), and a search for self-identity, life purpose and maturation (Patching & Lawler, 2009; Pettersen et al., 2013; Weaver et al., 2005).

A common theme that emerges from these accounts is that recovery extends beyond illness markers and focusses on life "in" recovery, amidst symptoms. These qualitative studies identify themes of recovery that align with the personal recovery model and offer an

alternative conceptualisation to symptom remission and weight restoration. Collectively, it is from these experiences that we can begin to see that people with lived experiences may have different perspectives to mainstream views on recovery. Thus, their recovery needs and wishes may also not be best matched within services that operate within a clinical recovery framework (Noordenbos, 2011). A perspective that repositions recovery as deeply entwined within social inequities and possibilities allows us to understand recovery as both a personal, social, and cultural experience (Morrow & Weisser, 2012). It is through this perspective that I believe personal recovery stories can really illuminate understandings on the contextual influences of this time and place.

Dawson et al. (2014) examined the process of recovery from the perspectives of eight women who had recovered from chronic anorexia nervosa. While the diagnostic model may refer to such cases of AN as "severe and enduring" or "chronic", it is important to note that the literature is not always sensitive to how people with AN define their own distress, nor the impact such labels may have on the lives of those living with AN (Waller, 2012). This study was one of the first to explore the recovery model among those with AN, helping to pave the way for more recent research among those whose recoveries are often deemed "impossible" by clinical definition (Conti et al., 2016; Hay & Cho, 2013; Stockford et al., 2018). Participants spoke to the slow and complex process of recovery, suggesting both internal factors and external critical to the recovery process. With an acknowledgment of the complexity of recovering from chronic AN, there was equal acknowledgement of the possibility of doing so – an opposing view where recovery *is* possible (Dawson et al., 2014).

While this study highlighted some important alignments with the personal recovery model, this study, and several other qualitative studies exploring personal recovery within this space are characterised by several assumptions and limitations that require critique and consideration. A vast amount of research explores recovery perspectives amongst those

recovering from AN exclusively (e.g., Conti, 2018; Dawson, Rhodes, & Touyz, 2014; Hay & Cho, 2013; Hay, Touyz, & Sud, 2012; Jenkins & Ogden, 2012; Lavis, 2016; Rance, Moller, & Clarke, 2017), most often those deemed severe and enduring (e.g. (Calugi et al., 2017). The predominance of AN literature also signals an implicit hierarchy placing AN above other forms of eating distress (Ison & Kent, 2010). While Dawson et al. (2014) aimed to be led by lived experience perspectives, participants had to meet clinical criteria (weight metrics) that quantified recovery, limiting the results to a specific weight restored population. From here, I believe there is need for the personal recovery model to be applied across wider eating-related distress, particularly, beyond AN diagnostic and treatment-based experiences with a focus towards self-defined distress situated within a person's contexts.

Musolino et al. (2016) addresses the limitations around the sociocultural context in Dawson et al's (2014) work, by eliciting an understanding for the gendered and cultural contexts in which the women described their distress. The women in this study linked both the development and maintenance of their distress to the social context in which thinness and dieting is considered normal, and the idea that eating distress afforded them safety, pleasure, and protection from the trauma that had turned them to disordered eating in the first place. Recovery was understood to serve a purpose of care. Malson and colleagues (2011) noted the culturally constituted tension between clinical treatment goals and culturally normative ideas of thinness, in that a significant barrier to recovery lies within the context in which "healthy" and "normal" offer contradictory messages. Several women echoed the contradictions between "healthy" and "normal", where recovery is understood as a process to reach a state of health, defeating when sociocultural discourses surrounding thinness and dieting are considered the norm (Musolino et al., 2016). As a result, distress may be easily hidden within culturally normative ideas around food and bodies, where dieting and fat-phobic discourse is present across daily life. If recovery is positioned in a way that is contradictory to normative

societal practices surrounding “health”, recovery is essentially a request for people to “not only give up their protective and productive aspects of anorexia nervosa, but also to step outside of culture” (Musolino et al., 2020, p.8). This statement highlights the impossibilities that exist within society alone. When deeply embedded within a society coloured by fat-phobia and diet-culture, is the process of recovery a decision to live radically rejecting such discourses, or a journey learnt to live alongside? Perhaps it is neither ends of the spectrum, but instead an ever-changing process that requires on-going re-appraisal of self and body against and within these changing ideologies.

When re-appraising body image, feminist scholars have argued towards resistance of societal ideals and internalised messages, and towards self-care, joyful movement, and body functionality (Piran & Teall, 2012). Cultivating body functionality has been framed as a way to proactively resist individual and societal body surveillance (McKinley & Hyde, 1996). The literature offers insight into how functionality appreciation is a way to re-appraise body towards a more positive body image (Alleva et al., 2014; Alleva & Tylka, 2021). Body functionality is described as the physical capacities, internal processes, bodily sensations, and self-care processes; recognising and appreciating the various functions that the body provides (Alleva & Tylka et al., 2021). Limitations exist even within this construct. Fat phobia circulates across some research that assumes inactivity and lower body functionality among larger bodies (Alleva & Tylka, 2021). Physical capacities have also been limited to able-bodied individuals across some research, despite people with illness, injury, pain, and disability still able to hold gratitude for the health and function of their body. Expanding upon early feminist scholars who have long critiqued eating disorder research for a lack of contextual understanding (Burns, 2004; Malson, 1998), my research placed a particular focus on meaning making elicited through story, deeply situated within and across sociocultural

and relational contexts hoping to understand the alignments, contradictions, and varying perspectives.

A methodological limitation within eating disorder research to date is the focus on recovery experiences based solely on treatment or clinical intervention. With some exceptions (e.g., Musolino et al. 2016), most studies have recruited individuals who have been engaged in clinical intervention assuming that recovery is directly achieved or attributable through treatment (Hay & Cho, 2013; Pettersen & Rosenvinge, 2002). What we know from service user perspectives is that experiences of treatment or intervention are not always positive, and that treatment may not always be successful, yet alone accessible for all (Ben-Tovim et al., 2001; Escobar-Koch et al., 2010; Swain-Campbell et al., 2001). Although some participants report intervention or treatment as crucial to their recovery experience, others believe they would have recovered without treatment (Ben-Tovim et al., 2001; Maine, 1985). Pettersen and Rosenvinge (2002) found that treatment effects were dependent on a positive treatment experience, based on the quality of the therapeutic relationship. A therapeutic relationship that emphasised support, respect, empathy and understanding - viewing the individual "behind the symptoms" was imperative. Other positive life events unrelated to treatment were identified as important turning points to recovery, such as getting a job or having a child. These experiences, unrelated to clinical intervention, extend a situated understanding of recovery beyond treatment parameters. The idea of turning points supports the findings by Lapsley et al. (2002). Perhaps it is less about the intervention and more to do with *who* the service-user chooses to hear, *when* they seek help, and what other life circumstances support recovery at that time.

There is a need to extend beyond understandings of clinical intervention to the accounts of those who consider themselves recovered/ing irrespective of treatment. Musolino et al. (2016) explored the views of those who have chosen not to seek help, or those who

have been given a diagnosis but chose not to engage with healthcare services. The authors refute the dominant embedded assumption that treatment will lead to recovery and recovery is only possible with clinical intervention, instead, choosing to focus on the context in which recovery occurred without intervention. This idea formed part of my research rationale, as I aimed to explore a blend of treatment and non-treatment perspectives. Within this, it was expected some people would identify their distress and recovery through experiences of treatment and/or diagnosis; the inclusion of service user perspectives is just as important as including perspectives beyond treatment/intervention. I was not interested in replicating dichotomous arguments, but instead, I hoped to learn from a mixture of both perspectives, allowing for an in-depth understanding and integration of the richness that exists.

Another methodological critique of qualitative recovery research relates to the definition of recovery used. Certain parameters and assumptions of what recovery is and how this may look is conveyed through inclusion/exclusion criteria. Studies that focus on "patient perspectives of recovery" may still use diagnostic criteria to measure and include those "recovered" in a specific way within their study (Nilsson & Hägglöf, 2006; Shahar et al., 2012). Other studies allow self-report, however, impose minimal lengths of recovered status, such as five years recovered from AN (Dawson et al., 2014a) or symptom free for three years (Lamoureux & Bottorff, 2005). This offers a paradox, limiting the stories and experiences of those who do not neatly fit into the preconceived notions of recovery, homogenising what is inherently a heterogenous experience. To diagnose, or to name the distress for a person is to hold the power, which has implications on how a person may journey recovery. There is a need for self-defined perspectives of recovery that do not impose any limitations or exclusions such as these discussed.

A study by Patching and Lawler (2009) allowed participants to self-define status of recovery without any specification for duration of recovered status, nor specification for

formal intervention. This study is notable as it extends beyond the limitations discussed, and by doing so it is positioned strongly within a personal recovery orientation. Twenty women self-identified as 'recovered' from their eating disorder where the understanding of 'recovered' was kept unique to the interpretation given by each participant. Participants were, however, recruited based on diagnosis (AN, BN, or combined), which limits understandings of EDNOS and BED. The women in this study spoke about self-determination and self-help groups as significant contributors to the recovery process. This study refutes the dominant embedded assumption that treatment will lead to recovery and recovery is only possible with formal intervention. Themes of control, connectedness, and conflict weaved in and out of the experiences as the women spoke of a journey in search of self-identity, initially viewed through their disorder. Overall, this study encompassed a more diverse sample and took a novel life-history approach exploring the lived experiences of developing, living, and recovering from an eating disorder as a complete experience. However, this study did not seek to understand the issues or barriers for those who do not meet recovery by clinical or self-definition.

The findings from Patching and Lawler (2009) suggest the need for more self-help and peer support groups, an area particularly absent across eating disorder spaces. Hearing others' recovery stories has been repeatedly cited as helpful, encouraging, and important to a person's individual recovery journey for some people (Dawson et al., 2014a; Garrett, 1997; Lindgren et al., 2015; Thompson, 1994; Wetzler et al., 2020). In a recent study that explored recovery narratives as a means of improving motivation and self-efficacy, qualitative findings showed that the recovery stories generated hope, feelings of inspiration and understanding for those in the early stages of their own recovery journey (Dawson et al., 2018). Similarly, the views of multiracial people within the study by Thompson (1994) all reported self-help groups as the most common method of "healing", where hearing others' stories often

encouraged the women to speak about their own. However, it is important to note that while positive for some people, others may experience recovery stories to be unhelpful, found to be triggering as a means of self-comparison (Dawson et al., 2018). Perhaps it is the process of sharing one's story, one's narrative that may facilitate alignment with conceptual models of recovery, such as fostering hope, autonomy, and empowerment.

A discussion on recovery would be incomplete without discussion on whether recovery is seen as possible, or even desirable. In a study by Darcy et al. (2010), five participants believed that recovery did not exist, speaking of illness being a state that was easier than being in recovery. Perhaps this finding can be understood in the context where restrictive eating practices have been found to act as a safety net in a cultural context that prizes health, thin bodies, and control (Musolino et al., 2020). Similarly, Conti (2018) sought to provide a context for women to speak on their own terms unconfined to a clinical discourse; many of them found the category of recovery itself troublesome. These women uniquely framed their experiences and histories within an "identity formation" narrative instead (Conti, 2018). Their identity narratives may be interpreted as what Holland and Lave (2001) have termed "history in person", honoured by their refusal to take on the colonized discourse of recovery, essentially, rejecting master narratives. Shohet (2007) illustrates how some people in recovery fall back on describing themselves and their experiences through dominant clinical articulations, constructing themselves with "struggling to recover" or "full recovery" narratives, viewed as more credible than narratives with greater complexity and lack of clarity. Others prefer to avoid the term 'recovery' altogether (Garrett, 1997). This current project draws inspiration from both Patching and Lawler (2009) and Garrett (1997) in its self-defined approach. In this study, self-identification was kept broad and individualised, avoiding foreclosing a definition of recovery and eating distress (LaMarre & Rice, 2020).

Recent research by LaMarre and Rice (2021) follows through with the notion of self-defined eating-distress and recovery, while also mitigating some of the limitations above. This study is another key inspiration for this current research project. The authors situate the research with an acceptance of the complexity that comes with recovering; understanding that recovery and eating distress can be as complicated as lives themselves and equally entangled within social contexts where living occurs. Twenty participants identified as doing significantly better than they have in the past during a time of acute distress around food and body, where recovery meanings were self-defined. Participants came with unique experiences, both within and beyond diagnostic and treatment experiences. Many chose to refer to their eating/weight practices through the term "eating disorder", several also questioned the term "recovered" altogether. Each narrative was interweaved with influences of time, relationality, and societal pressures. A core tension comprised the theme "recovery is not all sunshine and rainbows", resisting the idea that recovery is linear. It is neither a popular nor perfectly curated story with a clear beginning and end, but a messy entangled experience enmeshed in life itself. These findings inform the suggestion of attending to the "shades of grey" to illuminate possibilities for navigating recoveries in their full complexity (LaMarre and Rice, 2021, p.1). Practically speaking this means allowing the time, space, and respect, for people to speak about recovery, beyond polished and proper "popular" and/or "clinical" narratives of "full recovery". Overall, this study reveals the great complexities of navigating identity, purpose, and meaning within and outside of clinical constructs.

Overall, these studies collectively offer a strong foundation for the current project, exploring recovery as self-defined, contextualised, beyond clinical perspectives, across multiple lived realities, including embodied ways of being. What I believe is required from here is an extension of research that critically builds on this existing literature and extends these conversations into the spaces that have been missed.

Personal Recovery Through Story

Story can help us understand personal recovery through a deeper understanding and contextualisation of experiences of distress and recovery, situated within place and time. Story can be explored through narrative inquiry; where some notable examples of a narrative approach within this field explore illness (Leonidas & dos Santos, 2017), identity formation (Conti, 2018; Holmes, 2017), family experiences of living with eating-related distress (Papathomas et al., 2015), and recovery (LaMarre & Rice, 2016a; Lapsley et al., 2002). In line with a narrative therapy approach, there is an ethic of collaboration where construction of meaning and dominant discourses can be explored collaboratively (Epston, 2001). It is through meaning that I believe there is power in translating lived experiences into stories that represents lived reality. Meaning making is central within storytelling, thus, also maps well within a social constructivist approach. It is hoped that the stories within this research may inspire, educate, and orientate the audience to deeper meanings. To allow for this, careful consideration is first required to explore the literature that utilises narrative methodology within this field, to date.

Conti (2018) used a narrative methodology to explore personal recovery from AN, paying close attention to how the women constructed their experiences, identified with distress, and shifted their experience and identity across a ten-year longitudinal study. Interview questions were drawn from the language of narrative therapy (White, 2011; White et al., 1990), which provided a discursive context for narratives outside the dominant discourse that constructs AN as an illness (Lock et al., 2004). From this study, recovery was better represented as a socially constructed category where the women described positions as authors to their identity narratives, rejecting the dominant clinical narrative that often left them excluded from the concept of recovery. Women claimed their experiences as significant in shaping their identities and in doing so they constructed counter-narratives. These women

resisted the idea that recovery is a shift from the presence of symptoms to an absence. They provided their own interpretations of how it will never be “gone”, but instead, is a reconstruction of growth through connection with other identities. From this study, the importance of constructing, and re-constructing identity throughout life stages is emphasised as the enactment of recovery.

Similarly, in a study by Matusek and Knudson (2009), long term recovery was portrayed by three women through personal positioning in relation to particular stories, known as master narratives. The women spoke about recovering in ways divergent from the master narratives of eating disorder recovery, where it is also noted that two out of the three women did not receive treatment. All women told stories of spiritual reconnection and purposeful engagement with communities larger than self, as pivotal to their long term, nonlinear, recovery journey. Narrative analysis as a methodology enables a focus on how stories are told, how experiences are lived and represented, specifically within the field of AN where the generation of counter-narratives (recovery is spirituality) challenge that of dominant narratives (recovery is weight restoration). Extending beyond the dominant model of illness and clinical recovery, these analyses allow for the accounts of experiences within one’s reality, showcasing a more holistic lived approach to recovering.

The notion of master and counter narratives has been described by Shohet (2007) within two genres of narrative: “full” and “struggling” recovery, developed from the perspectives of those recovered or recovering from AN. “Full” recovery is marked by a clear beginning, turning point and end, largely aligned with the clinical model of illness and recovery (Shohet., 2007). In contrast, those “struggling” to recover describe a more cyclical life course, often intertwined on a social and relational level (ibid). More recently, Shohet (2018) expanded prior full and struggling narrative genres to include a third narrative group “eluding a diagnosis”. This third dimension adds important understanding for those

undiagnosed individuals who self-identify as struggling with eating-related distress, in a system that may be ambivalent or not best matched to meet their needs. This category is particularly important within this present research project as it informed the exploration of self-defined experiences that "elude a diagnosis", generating important counter-narratives.

Frank's (1995) narrative typology can be considered as a guiding theory for illness narrative types; however, it must be noted that this theory was framed around bodily impairment rather than mental distress. Meaning making is guided by culturally dominant illness where Frank (1995) identified three broad narrative types that underpin personal stories of illness: restitution, chaos, and quest. "Restitution" is described in the narrative where an important event is overcome and the protagonist becomes the same again, replicating a similar notion to Shohet (2007) "full recovery" along the lens of moving from presence to absence of symptoms. "Chaos" is described when illness destroys one's life, and "Quest" is described as when the protagonist searches for meaning or what can be learned or gained from the experience (Frank, 2013). Quest, perhaps, is as closest alignment to a personal recovery orientation. At its core, storytelling is the communication of lives and experiences, impressions and interpretations, and while not the focus of this research it is important to consider other platforms of storytelling such as that of memoirs (McAllister et al., 2014) and digital storytelling (LaMarre & Rice, 2016a; McDonough & Colucci, 2021). It is hoped that through story, nuanced experiences that may be otherwise missed or untold come forth as people speak candidly to the messy and miraculous entanglements of what it is like to experience life amidst or beyond recovery. Meaning making is essentially the construction of a person's version of reality, in line with a constructivist approach that emphasises the role of personal meanings in shaping one's response to life events – such as recovery.

Daily Practices of Eating-Distress and Recovery

While there is a body of qualitative research on eating-distress, recoveries, and on stories of recovery, there is limited research that allows people in recovery to speak candidly about their day-to-day experiences of recovery. These day-to-day practices offer important insight into the concept of lived recoveries, taking an experience-close approach to understanding living well. However, research often abstracts recovery from the daily experiences amongst eating-related distress, separating out the practices from the process within itself. Qualitative approaches in particular, often produce data that operates at a fairly high level, which may not always reflect activity within its contexts and/or embodied nature of human experience, the experience-close aspects of living (Lyons & Cromby, 2010). For example, where Moulding (2016) aimed to explore the lived dimensions of eight recovered women's experiences of recovery and gender relations through an in-depth interview, analysis replicated similar higher level findings that already exist within the personal recovery literature. Findings such as recovery as a journey, turning points to recovery, and transforming relationships. What is missing amongst these broader recovery experiences (master narratives) is the day-to-day nuances of what it means to be "in" or "doing" recovery situated within and across contexts. Elements of this exist through the findings by Moulding (2016), where most narratives captured the everyday nature of gendered and often conflicted discourses and practices. Women's experiences call for a need to understand recovery within a cultural context where gendered violence, abuse, and gendered social control impacted emotional well-being. For some women, the eating disorder involved positive aspects as it contributed to self-development and a way to reclaim agency and control across gendered contexts. For others, gendered narratives impacted a person's sense of shame, guilt, and responsibility, leading to conflicting experiences of identity and practices of control. Extending beyond these broader themes into the entanglements of life, inclusive of the

intricacies, and contradictions is an example where daily practices will allow for a deeper, richer exploration.

Very few studies have explored the daily practices of recovery within the eating disorder space, most often taking a generalised approach to personal recovery. Musolino et al. (2016) notably explored differing perspectives of recovery through the cultural context of care (situating recovery within a social world) - specifically, how this cultural context shapes a person's perspective of recovery and openness to receiving care. While a daily practice focus was not central to this study, interviews were guided by questions that explored what types of practices participants engaged in on a daily basis (i.e., how they engaged in activities, how they ate) and the meanings they attributed to their daily practices (e.g. whether they considered their activities a 'problem', what cultural 'norms' helped to support their eating and activities). Understanding people's experiences through a lens of care was integral to understanding how multiple versions of this word can support therapists to broaden their possibilities and understandings of care. It is through the exploration of daily practices that this study adds unique insight into the nuances of eating-related distress, specifically through practices understood to serve a purposeful form of care (Musolino et al., 2016). From this, exploring a person's everyday life shows to me that by doing so, key behaviours and experience-close emotions can be highlighted through an exploration of wider contexts that go beyond what is traditionally explored.

Outside of the eating disorder field, researchers have engaged with using descriptive interviews that explore a "day in the life" approach, most commonly used within addictions research, for example, exploring Alcoholics Anonymous group practices through "one day at a time" (Ferrazzi, 2014; Valverde & White-Mair, 1999). This type of methodology, has, to the best of my knowledge, yet to be applied within eating disorder research specifically. Del Rio Carral (2014) offers an innovative activity-based methodology that develops in-depth

qualitative data from day-to-day experiences. This methodology was developed within the field of health psychology; however, it is proposed to be adaptable to any research related to human behaviour and social practices. This approach adds value through the way it micro-contextualises psychological processes to their day-to-day situations and relationships, allowing for a greater understanding of a person's social contexts. Del Rio Carral (2014) suggests that human beings are likely to switch between different life realms in their everyday life, for example, work, family, social, and/or personal social dimensions, where social dimensions reflect complex realities. Across each dimension, a person may present with varying motivation, behaviours, emotion, and identity, all interlinked when understanding the "who", and "why" behind a person's motives and actions. It is within each of these social contexts that a person embodies specific values, norms, and responsibilities through activity, giving researchers insight into the commonalities, contradictions, and overlap between different social dimensions. It is through these daily practices that an understanding of role and personal identities can be understood. By using an inspired approach by Del Rio Carral (2014), exploring day-to-day activity will improve understandings of how psychological processes play out in daily life.

Openings and Conclusions

Personal recovery narratives must take more of a central place in research since an orientation towards recovery and away from illness deficit is at the heart of a whole paradigm shift in mental health policy. This involves moving beyond diagnostic and treatment-based experiences. Similarly, there is a need to understand and articulate recovery in a way that transcends popular, polished, and "perfect" articulations of recovery. Within this, situating personal recovery within a person's social, relational, and cultural contexts is paramount. Gaining insight into the sociocultural context inclusive of barriers to recovery is the first step

for reflection on the way in which treatment to date is approached, how clinicians can better support clients towards recovery, and what changes must be made to bridge the current research to practice gap. A contextual understanding not only legitimises eating distress but gives personal agency and ownership as the individual is made expert and able to define recovery in their own terms (De la Rie et al., 2006).

An analysis of people's recovery experiences situated within their sociocultural and relational contexts will importantly fill the contextual gap that has continued to be a neglected area within research (LaMarre & Rice, 2020). This understanding will further illustrate sociocultural tensions, alignments, and contradictions to a person's identity and values. What is missing is research using a day-to-day experience-based framework, specifically one that situates practices of recovery within a contextual understanding of eating-related distress. This missing knowledge is important. These stories allow for a reconstruction of meaning, across a person's daily strengths and struggles. For example, where tackling fear foods may be considered a "strength" or a "win" through a clinical recovery perspective, for the *person* recovering it may be more complex than that. This initial accomplishment may lead to a deeper range of emotions and behaviours. It may be considered both a strength and struggle, or simply neutral. Regardless of the behaviour, over time the experience will change based on context. Contrastingly, what might be overlooked within a clinical perspective may be highlighted when exploring daily practices. For example, the decision to meet a long-avoided friend, or intentional clothing choices.

A reconstruction and micro-contextualised analysis of recovery not only normalises the trials and tribulations within the journey but could also depict a more realistic view for people who may look to others for inspiration. The challenge is to illuminate implicit meanings of recovery through explicit, micro-contextualised situations. More specifically, the chronological and detailed description of a person's day that allows for a deconstruction of

habits and routines that may be otherwise overlooked, when asking about recovery more broadly (e.g., “what does recovery look like to you” versus, “talk me through your typical day, here and now”). Acknowledgement of recovery and eating-related distress situated within and across contexts is not a new concept, rather, it is one that requires the application of a conceptualisation through the everyday practices of care (Matoff & Matoff, 2001).

What is needed from here are narratives depicting realistic, lived realities of recovering amidst eating-related distress that are self-defined and unique to the individual. As the personal recovery paradigm privileges lived experience over clinical knowledge, narratives have played a significant role in the development of the recovery concept (Brown, 2008; Lapsley et al., 2002; Spector-Mersel & Knaifel, 2018). Therefore, it makes sense to apply this method to explore meaning making of eating-related distress recovery among adults in Aotearoa, New Zealand. Taken together, lived experience perspectives and the personal recovery model offer a counter narrative to the perspectives that have traditionally dominated the literature and guided service provision, to date. Ultimately, lived experience may provide an untapped resource towards actionable strategies that support a shift towards consumer-oriented practice and service delivery, unique to New Zealand.

The Study in Context

This research project focuses on a perspective where recovery is both a personal and social experience, as opposed to the end state of treatment, symptom remission, or clinical outcome. It aims to fill a gap specifically in the space of exploring self-defined recovery within the day-to-day practices of what this means “in” or “doing” so, situated within context, amidst or despite distress. A recovery model that prioritises self-identification of one’s own eating-related distress and recovery experiences, irrespective of diagnosis or treatment, can be proposed as the greatest alignment to the recovery model. Yet, the

considerable lack of such studies makes this research among the first in Aotearoa, New Zealand to address this from a lens in which self-labelled experiences are emphasised. A micro-contextualised view of recovery beyond diagnostic classifications elicits richness around daily activities, practices, and associated thoughts and feelings. Furthermore, purposeful sampling across diverse identities, cultures, and contexts to fill the gap where literature to date predominantly reflects a young, white, female demographic. As such, this study aims to avoid replicating similar samples through diverse sampling across contexts and self-defined experiences of recovery and eating-related distress.

Research Objectives

In this thesis, I examined individuals' understandings and constructions of eating-related distress recovery, deeply situated within sociocultural contexts and relationships. I aimed to explore the lines between recovered and recovering, either "in" or "from" distress, as well as the self-defined identification processes and preferred language used. Reconsidering what people mean by the terms they identify with broadens and deepens understandings and may help shift perspectives on what constitutes recovery. Situating recovery within a person's day-to-day practices provided scope for generating insight into the subtleties and nuances of eating-related distress and recoveries, often missed from the wider level analyses. The use of narrative methodology made room to explore day-to-day practices that emerge through story. With a focus on the sociocultural contexts in which living is done and recovery is negotiated and navigated, I am most interested in the day-to-day practices, relationships, and contexts that have helped people navigate a self-defined state of personal recovery, whether "in" recovery, "doing" recovery, or at a point of "reached" recovery.

Ultimately, I hoped to integrate the knowledge and *inner*standings within my professional practice, viewing eating distress recovery within a more holistic framework that

focusses on the *person* at hand and their daily nuances of recovery. By honing in on daily micro-narratives, it is expected counter narratives may reveal nuances that go beyond broader master narratives. It is hoped this level of understanding may strengthen clinical practice, inviting clinicians to explore across contexts that extend beyond treatment parameters with an increased sense of naïve curiosity and intentionality.

Chapter Three. Methodology and Method

This research aimed to explore the narratives of recovery in adults with lived experiences of eating-related distress. Specifically, I focused on examining ways of understanding and constructing recovery through daily practices, deeply situated within sociocultural contexts and relationships. Drawing on interviews with 15 participants who self-identified as having experiences of eating-related distress and recovery, the study was designed to gain insight into subjective meaning-making processes. The study focused on daily practices enacting recovery. Daily practices include day-to-day activities, routines, and rituals that enact recovery as a lived reality. Additionally, the interplay between participants' personal narratives and master narratives were also examined; specifically, what counter narratives may tell us about these broader, dominant, master narratives on recovery/ing.

This chapter begins with an outline of the theoretical framework of this research. Firstly, I will locate the current research in the context of qualitative research more generally, before describing the specific epistemological and theoretical framework upon which this study is grounded and the rationale for adopting a narrative approach. I will engage in a discussion on researcher reflexivity, specifically, where I drew inspiration for this current project. With an awareness for my own background and context, I understand that assumptions and knowledge will undoubtedly influence this research process; thus, reflexive practice is crucial for awareness of personal biases. Reflexivity is also at the core of the theoretical and epistemological underpinnings of this study. As such, I have attempted to engage reflexively throughout the research process, illustrated in this chapter. Following this, a detailed description around the process of participant recruitment, data collection, interviews, and narrative analysis will follow.

Theoretical Framework

Qualitative research is an umbrella term that encompasses many different epistemological assumptions, theoretical positions, and methodologies. Qualitative research, as a whole, seeks to understand meaning and experience, to explore the wide and varied ways people make sense of their world (Braun & Clarke, 2013; Willig, 2012). As such, qualitative researchers tend to foreground the contextual and the subjective, honing in on the meaning-making processes, while situating research findings in broader sociocultural and historical contexts (Creswell, 2009). This enables collection of diverse, rich, and multiple realities while also providing context to the participants' experiences (Miller & Glassner, 1997). Qualitative research allows for an experience-close understanding of recovery, constructed in social contexts and interactions, particularly suitable for this research project. As qualitative research often takes place in lived realities where events, people, and their experiences are uncontrolled, this may involve unexpected and unique phenomena presenting, for example, findings or experiences contrary to popular articulation (Rohleder & Lyons, 2015). While unique and unexpected phenomena can be considered a strength of qualitative research, this also demands researcher flexibility, open mindedness, and reflexive practice throughout.

This research is grounded in a social constructivist paradigm within a post structuralist narrative theoretical approach. By using a social constructivist approach, I seek to explore meaning-making processes, interpreting lived realities (Willig, 2012). How people made meaning and the way participants speak to their meaning making processes is the construction of their versions of reality. People construct knowledge between the interactions during their life, therefore, social interactions are particularly of interest within a social constructivist approach. It is through this view that the social and psychological world is seen as socially constructed, where language used may aid in bringing reality into being. It is the role of the researcher to attune to the constructed nature of social reality and form an

impression of the world as the participant sees it (Ratner, 2008). As knowledge is understood as a social and cultural construction, it is important to recognise that as the interviewer I come with my own assumptions, views, and biases that impact the research process. This may present across the questions I ask, the leads I follow, and the answers I further explore both within interview and analysis.

Social constructivism is aligned with the view that reality exists, however, how we come to know reality is through the multiple socially constructed versions of reality that shift across contexts. Language as a form of social action shapes, molds, and constructs reality (Angus & McLeod, 2004; Grant & Giddings, 2002). Within a constructivist paradigm, knowledge is always interpreted to discern meaning. Holding a critical relativist ontological perspective, multiple realities do exist, co-constructed in context. There is no one right or objective truth, reality is always interpreted, and all knowledge is derived from looking at the world from some perspective, which forms the rationale for exploring meaning making in this research. Guided by this stance, participants' accounts informed how they storied recovery within and across their contexts and relationships.

Language plays a key role in the construction and interpretation of knowledge. By utilising a narrative approach, the construction of meaning is central within story, aligning with a social constructivist post structuralist approach. Narratives establish a continuity of meaning within the lived experiences described. I have paid purposeful attention and effort with language choice across project design, interview, and analysis. Aiming to be inclusive and empowering, I was guided by lived experience perspectives within supervision and service-user perspectives across the literature. By being purposeful with the language I used, particularly, extending beyond diagnostic categories and recovery metrics, it is hoped a sense of inclusiveness and empowerment is conveyed; however, I also recognise that this is simply my hope and ultimately a subjective experience despite my efforts. This includes the self-

defined language of eating-related distress and recovery, inclusive broad definitions, and inclusion criteria, as such, contesting the power structure inherent within clinical models and terms around eating disorders, and clinical recovery.

This research attuned to how power interweaves with constructions of reality. Power is related to dominant discourses that exist in society and are present in everyday practices (Angus & McLeod, 2004). Michael Foucault was noteworthy for his elaboration on the interrelatedness of knowledge and power (Foucalt, 1980). Perhaps, the most relevant part of Foucault's perspectives on power is the concept of "modern power", gradual in the development and circulation within societies and communities (Kirkegaard, 2022). Power is described as a major source of social discipline and conformity to the promotion of norms. As such, the dominant narratives and discourses that prevail within a culture are generally linked to structures and institutions of power and control. Critical feminist perspectives acknowledge that the construction of reality is inherently tied to power dynamics. By emphasising the role of power in shaping knowledge and societal norms, critical perspectives can thus provide a more nuanced understanding of how certain realities are privileged while others are marginalised (Phillips, 2023). Thus, is it important to situate an understanding of recovery, both within and outside dominant narratives and power structures. For example, as modern society changes and women resist and dismantle patriarchal norms through liberation, older forms of power are abolished. However, new forms of disciplinary power exist through the cultural messages that circulate through social media and body expectations through a post-feminist lens (Bartky, 2020). Women are located within a set of inconsistent and complex discourses through which disciplinary power positions weight as an important measure of health, fertility, attractiveness, femininity, and morality, as an example of disciplinary power that circulates in contemporary culture (Riley et al., 2019).

Being aware and attuned to the concept of power throughout interviews and analysis was paramount. An awareness that both the interviewer and interviewee may subconsciously play into power hierarchies by aligning with master/dominant narratives, as an example. As a researcher without lived experience of eating-related distress, it is important for me to be aware of the impact I have as I occupy positions that are arguably less dominant, positioning myself as an ethnic minority, a young adult, and a female. Participants with lived experiences hold the power over their own experiences, a position I believe is important when aiming to elicit their story. Given my marginalisation in areas noted above, I must also note my position of power within my professional role as a clinical psychology trainee. This role may inadvertently create a power dynamic that requires careful consideration and mitigation. Recognising my positioning across different contexts, spaces, and places, also brings to light the marginalised positioning of this research within an academic context where power structures also exist. Quantitative largely outweighs qualitative research, similarly, with a focus on anorexia and outcomes within the field.

An Introduction to Narrative Analysis

Narrative enquiry is a broad form of research that is cross-disciplinary, ontologically and epistemologically diverse (Murray, 2015; Riessman, 2008). Narrative analysis is a type of qualitative data analysis underpinning narrative enquiry as a research strategy, focusing on the interpretation of experiences. Unlike other pattern-based methodologies such as thematic analysis or discourse analysis, narrative analysis is, at its core, a case-centred approach (Riessman, 2008). Riessman (2008) describes the sharing of narrative as an organisation of lived experiences; integrating the stories of one's life into meaningful plot lines that expands beyond a mere sequence of events (Murray, 2015; Riessman, 2008). This makes collected

narratives a rich source of research data where stories are considered the primary means in which meaning making is constructed.

When considering most people understand their world through dominant sociocultural understandings (Bamberg & Andrews, 2004), attention must be given to when an individual rejects the majority view and/or master narrative. Counter-narratives can be defined as "the stories which people tell and live which offer resistance, either implicitly or explicitly, to dominant cultural narratives" (Bamberg & Andrews, 2004, p. 1). The two are not dichotomous; instead, counter-narratives can exist in opposition of dominant narratives, but also, function alongside them (Bamberg & Andrews, 2004). Many people who oppose dominant narratives come to do so as a member of an outside, sometimes marginalised, group. Given the under-representations of diverse experiences among those recovering from eating-related distress, there are highly prevalent master narratives within this field across the broader concepts of recovery that continue to dominate cultural understandings of recovery, predominantly through a clinical framework (Shohet, 2007). This study generates an opportunity to explore counter-narratives among those with diverse perspectives who may not identify within the dominant framework (Shohet, 2018); specifically, how daily practices illustrate personal interpretations of recovery that are shaped, influenced, and rooted within social, cultural, and political contexts. Counter narratives expressed through daily practices may also offer an innovative way in which to explore stories that might otherwise be untellable without a micro level analysis of day-to-day narratives. For example, by probing into morning routines, practices of self-care, and choices made on a day-to-day basis, illuminates a different way of asking about and exploring how a person remains well.

From a post-structuralist and post-modernist lens, identity is fluid in that it is formed and reformed; constructed through the stories one tells others about themselves and the groups in which they live. An individual's experiences occur, are understood, and are re-told

within realms of sociocultural norms and expectations. Within a social constructivist view a person may have a variety of selves. These different selves are produced through linguistic exchanges with one another, where identity is constantly in flux as a product of language and social processes (Burr & Mackay, 1997). The notion of self/identity from social interaction can be understood as subject positioning (Davies & Harré, 1990). Subject positioning refers to the process by which identities are produced by socially and culturally available discourses. People take up subject positions in available discourses which inevitably influences how they experience the world and themselves from that perspective (Davies and Harré, 1990). Surrounding any aspect of a person's life are a multitude of discourses constructing and producing identity, from the social world. Prevailing discourses or master narratives, such as femininity for example, may impact how a woman constructs a sense of self. Some discourses have widespread acceptance while others are rejected, where discourses are also ever changing in this social landscape. Positions offered, accepted, or resisted, are important when understanding how people manage social interactions and how positions are drawn from such discourses (Burr & Mackay, 1997). The discourses that form a person's identity have implications for what they do, ultimately tied to daily practices.

Narrative Identity Theory is also drawn upon (McAdams & Adler, 1985), referring to the internalised and evolving story that a person constructs to make meaning and sense out of his or her life. Self is considered and constructed as story (Neimeyer & Raskin, 2000). When constructing life stories, master narratives are heavily drawn upon in constructing a person's narrative (McAdams & Adler, 2010; McAdams & McLean, 2013). Identity is thus constructed out of the master narratives culturally available to and drawn upon in communication with others. As such, aligned with a post structuralist view, language is the main site where identities are created, changed, and challenged (Burr & Mackay, 1997). Narrative identity has relevance for this project, in the way that participants construct

meaning and narrate their own story of eating-related distress and recovery, in turn, forming an identity narrative. In this research, identity will be used interchangeably with a sense of self, to describe the self as a reflection of individual and social processes that the person experiences situated within and across contexts.

How identity is constructed across both mental and physical health has gained traction across the literature. Williams et al. (2016) took a relational approach to exploring the concept of identity among individuals with a lifetime history of AN. Consistent with the structure of a narrative, identity was formed and reformed through a process of initially being changed by AN, sharing the self with AN or described as being in a relationship with AN. Recovery was described as threatening to a participants' sense of self, for some this meant losing a part of themselves where a strong sense of identity was formed within distress. To recover, participants described needing to accept fear of separating from AN to create a new identity based on their own desires and interests. The rebuilding of self was described as participants breaking free and re-discovering parts of themselves that had originally been taken over by AN. Rooted within a social context of change, group memberships (such as peer support, or recovery communities) may facilitate social positions that are helpful to recovery (McNamara & Parsons, 2016). As identity within illness has been positioned as a process worked through to reconstruct a sense of subject and social positioning in recovery, this framework may guide a contextual analysis of lived recoveries in this research. Within this view, identity itself can also be considered a narrative (Conti, 2018).

Approach and Rationale for Narrative in this Project

Narrative enquiry is rooted in time, place, and relationships (Clandinin & Connelly, 2000). Spector-Mersel and Knaifel (2018) go so far as to refer to narrative and recovery as "sister paradigms", due to the ontological and epistemological similarities (p. 4). Eliciting

narratives is thought to provide insight into a person's inner world and their subjective meaning-making processes (Riessman, 2008). Narrative researchers foreground the specific social and cultural context within which narratives are produced (Clandinin & Connelly, 2000; Riessman, 2008). Narrative is a form of language use and meaning making that is embedded in both place and forms of life, across contexts and relationships narratives are constructed (Angus & McLeod, 2004). Thought of as both a psychological and social process, narrative construction provides an interface between personal experience, social structures, and meaning-making processes (Avdi & Georgaca, 2007).

Narrative methodology is particularly suitable for this research for two key reasons. First, it aligns with the theoretical base of this study with its focus on co-constructing and understanding multiple realities, embedded within contexts. Second, it allows for a flexible person-centred approach which values experience-centred narratives that may also empower participants through the agency and autonomy some may feel, through storytelling (Blum-Kulka & Snow, 1992; Ingraham, 2017). From a social constructivist perspective, the idea of narrative operates as a means of bridging the multiple realities of contemporary life through the way participants speak to their daily practices within their wider story. The post-structuralist approach within narrative methodology acknowledges how narratives become possible within existing power structures (Bamberg & Andrews, 2004). As such, exploring eating-related recovery within its contexts and relationships from stories, is the purpose of using narrative for this research. The use of narratives allowed for the telling of day-to-day practices to be co-constructed between the researcher and participant through storytelling and analysis, allowing a view on both broader narratives as well as the daily micro-narratives and what those might reveal about the broader narratives.

The basis of my narrative method was a thematic approach to personal narratives, outlined by Riessman (2008). Within a thematic approach, emphasis is on *what* is said, the

told rather than the telling. However, expanding on this to explore language and the construct of meaning within contexts, a structural analysis was integrated when shifting to the *way* a story was told.

Researcher Reflexivity

Qualitative methodologies assume that research is a subjective process and thus researcher influence is inevitable. Several factors inherent to the researcher will likely influence a project from conception to completion, from a researcher's personality, power and positioning, socio-economic status, life experiences, and political stance (Braun & Clarke, 2013). Unlike quantitative methodologies (and some qualitative) that attempt to control for influencing factors and mitigate bias, often, qualitative methodologies embrace researcher subjectivity and acts to harness this within research. In order to harness researcher subjectivity, ongoing critique, consideration and reflection is needed (Braun & Clarke, 2013). This was a particularly interesting point for me to note as a researcher who had previously conducted health and clinical related research through a quantitative framework. Initially, I grappled with the complexities and difficulties with changing mindset and paradigm; however, I can appreciate the space and value for personal interpretation and researcher subjectivity. I have engaged in thorough reflective practices throughout. This has involved journaling, discussion, and reflection of decision-making practices within supervision to justify the reasoning behind each decision I have made to date. From language, inclusion, and exclusion criteria to the way in which I build rapport and facilitate a sense of trustworthiness as an outsider to lived research, reflexive practice behind each decision made has been pivotal to my research to ensure consistency in honouring the tenets behind a personal recovery orientation.

To continue this chapter without a reflection of my own standpoint would be contradictory to my writing. I position myself in this writing from a place of privilege as a young, female academic. I acknowledge that although I do not have lived experiences of eating-related distress, my utmost gratitude and goes towards my dear friend A.L.K who has taught me everything I know to date about recovery beyond the clinical lens. Among this, I have witnessed the immense support and understanding required from family and friends to view recovery beyond relapse. Such as the inherent sense of personal "failure" and "punishment" the "system" conveys for those who take a curvilinear process of recovery. From these accounts, I began to understand that recovery isn't linear, one where "recovery" can be synonymously replaced with "treatment outcome" or "symptom remission", but instead, what some may describe as a journey with ups and downs towards a sense of self.

This project was also inspired by my professional work experiences as a practitioner across youth mental health residential settings, and drug and alcohol addictions treatment residential programme; namely, Corstorphine Baptist Community Trust, and Odyssey House. When supporting young people or adults with eating-related difficulties within a context of trauma, I became aware of the various complexities and contradictions involved, particularly, when managing "clinical risk" at odds to the individual's wishes for autonomy, in recovery. The accounts of those with lived experience have truly touched me, inspired me, and sparked in me a desire to explore recovery beyond the limiting categories in which we are taught. Completing my clinical internship at an eating disorder private practice allowed me to hold this orientation in my clinical practice, while also noticing the tensions within the system inclusive of financial barriers and clinical markers.

My academic experiences have also undoubtedly shaped who I am and the lens in which I view distress and recovery, recognising that my role as a Clinical Psychology Trainee/Intern Psychologist will continue to influence my research and underpin my

professional values. I also reflect on my former education, where it wasn't until my third year of postgraduate education that I was introduced to the concept of consumer recovery. Until then, my clinical education was largely within the dominant biomedical paradigm. This was a pivotal turning point for my research career, changing from a quantitative clinical approach to a qualitative lived experience perspective. Although this shift is not as easy as stated, I believe I am joining many others in clinical psychology who are beginning to critique and be critical of dominant narratives of mental health. I do not see this as a negative; in fact, I feel privileged to have a foot in the door so to speak, into two realities, where I hope my future professional career is eclectic in choosing merit from both paradigms. Thus far, this positioning has been both a privilege and an area of difficulty as I continue to work holistically within a clinical framework, carving out a space at the intersect of two worlds.

Although I do not draw from a place of lived experience of eating-related distress, I draw from a place of lived experience of the complexities of embodiment and weight stigma. As a female acculturated to a western world, I grew up at odds between my two identities: ticking the "other" box when identifying my Sri Lankan ethnicity. Eventually, I realised that the western world does not cater for the health complexities and intricacies of those who fit into an unspecified categorisation, a minority amongst a dominant culture, an outlier on a graph. Throughout adolescence, I experienced frequent weight stigma from others in society. People would make assumptions about my eating and exercise practices based upon my smaller body shape and size, deemed "severely underweight" by body mass index parameters. Embarrassment, shame, humiliation, over-explaining and justification, were some of the many feelings and reactions this provoked at the time. I reflect on how damaging such discourses are, for those in smaller bodies and larger bodies alike, when society reflects assumptions and preconceived notions around body shapes, sizes and eating practices. One can only imagine the silent impact of such discourses and messages for those struggling

behind closed doors. Presently, as a young woman living at the intersect as an ethnic minority within a dominant western society, I am at ease with myself and my body – comfortable and confident with who I am. I am particularly interested in diverse stories from others within underrepresented and underserved communities who may struggle with eating-related distress, particularly stories that are often not told or narrated under popular discourses.

Reflexivity is crucial for this research, with ongoing reflection necessary to attune to the bidirectional impact of my own beliefs, attitudes and experiences on research, and the impact of research on my world view. It is crucial the voices and experiences of the participants inform this research, recognising that the presentation of the results is simply my interpretation of their experiences.

Method

Ethical Considerations

Informed Consent and Confidentiality

The researcher provided information and numerous opportunities for questions to aid participants to be informed in their decision-making process regarding participation. Consent was obtained by participants signing a consent form, sent to them individually and electronically through a secure link through Qualtrics. Participants were interviewed individually, and all data was kept confidential to the research team. Interview transcripts were de-identified using pseudonyms, and audio-recordings were deleted after the transcript release forms were signed. Participants were made aware of document storage. All electronic documents were password protected and all physical copies stored in a locked cabinet at Massey University for five years.

Management of Distress and Safety

Participants were strongly encouraged to discuss potential participation with their support networks. This was included as a pre-interview question to ensure participants held autonomy and choice when deciding whether participation was in their best interests to their personal well-being. As mental distress can be a sensitive topic of discussion, participants were told that they may feel some level of distress or discomfort recounting experiences; however, were also assured that processes were in place to ensure that participant felt safe, willing, and able to do so. Participants were told that they could pause/take a break at any time, further, requesting the recorder to be turned off should they wish to discontinue. Participants were supported to seek additional support from their network and/or relevant services (contact details were provided to all participants), as needed. At the end of each interview, I checked in with all participants on how they felt.

Cultural Sensitivity and Diversity

Although this research is not primarily focused among Māori, it extended participation to all ethnicities given New Zealand's multicultural context which reflects growing diversity among Māori, Asian, Pacific, Middle Eastern, Latin American, and African ethnic groups. As such receiving cultural guidance, advice, and supervision was integral to the project. Cultural consultation with Dr Pikihuia Pomare involved collaborative consideration of Māori culture and values and the importance of these when understanding experiences from a Māori worldview. The guiding principles of Te Tiriti o Waitangi[3] were acknowledged throughout the interview and analysis process. Tikanga[4] Māori principles were respected throughout each stage of the research process, such as, the opportunity to share

[3] The Treaty of Waitangi (Te Tiriti o Waitangi) is New Zealand's founding document, signed by representatives of the British Crown and Māori Chiefs.
[4] Tikanga is the concept of incorporating Māori customary practices and values

food/drink at the start of the interview placing a focus on whakawhanaungatanga[5]. As this research recruited participants across diverse cultural backgrounds, the researcher took particular care when interpreting findings making the effort to ask participants for further meaning and clarification to ensure culturally responsive interpretation. As such, participants were recognised as experts on their cultural understandings and experiences.

Participant Inclusion and Exclusion Criteria

Criteria for participant inclusion and exclusion required a lot of thought and iterative discussion within supervision. As I aimed to invite difference by asking about recovery in a way that had not been done before, doing so involved people self-identifying as doing better currently than in the past. As such, it was important that inclusion criteria also conveyed an inclusive approach. Participants were eligible to participate if they were at least 18 years old, had experiences of eating-related distress (struggled with food/kai[6], shape, weight, and/or exercise), and identified as doing and feeling better now than they have in the past (relative to their own experiences).

By placing no restrictive definition on the terms recovery or eating-related distress, I aimed to elicit self-identification of one's own experience (Garrett, 1997; Musolino et al., 2016; Patching & Lawler, 2009). This study was not limited to those with a formal diagnosis, or previous or current psychological treatment, due to the significant exclusions this holds for people with experiences that may not be recognised at a clinical level, or for those who have chosen not to seek psychological support and/or recognise their distress within this lens. Similarly, resisting the idea of any clinical criteria required to meet a diagnosis, the more general term 'eating-related distress 'was used as a proxy for challenging or problematic

[5] Whakawhanaugnatanga is the process of establishing relationships
[6] 'Kai' in te reo, Māori, means 'Food' in English

relationships with food, weight, shape and/or exercise, self-defined and identified by the participant. By purposefully excluding the word "recovery" from inclusion criteria, it was hoped this would remove any connotations of what recovery looks like in research and limit the self-doubt participants may have when they ask themselves whether they meet "criteria" to take part, or if their story is what researchers are looking for. By reframing recovery to encompass those who have seen an improvement in their own distress, identifying as doing better now than they have in the past, it was hoped participants would not compare recovery to popular discourse, but instead, focus on personal experiences. It was important for me to not use a standardised definition of recovery or eating distress, as this would be incongruous with the theoretical framework and my reflexive stance on recovery. Articulating recovery in such a way limits the value of all the stories that go untold because they don't fit the mould, so to speak.

While I was initially wary about interviewing people who may be acutely unwell (experiencing acute psychological and physical complications related to eating-related distress), upon reflection, I recognised that the perspectives and experiences of people who may be clinically deemed acute (yet identify with recovery) are just as important and valuable as any other. Given ethical considerations around risk and safety, initially, I thought to screen to assess risk and suitability for participation. However, I realised that in line with the ethos of this research, participants hold the best knowledge of their needs and experiences, and therefore, are in the best position as experts to make an informed decision (in conjunction with their support network, family/whānau[7], friends, healthcare professionals) about whether this research is something they wanted to and could do. This was the process in which I, the researcher, collaboratively explored participants 'willingness and ability to participate in this research project, encouraged to discuss this research with those who

[7] 'Whānau' in te reo, Māori, means 'Family' in English

support their care and recovery. Comprehensive information was given to participants on the information sheet to aid them in their informed decision-making process (see Appendix A). As such, there were no limits to exclusion within this study; these were largely subjective, and participant led. Participants were given numerous occasions to ask questions prior to signing the consent form electronically.

Procedure

Ethical Approval

This research was reviewed and approved by Massey University Human Ethics Committee, Application NOR 21/04. All relevant documents can be found in the appendices of this document.

Participant Recruitment

Recruitment was predominantly conducted through community outreach and supervisory and researcher relationships. The research advertisement (see Appendix B) was distributed across communities with a particular emphasis on wide physical distribution across Auckland and Dunedin, two locations physically accessible to the researcher. In Dunedin, the research advertisement was distributed predominantly across the student population, amongst various sites at the University of Otago including lecture halls, library noticeboards and bathrooms (male and female), community recreation halls, mental health organisations, Kokiri Training Centre, Te Wānanga o Aotearoa, and public noticeboards alike. In Auckland, the advertisement was physically distributed across Otara Recreation centre, Otara library, Otara Medical centre, Manukau Institute of Technology Library and bathrooms, Barry Curtis Park Recreation centre, Pak'n'Save Ormiston, Beachlands Sushi, Beachlands Countdown, Ormiston Hospital Café, and Ormiston Hospital Pharmacy,

Auckland City Library, Massey University Library, and the School of Psychology noticeboard at Massey.

Social media platforms such as Facebook and Instagram were also used, to provide varied avenues of distribution. This included psychology groups, eating disorder recovery groups, and professional groups that number approximately 1200 people identifying as recovered. In Auckland, key organisations/services that were contacted via email and offered advertisement of the research project to their eating and recovery networks include: Voices of Hope, Tupu Ora, Shelly Beach Clinic, Women's Health Action, Nurture Psychology, EDANZ, Canopy ED, University of Auckland, ED research team in Christchurch, NZEDC, and Recovered Living in NZ. Supervisor and researcher connections within the eating disorder field and the broader field of mental health spanned the Auckland, Dunedin, and Christchurch regions. This wide dissemination allowed for increased opportunity for participant recruitment.

The advertisement and information sheet were particularly directed to underrepresented and underserved groups and communities in Aotearoa, New Zealand, given the importance of including the stories of people with diverse experiences (included but not limited to those from different cultures, ethnicities, genders, and age categories). Through targeted community outreach and purposeful recruitment to those often not included in research, these efforts aimed to address the current gaps in sampling, encouraging diverse perspectives across wider contexts. The research advertisement was distributed in geographic areas populated by minority and migrant communities such as South and West Auckland, while also utilising relationships built within and across diverse communities and ethnic groups. These included people within the Sri Lankan, Korean, Māori and Pasifika community through Kaupapa Māori lecturers, Pasifika academics, Māori cultural advisors within Odyssey House, and personal and professional contacts alike. My partner, who is of Korean

descent provided invaluable insight into the Korean cultural community and was able to disseminate the advertisement across male bathrooms, which was a huge help in itself.

I initially thought that recruitment would be difficult due to the stigma that surrounds mental distress; in particular, the stereotyping attached to eating-related distress. Instead, I received an overwhelming amount of interest in my research study, with 45 expressions of interest in total. I found my limits were tested as I wanted to interview them all; however, only able to interview the first fifteen. As interest outweighed my capacity, this was explained to those who were not included and participants were informed about other research opportunities, should they be interested. Two participants were excluded (one living out of New Zealand, one self-identifying concern over symptoms worsening and unsure of recovery positioning presently). Several participants ceased contact with no explanation (despite follow-up emails) while one opted out as a change of circumstances entailed a change in recovery status. Out of the 45 expressions of interest, one male expressed interest, however, no follow up response was received. The volume of interest I received speaks to the need for more research in this field as there is certainly no shortage of people willing to share their story. While diversity is not a central aim of this research, I was pleased to recruit across diverse people and populations (particularly ages, ethnicity, gender, and sexual orientations).

Fifteen participants were recruited within a week, beginning the 15th March 2021. Some participants described seeing the research advertisement in public spaces (such as the university library and public parks). Others were shown the advertisement by people within their treatment spaces and recovery groups. Some participants saw the advertisement through social media platforms and were encouraged to participate through their wider friends and family network. It was clear that the wide recruitment strategy was successful. Once participants emailed their expression of interest, I ascertained their suitability for the study through pre-interview questions (see Appendix C) and offered the opportunity to answer any

questions they may have from the distribution of the information sheet. After participants signed the consent form, a time and place were set up for the interview. Participants were given the opportunity to bring a support person along if desired, however, no participants chose to do so.

Research Participants

Participants comprised of 15 people, living across New Zealand. 6 participants were living in Auckland, 8 participants in Dunedin, and 1 participant in Christchurch, at the time of the interview. Pseudonyms were chosen by each participant. See Table 1 below for participant demographic information, inclusive of name, age, identified gender, ethnicity, and sexuality.

Table 1

Participant Demographic Information (n = 15)

Name (Pseudonym)	**Age**	**Identified Gender**	**Identified Ethnicity**	**Identified Sexuality**
Jenny	20	Female	Chinese	Bisexual/Heterosexual
Amy	21	Female	NZ European/Chinese	Heterosexual
Bianca	36	Female	NZ European	Heterosexual
Rainbow	37	Female	NZ European	Homosexual

Sarah	20	Female	Sri Lankan/European/ Indian	Heterosexual
Ivy	20	Female	South African	Unknown
Eleanor	19	Female	NZ European/American	Asexual
Zaza	27	Female	NZ European	Heterosexual
Tegan	21	Female	Malaysian	Bisexual
Alex	22	Non-Binary	NZ European	Lesbian
Mary	20	Female	NZ European/British	Bisexual
Rudy	36	Female	Filipino / Australian	Lesbian
Ann	47	Female	NZ European	Heterosexual
Sophia	30	Female	British/Pakistani	Heterosexual
Flo	26	Female	NZ European	Queer – Women

Data Collection

Data collection took place as 15 individual interviews between the 27th March and 11th May 2021. To prioritise the general safety and comfort of participants, the five interviews that were held in-person were done in an accessible public place, such as a private community room, arranged between the participant and researcher at a time and place most

convenient to them. To accommodate for participants primarily located out of Auckland (South Island region) and the possibility of COVID-19 resurgence and government restrictions, 10 interviews were conducted through Zoom. All participants were given both options making no assumptions about preference; one participant living within Auckland opted for Zoom. Interviews took anywhere between 1 hour and 26 minutes, to 2 hours and 22 minutes, on average between 1.5 – 2 hours. While some interviews were longer than I had anticipated, it was important I didn't rush participants as the time spent building rapport was equally important as talking through their story. I found the process of data collection enriching, inspiring, and a true privilege as a researcher.

Interview Guide

A narrative interview approach was used, with an open-ended conversational questioning style to elicit rich, in-depth data. Each interview began with the process of whakawhanaungatanga[8] (sharing and introduction process) to build rapport and trust. This enabled participants to feel more comfortable sharing their story. Interviews were semi-structured in nature, largely guided by participants 'experiences and the stories they chose to share. While the researcher predominantly took an active listener role in the interview, a few broad questions were asked to guide the discussion (see Appendix D for Interview Guide). Participants were first asked how they choose to self-define, identify, and refer to their experiences of eating-related distress and recoveries, endeavoring to reflect their preferred language/terminology/identity across the interview and narratives.

Participants spoke to their story of recovery broadly initially, most beginning with their story of distress. Participants spoke to their story of distress from anywhere between 28

[8] Whakawhanaungatanga (te reo, Māori) is the process of establishing links, making connections and relating to the people one meets. Whakawhanaugatanga is an important practice of Tikanga (custom) in Māori culture.

minutes to 82 minutes before leading into their narrative on recovery, honing in on the turning point and daily practices. For the daily practices portion of the interview, a "day in the life" style of questioning was used, adapted from the methodological approach created by Del Rio Carral (2014). Within this, broad questioning such as "*Can you talk me through a typical day from the moment you woke up until the moment you went to sleep*?" or "*Can you talk me through your morning routine*" probed at simple yet significant activities that may be tied to broader contexts, emotions, and relationships, exploring motivation underpinning everyday practices. When following a broader 'typical day in the life' approach, I honed in on exploring days that may have been easier/harder than a "*typical*" day to get a sense of when recovery felt *good* (in terms of eating-related difficulties), versus when recovery felt *not so good ('bad day')*, probing these feelings to people, places, things, situations, and activities that may surround this particular day.

Exploring daily experiences of recovery and eating-related distress amongst those who have not engaged with formal intervention offers insight into the context of care and recovery beyond clinical intervention, a point of difference to participants who have either presently or in the past, accessed treatment or diagnosis. The experiences and counter-narratives within this framework are of interest alongside personal recovery. Two questions were asked of all participants after the daily life questions. The first question specifically asked those who had accessed psychological treatment before, how formal treatment may have impacted a person's personal recovery and self-identified positioning. The second question asked all participants about ways services and support can be better improved for those accessing support for distress.

Following each interview, I took some time to reflect on my thoughts and feelings towards the interview content and process. I felt inspired, humbled, and privileged by each story and felt motivated, touched, and energised throughout the interview process. Some

stories elicited the "story" I envisioned; others taught me more about daily recoveries than I could have ever anticipated or hoped for. There was not one story that felt any less "rich" than the others. I felt a real sense of connection with each participant, able to establish some commonality. I noticed that at times, my interviewing style was more "clinical" than narrative, likely informed by my clinical training where areas of interest pursued included clinical markers of distress and a formulation-based understanding. This may have impacted the process of storytelling. With some participants, I noticed how power dynamics could influence our relationship and my interpretation of their interview. For example, psychology students who expressed interested in the clinical psychology programme, or when speaking to adults much older than myself. Many participants gave me positive feedback about my interview style and passion, an unexpected but motivating part of the research process.

Transcription

Audio-recordings were transcribed verbatim. To preserve the confidentiality of all participants, all identifying information (e.g., names and places) were removed. Although the main focus was on the thematic content of the transcript, phonological details and speech characteristics may offer insight into important utterances (Cole & Shattuck-Hufnagel, 2016). For example, when knowledge is not easily accessible to a person or through speech characteristics that suggest the topic may be difficult to discuss (Bucholtz, 2007). Thus, some speech characteristics were transcribed where significant to content and process, for example, emotion (laughing, crying, hesitation in speech). In recognising the co-construction of narrative, the voice of the interviewer was also included, including prompts and utterances where content-enriching. Participants were given the opportunity to review their transcripts, however, no one chose to do so.

Data Analysis

The epistemological, theoretical underpinnings, and method of data collection are primarily aligned with a narrative thematic approach. In line with this approach, transcripts were first analysed using a holistic interpretive approach where both the content and form of the stories are considered as a whole unit as opposed to being parsed into smaller units for crosscutting themes (Murray, 2015; Riessman, 2008; Spector-Mersel & Knaifel, 2018). I attended closely to each participant's story through reading and re-reading each transcript before organising data both within and across individuals. Throughout the coding process, I paid particular attention to the ways in which meaning was constructed and influenced within micro and macro sociocultural and relational contexts. A narrative thematic approach is best suited when exploring the content of the data, deepening insight into the daily lived experiences of recovery by exploring themes and patterns of meaning-making (Fivush et al., 2017; Riessman, 2008). I used narrative analysis to gain insight into how people make sense of their experiences of eating-related distress and recovery, and to foreground the interplay between subjective and cultural meaning-making processes through an experience centred approach. Crossley (2007) laid out six sequential analytic steps which guided the analytic process: reading and familiarising self with transcripts; identifying important concepts, identifying 'narrative tone', imagery and themes (McAdams, 1993); weaving these images and themes into a coherent story across the data set; and writing up into a report. In addition to a thematic approach, a structural approach was utilised for content organisation, referring to a genre or a larger storyline. A combination of both approaches allowed for an analysis of both the micro-details, the wider conceptual master narratives, and the alignment of counter-narratives, in line with the work of Bamberg and Andrews (2004). More detail on the narrative analysis process is described below.

Setting up the Narratives

Setting up the narratives was an iterative process. I began by printing out all the transcripts, highlighting and allowing free-flowing thoughts to be scribbled in the margins. Familiarising myself involved reading each transcript multiple times, attending to new details and interpretations each time. Important concepts, content, images, and speech tone were identified and colour coded as narrative blocks. I attended to reflections and questions I had, in the margins. My process of weaving these ideas into a story involved several A1 pieces of paper, one for each participant, parsing out parts of their story into themes or categories, significant turning points, contradictions, and reflections. I returned to the transcripts many times during this process. I questioned multiple versions and interpretations of the text, aware of my own background that I brought into interpretation. I used a variety of methods including dividing the interview into past (historical, recent, present, future), whilst at other times taking one theme per page and using a mind map to further understand the over-arching theme or activities across a typical day. For each participant, I structurally parsed out each story into a timeline, which helped to clarify themes and the progression of an idea and of identity. Initially, it was helpful to make sense of the material within story structure – for example, activities under a morning routine, or identifying the "turning point" in each story. I highlighted key direct quotes, drawing on wider analytic interpretation such as "sociocultural", with a deeper reflexive lens and interpretation as I asked myself, how am I understanding and connecting with the emerging theme. From here, I began grouping over-arching themes or content commonality as larger subheadings. By parsing out the main themes across each participant account, I was able to see the prominence of certain themes in relation to other participant accounts, with attention given to narrative type, recovery construction, and relationships throughout the story. Initially, content was organised by similarity, later nuancing my approach by looking for points of difference or contradiction.

The themes then moved to increased levels of abstraction. Sometimes storied accounts complemented or contradicted a common theme, while other times a new category or narrative was formed altogether. Over-arching narratives were devised by attuning to content that reflected key ideas or areas of recovery with a focus on daily practices under each theme or sub-theme, specifically, routines and rituals through a typical day. Excerpts from participant good days or bad days, were used to exemplify the lived realities of recovery, sometimes contrasted or contextualised to experiences of eating-related distress.

Analysis required a thorough review of process, paying particular attention to constructed stories, consistencies, and inconsistencies in content, themes, and temporal narrative features. Certain narrative analytic features were emphasised such as content (what is told), theme and sub-themes, structure including beginning of the story and turning points, and overall narrative tone. Some features were less of a focus (e.g., setting). Decisions were made around analytic features based on the research aims which sought to explore meaning through story, thus, theme, point of view, and turning point, were integral to illustrating personal experiences. What was clear across the analysis was the great variation across participant stories, even those represented under the same narrative type displayed marked differences and subtleties, each unique to individual contexts. The process of setting up the narratives was iterative, requiring on-going analysis, re-organisation and analysis of structure to best exemplify nuances across story. Analysis centred around finding an overall coherence in one's daily life experiences in search for wider meaning, illustrated through story.

Each narrative begins with a description of the key narrative features, honing in on daily practices and weaving together threads of participants' stories of distress alongside recovery, as participants invariably spoke about distress and recovery in tandem with each other. Each narrative depicts a way of understanding and constructing recovery, primarily focused on attuning to each participant's construction and description of "doing/feeling better

than they have in the past". While narrative patterns identify similarities across participants' meaning-making processes and sociocultural influences, each participant's story holds its own complexity and nuanced insight into the ways in which participants navigated their distress and recovery in a largely diagnostic, patriarchal, fat-phobic world coloured by varying socioeconomic status, culture, race, gender, age, sexuality, within a New Zealand context.

I engaged in reflexivity throughout analysis. Analysis was a long and cumbersome process at times; at other times, I had crystal "ah-ha!" moments. While I analysed every component of each interview, the process of analysis had me refine my focus to the most salient themes and constructed narratives. I felt lost in the contexts of distress and recovery at times, feeling torn as I wanted to do "justice" illustrating the complexity of each story. I had to remind myself of the research questions and orientate myself to my purpose. Initially, I felt inclined to write in a more case-study style, likely informed by my clinical training where I am required to submit case studies. I had to be mindful of this tension when approaching analysis, frequently re-visiting feedback in iteration with my supervisors to create more space for discussion and showcase fluidity in my findings and conclusions. I discuss research and clinical practice tensions further in my research case study (see Appendix E). I restructured my analysis many times to best represent the participants stories, a process that never had a clear start or finish. As the participants hold agency over what is shared, it was important for me to consider why this participant is sharing this story, through this way, with me as a researcher? What these questions demonstrate is that the participants 'stories, and how they choose to tell them, are at the root of the narrative content.

Summary

This chapter has outlined the social constructivist epistemology aligned within a post structuralist narrative approach which underpins this research, as well as the specific methods of data collection and narrative analysis that was used. This research elicited rich narratives from fifteen participants, spanning various experiences of distress and recovery. Thematic Narrative analysis was used to primarily analyse the findings in relation to the research questions and aim. The following chapter presents the findings of this analysis.

Chapter Four. Results

In this chapter I present the analysis of 15 stories gathered during the interview process. Participants spoke to their recoveries across various processes: some reflected on the challenges they had moved through in past tense while others spoke to the on-going, complex, and challenging nature of recovering. All participants articulated a turning point (see also (Arthur-Cameselle & Curcio, 2018; D'Abundo & Chally, 2004; Stockford et al., 2019) which they identified as the beginning of their "recovery" journey. These happened at different points in time for different participants, ranging from 6 years ago to 4 months ago.

An understanding of where people situated themselves in relation to master narratives through the language they used helps us understand what constitutes recovery for each person. Below, I outline participants' preferred language of distress and recovery. From there, the four broad narrative patterns identified be outlined.

Participant Language for Eating-Related Distress and Recovery

Participants used various words for recovery and distress. The language used to define eating-related distress illustrated whether participants identified with dominant clinical constructs, such as diagnostic classification, and/or rejected these constructs, or identified with a blend of both perspectives. Foregrounding language is important, as this likely influences how participants construct and explain their daily experiences of recovery.

Distress. Ten participants used DSM-5 diagnostic terminology such as Eating Disorder, Anorexia Nervosa, Binge Eating Disorder, and Bulimia Nervosa. However, not all participants who talked about their experiences using diagnostic criteria had received a formal diagnosis. Seven identified that diagnostic terminology afforded them a common language of understanding, despite not having a diagnosis.

> "I guess I would call it an eating disorder because that's what I have always heard […] I don't have a diagnosis or anything, but to me it was pretty disordered, and my life was all over the place" (Eleanor, term used: *Eating Disorder*)
>
> "Sometimes a diagnosis doesn't mean anything but as far as this is concerned it has accountability" (Bianca, term used: *Binge Eating Disorder*)

For these participants, diagnostic terminology allowed familiarity, a shared understanding, and accountability towards themselves. Accountability facilitated a previously private experience of distress towards greater openness towards help seeking from others.

Tensions arose between participants and others when they did not have a formal diagnosis but chose to use this language. For example, Mary spoke about feeling "imposter syndrome" and the need to justify her distress with her friends for her experience to be perceived as "real".

> "I find it really hard to talk about like and verbalise, like I'm feeling more comfortable here because you understand that people go through these things, but not having a diagnosis is really hard because you don't know how to… I think its imposter syndrome a lot because it's like 'oh I do this but I don't know if it's that bad because I never got a diagnosis 'so my friends might just think I'm silly or making it up, or it's not that bad or kind of thing" (Mary, term used: *Anorexia/Orthorexia*)

Some spoke to their experiences as not severe enough to be classified diagnostically, in turn "othering" themselves from "mental distress", or "being othered".

> "I also don't like to identify with it because that just sounds like… I still didn't think it was *that bad*, bad enough to be anything like *that..."* (Sarah, term used: *Disordered Eating*)

This othering was closely linked to feelings of imposter syndrome for some who felt their distress was not "bad enough", to meet diagnostic criteria. This closely replicates the notion

of “not sick enough”, where severity is based on physical and behavioural parameters such as weight metrics (Eiring et al., 2021), signaling a diagnostic hierarchy that legitimises certain diagnoses over others. This has implications for whether people can access support, influenced by both self-interpretation of severity, and fears of not being believed.

While Tegan identified with diagnostic terminology, she provided a contextual description of what this meant within her contexts, linking distress to the power food holds.

> “I just call it an eating disorder defined as an unhealthy relationship with food. It is when food has taken a higher power over me” (Tegan)

Some sought treatment and identified with other diagnoses (Autism Spectrum Disorder, Post Traumatic Stress Disorder, Depression and Anxiety), where eating-related distress was understood within a bigger contextual picture of con-current distress.

Five participants preferred to describe their experiences through non-diagnostic language. These explanations varied. For instance, “social stress around dieting that affected my eating and body image” (Jenny), “history of poor body image that led to unhealthy eating and weight management strategies” (Flo), “eating problem” (Amy), “disordered eating” (Sarah), and “over-eating and emotional eating” (Rudy).

While some participants were not diagnosed, others were “eluding a diagnosis”, described as someone who “hovers around a seemingly invisible line that locates the person as “not sick” and yet struggling” (Shohet, 2018, p. 506). These participants recognise the limitations of the clinical system, opting against diagnostics. However, for others this was not a choice they had, situated within a context where the opportunity to receive a diagnosis was limited or absent. These participants provide insight into self-identified struggles with eating-related distress, an area often missed within both the literature and clinical practice.

For some, distress was referred to in past tense, while others reflected diagnostic classification changing across time, for example, moving from anorexia/orthorexia to binge

eating, or vice versa. Zaza described shifting from using diagnostic terminology ("ED") to using more general descriptions in past tense; "Now when I look back on *it* I say, 'when I *was* ill". Other participants talked about their ongoing distress in the present tense.

Recovery. Participants used various language to reflect their recovery/ing/ed status. Most participants referred to themselves as "recovering" or "doing so much better*"*, describing an on-going process. Some referred to "recovery" more holistically as "healing", "getting more balance", "a journey". One participant reflected on recovery as maintenance, "the finishing touches*"*. Some described being recovered from eating-related distress but experiencing distress in other areas. Participants had different perspectives on whether "full recovery" was possible or even desirable; however, this did not mean they were "giving up" on recovery.

> "I say *I'm doing so much better*. When I say the word, in recovery, I don't know why but that makes me feel like…a bit *intense*? I just don't think I'm in recovery yet, I think I'm just doing a lot better… and then eventually I will get to a point…or maybe I won't get to a point because something else will trigger it [Binge Eating]" (Sophia, term used: *Binge Eating*)

For Bianca being fully recovered was articulated as the absence of eating-related distress, questioning whether this state is even achievable when food is embedded in daily lives.

> "I am recovering… I really doubt I will ever be fully recovered just experiencing how strong the feelings are and I don't know what would ever make it go away because eating is a natural thing and you have to eat every day!" (Bianca, term used: *Binge Eating Disorder*).

Many described what "full" recovery would look like for them within their contexts. For Rainbow presently in "active recovery", "full recovery is the goal", described as:

> "There have been periods of time where I've been in *full recovery* where I've had no symptoms, I've been able to eat normally, where I've been able to function without worrying about food 24/7, where I wasn't vomiting." (Rainbow, terms used: *Bulimia Nervosa and Binge Eating Disorder*)

Both Eleanor and Tegan describe recovery as re-gaining control, where for Tegan, this was linked to establishing power and control over her distress.

> "Recovered would be not letting it have a hold over me, not letting food be such a big deal that I think about it often" (Tegan, term used: *Eating Disorder*)

Several participants critiqued clinical definitions of recovery they had encountered, instead, aligning with personal recovery and recovery *beyond* weight restoration. Some participants spoke to "doing so much better", others spoke to a state preceding recovery, and others saw "doing so much better" as being equivalent to recovery. The way recovery was spoken about varied depending on the audience. For example, Sarah specifically reflected not needing to put a term on it "when I am having those conversations with people they get you, you get them, you don't have to explicitly spell it out". Some endorsed a recover*ed* standpoint through past tense terminology. Flo rejected the use of any recovery-based terminology or identity, preferring to label her current positioning more generally and holistically, "I'm just good, I'm chilling, I'm dandy". Some participants held skepticism over the term "recovery" altogether, opting for alternative language and/or questioning the process of letting go of their eating distress.

> "I think what is recovery? Will I ever be recovered?" (Zaza, term used: *Anorexia Nervosa*)

> "But it is really hard, and it does take for some people years and it's something you'll always live with a little bit, you'll never forget the calories in an egg…" (Sarah, term used: *Disordered Eating*)

Preferred language reflects the various positions participants identify with. This suggests that like distress, there are various shades of grey where a simple categorisation (recovered/recovering/not recovered) may not best match a person's experiences or desires.

Narrative Analysis

I identified four narrative types: 1) Re-Appraising Body, Image, and Identity, 2) Neutrality and Nourishment, 3) Structure and Routine, and 4) Media and #Recovery. It is important to note that although narratives have been extracted and presented as coherent "types", they are not entirely representative of any one participant's full story. No two narratives were the same, and it is not my intention to generalise experiences, but instead, attune to the richness and highlight both the similarities and variations in meanings within a narrative. The core tenets of each narrative are illustrated in terms of intentional decision making and daily practices that support recovery, situated with an understanding of the contexts that surround eating distress.

1. The "Re-Appraising Body, Image and Identity" Narrative

In the "Re-Appraising Body, Image, and Identity" narrative, recovery was broadly constructed through a shift in appraisal from body appearance to function and a re-storying of identity. The main sub themes are: Navigating Sociocultural Standards of Beauty and Food Norms across Family Context, Shifting from Body Appearance to Function, and Re-Storying Identity. Within the first subtheme, Sociocultural Beauty Standards and The Influence of Family and Cultural Food Norms are explored. From Body Appearance to Function, an analysis of Exercise as Energising is explored. Re-storying Identity involved the various states of identity Constructed Within and Beyond Illness Identity, Living an Authentic Life beyond Gender Roles and Identities and Fit for [Recovery] Purpose Clothing. In this narrative, recovery was described as an on-going process of self-discovery where participants reflected learning how to challenge dominant sociocultural ideas and influences around beauty and body situated within a tornado of external influences. This narrative is characterised by a tone of acceptance, growth, honesty, self-compassion, connection, and courage, as participants navigated several intersectional sociocultural and relational challenges and identified an intentional focus towards recovery within daily routines.

Navigating Sociocultural Standards of Beauty and Food Norms across Family Contexts

This narrative will begin by setting the scene on how participants navigated and ultimately resisted societal and cultural beauty standards across western and non-western contexts. There was a strong theme in which participants shifted in re-appraising their visual appearance towards functionality. They began to critically examine body image ideals by expanding their definition of beauty towards an appreciation of body functionality; focusing on what the body allows them to do. A discussion of the beginning contexts of eating-related distress and influence of such body image ideals is important to understanding how people

storied a shift in daily practices, understood as the "beginning" of the storyline. Similarly, understanding food and eating norms, rooted within both sociocultural and family standards informed shifts in recovery.

Sociocultural Beauty Standards. Several participants spoke to the idea that beauty ideals, particularly thin ideals, mapped a definition of beauty which they felt compelled to conform to – one where beauty was defined by a smaller body shape and size (see also Yan & Bissell, 2014; Afful & Ricciardelli, 2015). Navigating and re-appraising these dominant beauty standards was important to most participants' stories of recovery.

Mary (20, NZ European, Female, Bisexual), identified negative body image to be the foundation to her distress. This realisation was integral to the way she constructed a sense of self in recovery. Mary experienced distress from the age of 16, an age of particular developmental influence and vulnerability to sociocultural influences (Culbert et al., 2015; Harrison, 2001). Mary aspired to look like a model, illustrating the desire to reach the thin-ideal standard of beauty.

> "It really did come from a 'I want to look like Cara Delavigne, I want to look like the models'. I think it really was a change from the skinny 12-year-old to hitting puberty and thinking 'what the hell, I'm no longer a twig anymore' and being really stressed about that and finding a way to cope. I think it really was body image driven" (Mary)

Grappling with body changes throughout puberty and a media-inspired ideal of beauty, Mary began restricting through calorie counting to cope with the emotions this evoked. Mary self-identified the development of "anorexia in year 11", over time, shifting identification to "orthorexia", enmeshed within a diet-culture and thin-ideal context. Presently, body ideals no longer have a place in her life, self-identifying with recovery for the past 2 years. The idea of choosing to not exert energy scrutinising self or others was discussed by participants through a shift in mindset, viewing energy as limited and better re-directed towards purposeful

activities. Mary finds value in seeing diverse representations of beauty, re-constructing standards of beauty beyond thin ideals to include people of various shapes and sizes.

For Mary, societal influences were a point of vulnerability while for Flo, self-comparison and self-scrutiny was made in comparison to the appearance of a close friend. Flo (25, NZ European, Female, Queer) described the beginning of her distress from the age of 15/16. Flo maintained several diets, often grappling with food guilt, self-hate, and disgust, "purging to reverse over-eating" which led to further body dissatisfaction and lowered self-esteem. Flo spoke to the daily, insidious, growing influence of self-comparison, where her close friend modelled society's definition of the "perfect body". Here, sociocultural standards of beauty were interwoven within key relationships.

> "I was comparing myself looking every day at this person who had what I wanted, that became a thing […] I wanted to look like her, I wanted to be as fit and small, and I remember thinking it was not possible. I remember getting quite sad about it when people came into my room and I was crying once and I was like 'I just really hate my body, it's not working for me' and my friend was like 'maybe it's time to see someone again…' so I went to a psychologist and did a few sessions and it really helped. I went to a nutritionist too which I hadn't done before which also really helped…and I would say since then I have been dandy […] I think because of the industry I'm in that became my first thought 'I'm sad about this I'll talk to a mental health professional'. I'm just very lucky that was the normal thing to do" (Flo)

When Flo's self-comparison to her "perfect" friend reached its peak, she noticed the impacts this had on her mood and relationships, the turning point in her story which prompted her to seek psychological support. From this point onwards, two years ago, Flo has identified with recovery. Her positioning as a mental health trainee informed the support she saw as important in supporting recovery, possibly also informing her views on recovery.

The Influence of Family and Cultural Norms. Participants also experienced the influence of body ideals within their family context. Family dynamics impacted participants in different ways. Several participants described the normalised nature of dieting. Having observed food rules and diet discourse around the table, diet adherence was praised and linked to self-control. Aligning with narratives around healthism, Ivy was expected to take control of her health and well-being through body and diet management.

> "I started developing a little bit differently and I had all this messaging going on…even though it was always like 'be healthy and just exercise', I always saw them controlling things, so it didn't help" (Ivy)

Ivy (20, South African, Female, sexuality "unknown") described entrenched diet culture within her family context. Informed by her mother's own experiences of anorexia, Ivy was also exposed to her sisters fitness focus. Ivy described how her father frequently scrutinised and objectified her weight and appearance where family expectations encouraged careful control over diet and physical activity. For Ivy, this template of beauty and body was ingrained from childhood, leading to self-identified "orthorexia with binge eating tendencies" situated against a backdrop of trauma and abuse.

> "It felt unsafe to not be in a body that wasn't acceptable to people who were dangerous to me, like my Dad" (Ivy)

For Ivy, safety was found conforming to these sociocultural and family standards. The turning point in Ivy's story occurred at the age of 15, after relocating away from her abusive family context where she was no longer under threat and scrutiny. Within this safe context, she began to reframe her understanding of body image to hold more neutrality and balance. Marking the beginning of her "recovery" two years prior, Ivy identified her life to be presently more stable. Ivy actively resists beauty and body ideals by taking part in accreditation programmes for fashion and media companies that de-body size towards

inclusivity. Her decision to step out of a societal and family context where conforming to such standards provided safety, represents how these professional and personal practices illustrate her commitment to recovery.

Similarly, Sarah's story illustrates how family influences may intersect with cultural expectations. Sarah (20, Sri Lankan/European/Indian, Female, Heterosexual) discussed the role food played within her family and cultural context, where feasting on traditional food of typically higher caloric value was considered normative. She described body image concerns as a "half-caste female", tied between two worlds. Taking after her mother's "Scottish hips" she also felt pressure to maintain a small figure reflective of Sri Lankan beauty ideals. This cultural paradox, where feasting was encouraged while weight surveillance was also prominent led Sarah to understand both standards as simultaneously unattainable.

> "All the grandchildren on my Dad's side of the family which is mostly Sri Lankan, we are all biracial so it's always been a huge interest of the extended family how we look. To them it probably wouldn't be an insult but when you're examined every single time and compared to your cousins, I felt pretty bad about that because they would comment 'oh your bigger than your cousin […] It was kind of like a body check that I didn't want or need" (Sarah)

Navigating this cultural paradox where food is love and identity, but body is scrutinised, was an on-going challenge in Sarah's recovery. The multiple influences at play that define and construct beauty were internalised by Sarah, who identified the beginnings of her eating-related distress as body dissatisfaction, pressure to diet and conform to western norms, and in turn, a gradual distancing from her own culture. Distancing from one's own culture can be seen as a way to resist standards of beauty, or as a process in which pressure from western cultural ideals take over. However, still contending to the scrutiny within her family suggests distancing can only occur to a certain extent. When western cultural ideals are positioned as

the dominant prescription of beauty, Sarah may seek to conform into the dominant culture to feel accepted and fit in, particularly if her own culture invites self-comparison, fat-phobia, and marginalisation. Sarah's story invites reflection on what it may be like for bi-racial people, navigating multiple cultural contexts and norms in this world.

Participants also spoke to the ways in which beauty was defined and food was influenced and understood within specific cultural contexts. An understanding of the navigation of one's culture includes discussion around cultural transitions, acculturation, and points of similarity and difference. Jenny's story provided insight into the struggles she faced within her Chinese culture, particularly related to the ways in which thin bodies are idolised, patriarchal gendered norms are upheld, and family pressures are powerful. Jenny (20, Chinese, Female, Bisexual/Heterosexual) moved from China to New Zealand with her mother at the age of 14. Jenny described her distress beginning at the age of 6/7, speaking to her distress and recovery spanning across cultural contexts. Her story began by reflecting on the normalised nature of restriction and the pursuit towards the thin ideal within her Chinese cultural context.

> "I was so used to people with a BMI of 20, or 18 talking about 'today I'm just going to have rice porridge'… rice porridge means just rice and water, that's nothing! And they would just have that for dinner […] They don't prioritise exercise like at all… it was just dieting… because they just want to be slim, they don't want to have muscle" (Jenny)

Here, dieting can be understood as expected, both socioculturally and relationally to the point that Jenny believed this was the only standard that existed. Body expectations were gendered, where thinness reflected dominant expectations of the female body. Both Jenny and Tegan spoke to weight metrics tied closely to beauty ideals.

> "I always wanted to be under 50kg because of culture. Once you are over 50 means you're already fat, even though you're not, it is just deemed that way" (Tegan)

> "I was not big by any standard but that was how I felt. I was not even 50kg yet" (Jenny)

Tegan (21, Malaysian, Female, Bisexual) described living in Malaysia before moving to the South Island two years ago, also offering insight across two cultural contexts against a backdrop of migration and acculturation. Tegan reflected on the realisation in recovery that the weight metrics that determine slimness and define beauty within her culture illustrate one version of beauty, a form of modern power. However, like Jenny, subscribing to such notions influenced her eating distress, defined contextually in relation to a loss of power.

For Jenny, sociocultural views on beauty were modelled through "Asian idols" and "K Pop", whose body shape, type, and appearance are defined by a slim figure, a small face, pale skin, and flawless skin (Leem, 2017; Williams, 2014). Jenny described feeling different from her friends as she transitioned into adolescence, describing herself as having "bigger calf muscles than a lot of my female peers" and remembering comments like "calves like a boy". Within Jenny's contexts, having muscle was viewed as masculine, contrasting with expectations of conforming to feminine standards of beauty.

> "Everyone around me was just talking about, idolizing all these Asian idols, all these K Pop idols who were thin with twig legs, no muscle at all, pale skin… and I just didn't want to show my legs because I thought my thighs were thick, my calves were thick, too masculine… not feminine enough […] so I would just go on runs in PE classes with all these layers just to feel small and covered […] It was to a point where on summer days, like 31-32 degrees hot humidity, I would refuse to wear shorts" (Jenny)

Her relationship with her body and image was driven by multiple gazes at the intersection of gendered femininity, culture, and ethnicity, based upon the dominant discourses and

prescriptions of beauty across each. Jenny would cover her body in layers of clothing, suffering in heat to hide her body and herself from the various social impossibilities at play. Both Jenny and Amy described feeling immense pressure from their mothers who modelled diet culture entrenchment. Amy (21 year, Chinese/NZ European, Female, Heterosexual) described a Chinese cultural context where intergenerational narratives around food and weight were also passed down within her family. Amy believed diet-culture and fat phobic discourses allowed her to hold the belief that "food is bad and we should be in a constant state of wanting to lose weight", messaging primarily received from her mother and adopted without question growing up. Similarly, Jenny described her mother encouraging diet shakes as meal replacements. Jenny believed the messages surrounding her both on a sociocultural and relational level really impacted her positioning and the pressure she faced to fit in. Where Jenny held a lack of autonomy, recovery involved finding her voice to navigate cultural differences, holding choice over her body and daily practices. Moving to New Zealand was described as a turning point in her story. She was exposed to a new perspective on beauty, one that contrasted beauty standards she was previously influenced by within her cultural of origin. Since relocating, Jenny reflected on becoming autonomous, a shift where her mother relinquished control over Jenny's body and beauty. It is likely both Jenny and her mother were influenced by the process of acculturation, the cultural modification of an individual or group as a result of adapting to or borrowing traits from the dominant culture (Sam, 2006), as she constructed new meanings for herself and body within a western context.

> "People of all shapes and sizes still felt confident, and I was just so stunned by how confident everyone looked, or comfortable, at least from the outside, that they could be bigger because I thought I was a big girl right but I wasn't…I was like how can they be so confident in that size! It was just so surreal for me, it was a different world […] I was like, these people aren't covering themselves up they go to swimming

> pools, in a bikini, showing their tummy how is this possible! And I kind of made solid progress from there" (Jenny)

Jenny believed New Zealand modelled a culture of body positivity and acceptance; while it may have felt that way for her in relation to her previous context, this is not necessarily the case or experience for all within a New Zealand context, as Flo described:

> "There's a lot of tiny behaviours that are really normal that are accepted by everyone when they shouldn't be… like all these tiny comments like 'omg I shouldn't be eating this' and then all of these little things feed into it" (Flo)

From Flo's story, it is suggested that the desire to change one's body has become normalised across sociocultural and relational contexts, where the normalisation of restriction and self-monitoring makes recovery within such a context a challenge. Normative expectations and master narratives exist surrounding working on oneself through lifestyle, health habits, exercise, and beauty products and procedures. This makes challenging the transformation imperative that is disguised under healthism, an on-going act of resistance for Flo.

While Jenny's immigration to New Zealand was significant to her recovery story, the effects of this new cultural landscape were gradual as her distress changed shape and form. In China, her distress was marked by a cycle of restriction and over-exercise; however, in New Zealand, Jenny began bingeing to cope with the stress of university and adjustment of moving, suggesting that eating-distress is non-linear, nor clearly bound to discrete categories. Both Tegan and Jenny came to the realisation in recovery that Asian and Western standards of beauty share many similarities and differences and instead of trying to achieve both, inventing one's own standard was the way forward.

> "I realise the standard of westernised beauty and Asian beauty is very different. I thought why should I follow both of the standards when I can just be the healthiest version of me. I realised being the healthiest version of me is the most beautiful

standard I can ever achieve, so I'm working towards reaching a healthier version of myself rather than being obsessed with Asian or western beauty standards" (Tegan)

Tegan remained mindful of this daily as she discovered herself and what "health" means to her. By situating herself amongst a diverse group of friends with diverse representations of beauty and body, Tegan turned to daily relational support to navigate her recovery. Tegan identified recovery from January 2021, described as "being in a better place, in tune with my body where food no longer has control". Like Jenny, resisting and shifting from ingrained Asian cultural ideals was an important part of re-appraising body, image, and identity. Several participants described the beginnings of recovery in line with understanding the cultural context that impacted and influenced their negative body image to begin with. For Jenny, Tegan, Sarah, Flo, and Amy, recovery was characterised by an overall daily act of resistance against such ideals, circulating within society, culture, and family.

Shifting From Body Appearance to Function

Recovery was constructed through the re-appraisal of one's body, image, and identity beyond physical appearance towards strength, power, mobility, flexibility, and physical and mental stamina for most participants. This sub-theme includes a discussion on Exercise as Energising – reflecting how participants engaged in a shift around exercise practices. For some participants this shift involved changing the form and function of physical activity, while for other participants exercise was something they began engaging with in recovery. There was an overall shift from over exercise for weight-loss towards a theme of strength focused activity and accomplishment. Daily activities illustrated the notion of strength and stamina and experience-close elements of recovery that are often overlooked, offering novel insights into the ways in which we understand and depict recoveries.

Exercise as Energising. For several participants, exercise patterns shifted in recovery and physical activity provided an energising role for both the body and mind. The shift in exercise showed up in different ways across participant narratives. For example, Mary re-appraised her body image and function through her daily activities. Specifically, her exercise routine shifted from cardio-based for weight loss to strength-based activity.

> "I'm kind of doing strength training because you're building up more muscle and you can eat more to gain. It's also very satisfying doing squats and going heavier, I don't really like cardio anymore" (Mary)

Mary spoke to the energising nature of strength training where a shift from cardio towards strength-based activity is explicit, eliciting a sense of achievement and satisfaction. The gradual act of "going heavier" resulted in Mary eating more, positively associating food as fuel for exercise, and gaining weight as a positive. This represents a shift in mindset. Similarly, Flo shifted from over-exercising for weight loss to strength-based activity, specifically engaging in boxing which brought a sense of strength and accomplishment.

> "I do different exercise to what I used to do, I'm back into dance and yoga and boxing is now my main thing. I enjoy the sensation of being strong. When we moved house I was like "oh my gosh look at me lifting this couch!" that's what exercise does for me. The people I exercise with also have those motivations, they are not motivated by body shape and weight" (Flo)

Flo's experience of feeling strong and capable illustrates an example of empowered femininity, deconstructing traditional gender roles and expectations of a woman (Deveaux, 1994). However, of note, empowered femininity is not a neat, singular notion, in a world that continues to impose hierarchies, nor is it a concept open equally to all women either (Budgeon, 2015). Flo's activities show resistance and flexibility of gendered norms. Where strength training and boxing have been positioned as masculine by societal standards, these

sit in stark contrast to the feminised exercise recommendations in recovery, such as yoga (Brace-Govan, 2004; Hockin and Warin, 2021). Flo formed her own version and prescription of what she engages in based on her affect and energy, flexibly choosing between any activity that makes her feel good and strong. This quote also illustrates the importance of like-minded peers who are also motivated by strength and stamina, peers active in her recovery. This contrasts with Flo's former experiences of self-comparison to friends motivated by body image ideals. From this contrast, it is more about relationships and ways of relating that do not invite or centre around comparison that are key to Flo's recovery. Crucial to the beginning stages of re-appraisal of body and exercise, Flo worked through the function of her body with her therapist, directly reframing her body as functional and worthy, moving away from worth being tied to appearance.

> "She [the psychologist] was very relaxed with her approach. We focused a lot on re appraising my body, instead of what it looks like but actually what it can do for me. So we talked through lots of examples where my body has done what it has needed to do, like we talked about when I go travelling where my body allows me to walk 40,000 steps a day and then allows me to go out clubbing all night till 6am, like the example we kept coming back to was that I had this body that could do this huge walking tour of Portugal and then went out all night and got home at 7am, she was like "your body can do all that" (Flo)

This passage speaks to the re-appraisal of body from appearance to function with a sense of gratitude towards what her body allows her to do as an able-bodied individual. An appreciation of functionality has been integral to increasing positive body image in the literature (Alleva, 2021; Engel et al., 2023). This foundation helped Flo to shift her exercise habits and fortify strength-training into her daily routines, where the importance of yoga and boxing to Flo's recovery is evidenced in her description of a "typical" and "good day":

> "Flexibility has always been important to me as a dancer, I always feel good about my body when it is moving well […] I would wake up around 7 […] do some yoga, and it definitely feels good because it feels like I've moved my body first thing. […] I do boxing and that will be around 5pm, and that's an hour class of high intensity stuff – pad work, bag work, very functional fitness which is really cool. It's also really social which is what I like about it, everyone's on a first name basis" (Flo)

Flo contrasted her positioning prior to recovery, to illustrate the difference in her mindset.

> "A bad day in 2018 would have been skipping breakfast… because I liked feeling empty in the morning, the heat and hunger would keep me going […] I would have gone to the gym, I would have compared my fitness level with ["perfect" friend] when she did the moves… and then I would have avoided all mirrors so I didn't have to look at myself [….] I remember crying on the way back from the gym…I would have just felt very not hot. I never thought I was fat in terms of actual fat tissue, I just wished my arm was smaller and my thighs were smaller and everything was a point of comparison to her…" (Flo)

This quote speaks to the relational and sociocultural pressures around beauty and body image, as she described self-comparison. In contrast to her eating-distress, Flo described a recent example of a "bad day" as a day where physical activity, balance, and routine, were absent. Both Flo and Jenny described these days to involve injury which impacted their ability to move their bodies. For Flo, this involved skipping her morning yoga due to back injury, which in turn, had flow on effects for the rest of her day. Jenny described her bad day similarly; injury in the way of her ability to exercise, impacting her distress.

> "My knees hurt a lot and I didn't have enough stamina, so I was just stuck… I think I got up at 9:30am, its already a bad start […] I just felt like I didn't have energy […]

> When my knees aren't good I couldn't go for a run I just had to sit down and not do much but study" (Jenny)

For both Flo and Jenny, exercise is energising and as such, an absence of exercise makes up part of a "bad day". For Jenny, a reduction in energy and a loss of strength and stamina impacts both her physical and mental well-being. Jenny described recovery as a re-appraisal from body appearance towards energy and stamina.

> "After the 6km I just tried running longer and faster… it was tough in the beginning but like it was just kind of addictive, to want to improve, and now I can run 10km without much struggle […] my switch from putting the focus on physical activities and building fitness… it's more like having the energy, having enough stamina, to do what I want instead of like focusing on looking physically fit"
>
> INT: "Switching your mindset?"
>
> JENNY: "Yeah switching my mindset and focus…like I have bigger calves, legs and arms than before and I still have a tummy because I like eating [laughs] but it's fine because I'm feeling strong, feeling active, feeling empowered"

Jenny specifically identified this 6km run as her turning point, an intentional decision to challenge herself 1.5 years ago which marked a shift in body image appraisal, confidence, and sense of self. From this point, running became an integral part to her daily practices that centered around staying well. This passage highlights the co-constructed nature of the interview; where I listened to Jenny describe this run and the impact it had on her, proposing "switching your mindset" as what Jenny was possibly doing. My cognitive orientation towards this analysis is informed by my clinical training where I am particularly attuned to thinking patterns and mindsets. Jenny accepted this suggestion and added "and focus…", expanding on the ways in which strength and stamina provided new ways of thinking about what "feeling strong" meant to her.

Rudy (36, Filipino/Australian, Female, Lesbian), described her distress beginning in her mid-twenties. Recovery was defined as "on the way to getting more balance", where exercise was also noted as integral to her recovery. Food provided a sense of comfort and escape from Rudy's context at the time, where she described feeling low, isolated, and susceptible to "peoples toxic energy" after relocating from Australia to New Zealand. Now, Rudy spoke to re-establishing a sense of self where exercise and identity are core themes within her story.

> "Exercise is massive, it absolutely makes a difference. I can definitely see when my mental health drops off after 1 week of not doing spin. Exercise sets my head to a blue sky rather than a grey and it keeps it there" (Rudy)

For Rudy, attending weekly spin classes provided a place to feel energised and to let energy out. Metaphorical reference to a "grey sky", is Rudy's reference to the common description of depression, a longstanding challenge for her. Within this context, exercise was identified as an important part of staying well for both general mental health and eating distress. There is a clear sense of intentionality in practice where Rudy engages in mindful movement.

> "Spin class is a massive outlet and focus for me. The music is awesome, dancing on the bike kind of feel and the energy…I just love getting into it. I'm always like yelling in the class "wooooo" really getting into it and pushing yourself on the bike. The people are cool and so lovely, yeah made some friends there and its awesome. When I really enjoy spin, which is often, it's a good end to the day" (Rudy)

Spin is an avenue that is enjoyable and a release for Rudy. She described like-minded people who share similar mindsets, where having fun during these classes overrides any preoccupation with shape, weight, or size. In line with the theme of exercise as energising, spin classes provided energy in Rudy's recovery in line with a reappraisal of body.

Rudy's experiences of "emotional eating" occurred in the context of monthly menstruation where her period impacted energy levels and depicted days of difficulty in recovery. As energy is so crucial to her recovery, understanding its contexts of difficulty is important. The quote below speaks to eating practices influenced by menstruation and the impact this has on body functionality and energy.

> "It's still not so good when I have my period coming but I just have to get through it […] I'm a builder it's a physical job I notice a drop in focus, drop in strength, moods get depression, but the drop in strength is the massive one. During that week or whatever pre-period, I end up just a bottomless pit, like starving. Always eating a lot of chocolate, increase in sugars like I'll just drink a couple of cokes three days of the week, lots of chocolate…lots of greasy foods…and I just kind of let go for that week" (Rudy)

Rudy identified this to not only impact her eating (where she "let's go" for that week), it additionally impacted her ability to work as a builder, further impacting her mood. Where food provides fuel and energy typically, Rudy's eating practices during this time reflected a reduction in strength and stamina. Here, food was consumed in the context of comfort/emotional eating, the type of food changed, and Rudy experienced low accomplishment, ability, strength, and stamina. Rudy turned to certain types of food on her period in the absence of energy, which suggests that different kinds of foods may help to alleviate or support certain types of moods. While Rudy described feeling out of control, to some extent, her decision to "let go for that week" reflects some acceptance of her body's needs and desires, choosing to go with it than actively resisting as she may have previously done. While Rudy identified as "on the way to getting more balance", monthly menstruation closely resembled her past experiences of eating-related distress and is described as an on-going challenge.

Overall, recovery for these participants was described through intentional practices of care that centered around energy and stamina, which in turn improved confidence, strength, mood, mindfulness, and an overall appreciation for body functionality.

Re-Storying Identity

Participants' daily practices shed light on how they constructed themselves and re-storied their identities through the adoption and re-appraisal of subject positions. This sub-theme includes a discussion on Constructing Within and Beyond Illness Identity, Living an Authentic Life Beyond Gender Roles and Master Narratives, and how Fit For [Recovery] Purpose Clothing was implemented. While all participants worked through identity re-evaluation to some degree, some participants constructed a new identity moving away from illness identity altogether, while others re-constructed subject positioning in subtler ways. Identity and sense of self will be used interchangeably to reflect an individual's goals, values, and beliefs taken together to describe identity. The process of re-storying identity occurs through the dynamic interplay between individual and context comprising of personal, social, and cultural aspects of identity (Van Hoof & Raaijmakers, 2002). Drawing on Narrative identity (McAdams & Adler, 1985), identity is a person's internalised and evolving life story, an integration of the past, present, and future through the organisation of self-understandings and social processes (Dunn, 1997; Schwartz et al., 2008). In the context of recovery, I understand this to be about reclaiming one's preferred self-understanding, in turn, re-storying identity and sense of self.

Conti (2018) frames recovery "as an identity journey", an opportunity to reconnect and reclaim a person's life and identity. For some participants in this research, reclaiming life involved moving towards a new sense of self where permission was granted to explore intersectional influences when re-constructing identity. Re-storying identity shares

commonalities and overlap with how participants spoke to re-appraising body image. It can be argued that a re-appraisal of body image, is the organisation of self-understandings, part of re-storying identity. However, for some participants, re-evaluating a sense of identity was done through the situated understanding of sociocultural and relational factors that may have been previously missed, such as culture, ethnicity, gender, sexuality, occupation, and religion. Overall, participants navigated, resisted, and even accepted subject positions drawn from socially and culturally available discourses.

Constructed Within and Beyond Illness Identity. Illness identity as a sub-theme was demonstrated through some participants' identifications with diagnostic and societal perceptions of eating distress. The ways in which participants described themselves as part of or separate to their distress was informed by sociocultural discourses around diagnoses where perceived value of certain behaviours (such as restriction) was glorified over others (e.g., binge eating). While storying recovery allowed for participants to re-organise their lives through daily practices, what was clear was that participants embedded their views of illness within master narratives, shaped by cultural norms and stereotypical illness identities. Illness identity plays a major role through the course of distress and recovery moderated by the meanings participants attach to their distress; how the illness is conceptualised and what that means about the person experiencing it (Marcussen et al., 2021; Yanos et al., 2010). These understandings map onto both narrative identity and a social constructivist approach to identity exploring subject positioning in relation to discourses within the social realm.

Sarah spoke to wider sociocultural discourses surrounding distress, where purging behaviours are positioned as shameful and “othered” from self, while restriction may be associated with pride and accomplishment (Goss & GilBert, 2014). Having linked purging to “stereotypical private school girls”, Sarah reinforced sociocultural ideas around eating distress only affecting a certain *type* of person. It is possible that by choosing to position the

behaviour within a societal stereotype, Sarah held distance from framing this as part of her own identity. The idea of othering was also echoed by Eleanor. Putting restriction on a hierarchy as more desirable and credible than binge eating creates a division between the two behaviours reflecting hierarchisation of illness.

> "I thought if I restricted a little bit over a long time I would finally get a real disorder […] I feel like if is really noticeably outwardly then you're like 'oh it's really sad you have to help this person' but I feel like with the more binge eating stuff when you're not actually looking like society's ideal I guess… you're like 'oh well they don't have a problem" (Eleanor)

This hierarchical view towards eating distress informed Eleanor's attitudes on her own distress and positioning/deservingness of support. Eleanor (19, NZ European/American, Female, Asexual) described restriction and binge eating from the age of 15. She held strong beliefs about being thin where adherence to diets were strongly linked to self-control, strength, and happiness. Bingeing, however, brought on feelings of guilt, with purging done to "undo the damage" and self-harm viewed as punishment. Identifying as "recovering" from a self-identified eating disorder, Eleanor described a difference between the intent to recover from behavioural change. Eleanor also spoke to society's view on and differentiation between AN and BN, further reinforcing the assumption that AN affects "private middle-class woman", in "thin bodies", an idea referenced by several participants. While emerging literature has debunked this myth, it may be less commonly known (or accepted) among society that eating disorders can affect anyone (Gibbons, 2001). This societal view, and the power that distributes through societal norms, expectations, and prescriptions, has clearly influenced the views Eleanor and Sarah hold about their own distress.

> "I would have never said anything like anorexia because again I don't fit the stereotype because I'm not really thin and I feel like that was only for 'properly

> diagnosed 'people. I was like I don't deserve an actual eating disorder label… even saying eating disorder I wouldn't have said it at that point I would have been like it's just me trying to be dramatic or get attention, or it's not bad enough, but now I think anytime it's that consuming there's no 'you deserve this or that '[…] When I was in the moment I never felt like I deserved the help, thinking there are so many other people who need it more…thinking my situation isn't bad enough or extreme enough, I don't deserve it or whatever. Which is a weird mentality to have…that being sick and asking for help are on two different scales" (Eleanor)

Eleanor described being outside of clinical categories, under evaluating the seriousness of her own experiences and in turn, othering herself from seeking support. Ideas around not feeling "sick" enough not only positively reinforce disordered behaviours to reach a point of seriousness, but in turn, glorify and stereotype the image of those who are "diagnosable" with "critically ill" or "acute". Part of her recovery story was recognising that although Eleanor did not have a formal diagnosis, she was able to frame her distress in a way that makes sense to her, acknowledging and accepting that it *was* severe enough for her at the time. This passage suggests a turning point from "othering" to owning her experiences. A big part of this process came from the acceptance and visibility of seeing others posting similar experiences online, circumstances that closely reflected her own. Recognising her distress as valid was an important step in acknowledging her needs in recovery. Where research cites recovery to be possible to the extent that an individual is able to successfully relinquish illness identity and develop a new recovery-oriented identity (Espíndola & Blay, 2009; Federici & Kaplan, 2008), these findings challenge this idea. For both Eleanor and Sarah, acknowledging illness identity was essential and facilitated through occupying social positions within groups where others shared similar experiences. How these social forces

generate collective and individual illness identities have implications on people's recoveries, impacting hope and self-esteem (Yanos et al., 2020).

While most participants spoke to constructing or re-appraising identity amidst distress, Alex (22, NZ European, Non-Binary, Lesbian) identified as "recovered". Alex was the only participant to use past tense terminology with distress and recovery identification, importantly linked to the way in which they see themselves as distinctly separate to distress identity. Alex's story aligned with the idea illness identity needed to be relinquished for recovery identity to be established (see Federici and Kaplan, 2000). Alex's story reflected experiences as lived through the meanings constructed and experiences gained, in line with narrative theory depicting a clear resolution and end (Kirkman, 2002; Sarbin, 1986). Alex described the beginnings of distress from the age of seven, speaking to the early influence of gendered roles and appearance-based sports such as ballet and gymnastics. They spoke to a long journey, receiving a diagnosis of Anorexia at the age of 15. Re-appraising body, image, and identity was multifaceted for Alex, restricted by prevalent discourses around femininity, gender, and sexual orientation.

Re-appraising one's identity for some participants involved extending *beyond* their own identity within distress to focus on the needs of others. For Rainbow it was taking on a caring role for her father's illness that catalysed her own shift in recovery. Rainbow (37, NZ European, Female, Homosexual), described her distress beginning at the age of seven, spanning several shades of distress over the past 30 years. For Rainbow, significant relationships, and life events such as the birth of her son and her father's death were described as the "biggest reasons for my recovery", the turning point in her story.

> "When he was getting told the news, the doctor wanted his wife there, but my dad said that my daughter was here and no one else would be, that was fundamental in my recovery […] Other than the birth of my child, my dad was one of the biggest reasons

> for my recovery. […] The second he passed away […] I was like boom we're onto it - the recovery started right away" (Rainbow)

By re directing her focus on supporting her father in his last few months of life, this key event signified the start of her "active recovery" in 2009. Towards the pursuit of "full recovery" over the past year, Rainbow described leaning into her social position as a daughter who was able to care for her father until his death. The relationships that sustain and motivate recovery are important in this story as Rainbow strengthens her identity as a daughter, a provider, a supporter. By putting care and energy into supporting someone else, there is a shift away from illness identity towards social positions that support recovery.

Rudy's story also illustrates identity progression across the lifespan in alignment with Narrative Identity Theory, beyond distress towards occupying social positions that support recovery. For Rudy, the transition to motherhood was a crucial turning point in her recovery, enacted by intentional shifts in her subject positioning since the birth of her three-and-a-half-year-old daughter. She described re constructing identity as a "provider, focused on the family role". Consistent with ideas around motherhood, Rudy illustrated a shift away from self to providing care towards others. While identified as helpful to Rudy's story, I note tensions may arise when focused solely on provider identity, prioritising other's needs above one's own. It is important to note that not all mothers experience pregnancy as a clear turning point in recovery, but many do reflect a shift in identity (Austin, 2016). Some mothers experience the societal expectation to conform to the master narratives of "the good mother" as unhelpful (Gotlib, 2016). Transitions within Rudy's story help us understand how her relationship with her body, image, and identity, have not only changed across developmental life stages but also exist beyond one identity, where identity is a fluid process not marked or limited by a single category or dimension (Jones & McEwen, 2000).

> "There was a time that I wanted to be skinny and focus on my weight, probably

> between 25 and 30 years old [...] Now that I've had my daughter, I'm getting older, I'm not worried about my weight, only for health reasons not aesthetic reasons. I just want to feel good in myself and be comfortable in my job is the main thing" (Rudy)

Rudy's re-appraisal of identity rooted within motherhood overlaps with a re-appraisal of body functionality, suggesting that identity re-appraisal occurs across various areas. The mother-child interaction can be considered a reciprocal relationship of growth in developing value and identity (Austin, 2016). While a large proportion of women are thought to achieve "full remission" from their eating related distress during pregnancy, a smaller portion of pregnant women still experience symptoms or develop distress (Bulik et al., 2007; Micali et al., 2014). The literature positions full remission within a clinical framework, offering little insight into those who continue to experience "symptoms".

Sometimes lived realities of recovering involve the experience of distress being stronger than that of recovery. Identity re-appraisal remains dynamic, situational, and context dependent, where for Rainbow for example, motherhood in itself, was not strong enough to override or replace distress. Despite motivation to recover from the birth of her son, Rainbow described the reality of still struggling with disordered eating and weight loss throughout her pregnancy implicating his health and development. This suggests that there is greater complexity and tension surrounding the provider identity. Whether it is possible or even desirable to forgo distress in motherhood is individually bound. Rainbow's experience of pregnancy is a contrasting example to Rudy's. For Rainbow, recovery was described as a journey chosen to embark on to strengthen her relationship and care towards her son. In contrast to a "turning point", re-appraisal of illness identity is an on-going process for Rainbow who leans into her role as a mother to lean into recovery. This social positioning is one that continues to motivate her to reach new recovery goals such as cooking for and eating dinner with her son.

Living an Authentic Life Beyond Gender Roles and Master Narratives. Living an authentic life, as a sub-theme was demonstrated through participants' re-constructions with purpose and value-aligning activity, beyond gender roles and master narratives. Strengthening authenticity within roles, relationships, and sexuality, were some examples of how authenticity was enacted in recovery, increasing self-esteem, growth, and honesty to self in alignment with one's values, beliefs, and identities.

One participant described a re-appraisal of identity through the strengthening of one's professional identity, extending beyond occupational gender roles. Against a backdrop of sociocultural barriers and gendered norms, Rudy re-storied identity with a focus towards authenticity. Six years ago, Rudy's relationship with food changed as her professional identity and purpose was established. Identity and purpose can be theorised as distinct parts of the self, where enhancements in each of these factors alone may contribute to an increased sense of self and improved well-being (Sumner et al., 2015). If one's identity is influenced by a sense of direction or purpose in life, re-appraising professional identity is one way to live an authentic life in recovery.

> "Once I finally got the confidence and the skills and earned my stripes" […] I got respect, I suppose its confidence and I felt happy doing my job every day and my eating changed… it was more about fueling my body, occasionally eating a treat here and there but not so much overeating and the reward food I suppose…that's pretty much stopped now" (Rudy)

This quote describes professional identity formation as a process, a journey that impacted on her eating practices. Confidence and happiness are interlinked, impacting a sense of self. Eating patterns shifted form and function. Against this backdrop, authentic identity formation wasn't easy; "It was a hard road in the beginning dealing with the culture… with the men". Rudy navigated several sociocultural challenges within the building industry. Rudy

positioned herself as a woman within a professional context where gender roles and stereotypes are pronounced. Master narratives exist that suggest men are better suited for physical strength-based tasks while women are expected to conform to gendered roles, such as child rearing. While this occupational standard and gender-segregated stereotype is changing against a modern landscape, the types of jobs which are stereotypically "suited" for specific genders are still heavily pronounced and exclude consideration of diverse genders beyond the binary. Rudy highlighted an example where stereotyping was evident, and the power and impact this had on her well-being and identity.

> "I get doubted all the time, 'oh can she do it, can she lift it but often I'm stronger than most guys! I work so much harder than these guys and I find that they can be a bit jealous and intimidated which is a reoccurring thing… I suppose it's because I'm in a male dominated industry. I'm boy-ish though [laughs]. I don't work to compete; I just work for myself because I love building and I just want to get better and enjoy everything" (Rudy)

She spoke to learning how to deal with this, recognising that this "came with the job"; however, at times, this wasn't an easy narrative to follow. For Rudy, identity formation and authenticity came with a level of acceptance for what was worth challenging. A shift in mindset and confidence was central to her recovery where she acknowledged her skills despite initially doubting herself "predominantly because of low self-confidence and dealing with the male culture [..]". A "good day" in recovery was described as a "hard day" at work marked by an internal sense of fulfilment and satisfaction, aligning with her identity as a "strong and able" builder where she described achieving more than she and others thought she could. She described a positive mindset as central to this good day, engaging in intentional morning meditation and "no negative banter". In contrast, a "bad day" was marked by negative banter at work, the decision to smoke cigarettes in the morning instead of

meditating, and an overall decrease in confidence in self and ability. Negative criticism and navigating gendered assumptions affected Rudy's ability to do her job authentically, impacting strength and ability. This in turn, impacts her eating-related distress, where food retreats to its comfort role and negative energy retracts Rudy's authenticity and courage. By understanding the context of criticism and gendered stereotyping, self-doubt has a significant impact on professional identity for Rudy. It is specifically the process of developing a position that resisted such gendered discourses, that was key in her recovery.

For some participants, navigating sexuality was an important part of recovering; one that required the development of growth and honesty to self and others to live an authentic life in line with one's values, beliefs, and preferred identity. For these participants, identity and sexuality were interlinked. Alex spoke to navigating sexual orientation, an on-going process, alongside gender identity.

> "I still had a lot of internalized homophobia about it [coming out] like 'I'm gay but not that type of gay' or 'I don't need to dress different I just need to follow the trends and stuff', but actually second year was a time where I was honest with myself for the first time. Honest about how I want to dress, how I want to present, what is my identity […] there's pretty good queer groups in the [South Island] and I'm still not out to that many people but I think I have just given myself permission to explore that side of myself" (Alex)

For them, "coming out" was the turning point required to reach full recovery. Authenticity towards self and others was the "the last hump […] the final stage of recovery". Recovery was not complete, until acceptance occurred, where experiences of distress collided with internalised homophobia. A "good day" in recovery is one where Alex felt particularly connected and supported by friends who had been there through the full journey, being able

to share with them progress made in recovery, sexuality, and gender identity. There is overlap between acceptance of self and sexuality, fostered further by the acceptance from others.

Shifting into a deeper analysis highlighting the interwoven nature of sexuality, religion, and cultural context, this allows for a greater appreciation of the on-going difficulties some participants face when aligning with an authentic way of living in recovery. Rudy exampled this, speaking to her experiences of navigating sexuality and spirituality in the context of her Filipino culture and catholic family context where she is expected to conform to certain religious and cultural norms.

> "Mum was Filipino, and she was always very traditional. She always wanted me to be this classic, typical girl, go out and get a husband kind of thing. That old school mentality. You know, be skinny… she would call me fat […] My mum wasn't very accepting when I came out, she thought it wasn't normal […] I lost a few friends...Christian friends" (Rudy)

Gender, sexuality, culture, and religion intersect with eating, body, weight, and identity here. For Rudy, re-constructing identity amongst this backdrop involved working through who she authentically wanted to be despite gendered norms around femininity, spirituality, and sexuality within her cultural context. Through a navigation of sexuality came the re-appraisal of spirituality and identity.

> "Not being spiritually connected was a big thing, now that I am I feel so much balanced. For me its energy and really focusing on that. I used to be religious mum being catholic and stuff, I think it stopped when I was 16 and realised I was gay and was like well screw these guys they don't even like gays! But you know, *for me spirituality now is more to do with energy and the passion for what you do*. You got to love what you do. I couldn't imagine going to a job where I didn't want to get up in the morning" (Rudy)

As Rudy moved through life, spirituality took a new form and purpose. Moving away from what was traditionally expected within a catholic context, spirituality was re-defined through purpose, passion, energy, and authenticity. Rudy's story around spirituality crosses over with her professional identity. For Rudy, focusing on a value aligning job that provides energy is crucial to who she is as a person, to her spirituality, her identity, and her recovery.

Growth is apparent in Rudy's talk below, where shifts in mindset allow movement towards a value-aligning life in recovery.

> "For a while there I was focused on perfection…Now my focus isn't on perfection, perfection just isn't achievable. Now it's about being me, showing up with love, joy, positivity and just enjoying life that's my focus…and trying to keep growing and improving" […] labels are blurring and changing and less… the picket fence doesn't seem like the ideal anymore, which is good because its bullshit! It's bullshit" (Rudy)

This quote speaks to navigating a sense of self in a world where strong societal expectations are set upon women, mothers, and wives which may inhibit identity development. Rudy strongly attests against this idea of a "white picket fence" and gendered norms, critiquing such expectations and redefining what it means to grow and be successful for herself. This is enacted by working within a male dominated field, and more recently leaving a long-term relationship to prioritise her own happiness. To counter the patriarchal objectification, Rudy resists these norms and no longer objectifies herself as she moves through stages of life and re-appraises her focus on growth and self-improvement as her mindset of recovery.

Like Rudy, religion forced upon Rainbow impacted her true sexuality which in turn impacted her eating, image, and identity. Formerly "stuck" in a heterosexual marriage for ten years, Rainbow described feeling unhappy and dishonest to herself. By acknowledging this internal conflict and leaving the marriage, Rainbow alleviated distress. Rainbow described presently living an authentic life in line with her values, beliefs, and identity. This decision

was another turning point in Rainbow's recovery, illustrated by daily practices where Rainbow made the time to surround herself with like-minded individuals who bring forth feel good emotions, motivation, and a sense of community. Themes of visibility connect Alex and Rainbow's recoveries, coming to terms with sexuality as part of identity was important to authenticity. For Rainbow, sexual identity was strongly tied to her subject positioning and illustrated visually throughout the interview by her choice of rainbow-coloured items. In addition, the selection and identification of her pseudonym "Rainbow" was explained; "As you can tell by all the rainbows, I am very gay, very very gay". Identity re-formation was ultimately the decision to live an authentic life in line with one's values, beliefs, and goals, themes of honesty and authenticity are apparent across stories. Participants described shaping their identities while navigating complex intersectional and contextual factors such as sexuality, culture, and religion.

Fit for [Recovery] Purpose Clothing. Re-appraising body and image was also enacted by participants intentional changes made to clothing and presentation, moving away from clothing that magnified shape and weight concerns to clothing that enhanced confidence. A shift from the mindset where the body needs to fit the clothes towards the notion that clothing needs to fit the body is an important one when thinking of clothing as fit for recovery, central to re-storying identity.

Ann (47, NZ European, Female, Heterosexual) identified as "in recovery, healing from everything". Experiencing eating-related distress from an early age, Ann reflected on how "binge eating" was her way of coping with early experiences of physical and psychological pain, including sexual abuse, surgery, and intimate partner violence. Comfort eating in the context of trauma was described across several participant experiences, where healing, in this instance, involved recognising the underlying root of pain (Brewerton, 2019; Thompson, 1994). A turning point in recovery was coming to terms with her alcohol-related

harm and lost sense of self. Residing within an alcohol residential facility, Ann described a "good day" in recovery as one where she intentionally presented herself through specific clothing choices that reflected care and a re-construction of identity.

> "Basically the only change to a typical day would be I put on makeup… I get a bit of a lie in, get up at 8am, put my makeup, put on perfume which I'm not allowed at level 3. I'm more mindful, I pick my outfit. I intentionally pick my outfits. I don't just go for comfort which we tend to do when you're just at home around here. I have a few tops I would pick out. One is my Nike top, its lime green with patterns on the logo. The first time I wore it I got lots of compliments here and yeah it makes me feel good" (Ann)

This quote depicts the interconnected nature between feeling good about oneself through intentional clothing choice and the act of mindfulness. Similarly, Flo described how intentionality around clothing was a way in which she was also able to elevate her mood, depicting a "good day" in recovery. She described a sense of confidence as she was also able to mindfully appreciate the warm weather, her improved mood, and the impact this had on how she felt in her body and clothing.

> "It was the first sunny day, and I was walking along…Oh and I got new trousers! They were leather snakeskin flares, and I loved it […] If I like the clothes and the outfit, I will like the body in the outfit" (Flo)

Here, there is a direct connection between enhancing body image through clothing that Flo likes, a way to shift body image perception without shifting body. Intentional clothing choice not only reflects a good day in terms of mood, but also represents a form of self-care, where particular attention is given towards wearing clothing/makeup/perfume that enhances a sense of self. This crosses over with the narrative of Nourishment, where these practices can also be considered as an act of putting the self into self-care.

Navigating gender beyond the gender binary is one way Alex spoke to re-appraising body, image, and identity. Alex's story reflects a shift in appraising body from gender based physical appearance and thin ideal, to gender neutrality. Where research surrounding eating-related distress and body image has been primarily based among cisgender samples, using body neutrality to inform recovery in a gender diverse world has been cited as one way to approach this re-appraisal (Cusack et al., 2022; Perry et al., 2019).

> "I do still have some anxiety around my shape because I want to look more masculine than I do, I have quite a feminine body. At the end of the day I can recognise, I do not want to do recovery again…at all…so my priority is not going into energy deficit or anything so I would not restrict to change my body shape or anything. Instead, I can work out to make myself feel stronger, and I can dress…clothing is a really nice thing for me now. For a long time, I selected my clothes on how skinny they made me look but now if clothes make me look bigger, I'm like okay, its fabric, I don't care. I think the main thing was just being honest with myself" (Alex)

The daily practices of clothing choices as part of recovery, represent a state of acceptance and enactment of identity where care is given towards the body. Alex identified as recovered amidst on-going anxiety around shape, rooted within masculine body image ideals and sociocultural pressures. This quote highlights the importance of functional clothing choices and how such intentional decisions illustrate simplicity– simplifying one's view of clothing as just fabric, made to fit our body not for our body to be forced into the clothing. For Alex, the shift in image and identity was evident as they accepted themselves and the way in which clothing fit on their body. When aligning with an honest version of themselves, Alex was able to begin re-appraising identity, moving away from anorexia, beyond weight restoration, towards an authentic version of themselves.

A shift in alignment towards authenticity and intentional clothing was also described by Jenny. In recovery, Jenny described accepting her body as it was and beginning to make peace with the daily variations in shape and size. This acceptance was reflected by her choice of clothing worn as she engaged in physical activity.

> "I'm very happy to wear a sports bra on a tramp […] I'm confident enough to do that now" (Jenny)

This quote illustrates a shift in alignment and visibility where previously Jenny felt marginalised, lacking confidence in self, body image, and identity at the intersection of gendered and cultural norms. Now, Jenny speaks to being seen and comfortable, opposing gendered, cultural norms of beauty, an example of empowered femininity. Wearing a sports bra on a tramp marked an intentional act of presenting herself as confident, courageous, and accepting of one's body. From a functional perspective, clothing choice that is intentional and allows for movement further illustrates exercise as energising. In contrast, Jenny reflected on the clothing choice further reflecting an absence of energy and physical activity on a "bad day" in recovery.

> "I wanted to put clothes on but all I wanted to put on was sweatpants because I was bloating. I don't really like wearing sweatpants outside. In Chinese it's called Jīngshén (spirit, having high spirit). If I wear sweatpants I would just sit down and be all energy less" (Jenny)

When Jenny is unable to move her body, a reduction in energy, spirit, and stamina was described, impacted further by her clothing choice. While one way of interpreting her decision to wear sweatpants when experiencing bloating is a way to functionally manage distress by minimising the situation for increased bodily awareness or checking, Jenny positioned this clothing as a point of difference to her usual clothing. These contrasting daily

practices are shown to illustrate the power of clothing choice in itself with its influence on how she feels about herself and her body.

Summary. Across the narratives, there is an overall focus on a shift and re-appraisal across both body image, and identity, highlighting the alignments and contradictions between each facet in recovery. This chapter began with a discussion on the sociocultural barriers to recovery, rooting an understanding of participant distress within a society that prizes the thin-ideal, where fat-phobia circulates on a societal, relational, and cultural level. Participants rejected these dominant master narratives, shifting focus from body appearance to body functionality. The sub-theme Exercise as Energising exampled this through a focus on daily practices that centered around strength over aesthetic (such as strength training or yoga). Re-storying identity encompassed a larger process that participants worked through, re-defining authentic versions of themselves that best aligned with their beliefs, goals, and values. Identity reformation was constructed within and beyond illness identity, where some participants troubled the complexities with the categorisation system and created distance or "othered" themselves altogether. Others worked through illness identity by finding a sense of self and purpose within other areas of their life. Re-storying identity included living an authentic life beyond gender roles and discourses, re-defining goals and values, accepting self and sexuality, and overall, resisting sociocultural norms where they did not align with recovery. Constructing identity also involved re-appraising clothing that enhanced comfort and confidence, and for some neutrality. Understanding the complexities of recovery involved establishing daily practices that centered around strength and stamina with exercise, visibility, and acceptance around body, re-defining spirituality and authenticity, and ultimately, refuting and continuing to challenge facets of life when re-appraising body, image, and identity.

2. The "Neutrality and Nourishment" Narrative

In the "Neutrality and Nourishment" narrative, recovery was characterised by over-arching shifts, from inflexibility and negative affect around food to intentional daily practices that surrounded neutrality and nourishment. Neutrality, in this context can be understood as not holding strong feelings or views towards food and body. Nourishment is described as both nutrition necessary for survival as well as practices that provide energy, beyond traditional definition. Within these broad concepts, participants endorsed various meanings. Neutrality was nuanced, reflected by shifts beyond binary categories to illustrate shades of grey with food and body image. Deepening nourishment involved moving away from dieting towards self-defined intuitive eating, food as fuel, the practice of intentionality, and prioritisation of both pleasure and health when it comes to food. For several participants, nourishment transcended beyond food. This included feel-good practices evidenced within daily routines ranging from "treat yourself" moments to practices of mindfulness and spirituality. Relationships were viewed as nourishing, alongside prioritising putting the self into self-care. Across each of these, recovery was described as an on-going process discovery, habit formation, intentionality, and re-alignment towards value aligning activity and purpose. Overall, the "Neutrality and Nourishment" narrative was characterised by a tone of stability, acceptance, introspection, connection, comfort, joy, and feel-good activity.

Neutrality is Nuanced

Some participants described embracing neutrality around food, eating, and body image as key to recovery. This involved not having strong emotions, reactions, perspectives, and mindsets, coming to a place where food and body no longer felt over-powering or negatively experienced. For some participants, there was little difference between a "good day" and "typical day", which shows that good might not necessarily mean remarkable or

extra-ordinary in recovery, but instead reflect neutrality marked by an absence or reduction of distress. Neutrality is nuanced, in the sense that recoveries are marked by day-to-day activities that are not hugely celebratory, but instead, almost mundane within day-to-day life. Recovery, therefore, is less about the large milestones, and more about a shift towards life stability, consistency, and normality across daily practices. Some participants described a shift in recovery mindset, viewing food as neither "good" nor "bad", reconstructing dichotomous black and white thinking styles to reflect greater cognitive neutrality. As such, simply categorising a "good" or "bad" day may in turn be too simplistic to reflect complex human emotions and layers of distress, variable across the day. There is nuance in the way recovery can be understood from these stories, extending beyond a binary categorisation, towards themes of stability, normality, flexibility, and acceptance.

Neutrality was evident across some participants daily practices. Alex described neutrality in relation to simple moments where progress was made around eating food without self-loathing and guilt, recognising that such foods were now considered neutral in their life, where previously they were distressing or "bad".

> "My flatmates would be like "do you want to go get ice cream" and I would be like "yes I do actually want to get ice cream" and then I would be holding an ice cream and be like "oh my gosh that is so weird, that I could a) be open to the opportunity that I wanted ice cream and b) being like yes I do want it at whatever time. Stuff like that didn't come into my brain" (Alex)

Alex described experiencing food freedom, no longer under scrutiny and self-loathing, previously experienced as guilt and shame throughout daily life. Similarly, Flo described an absence of guilt around food as a key feature of her current positioning in recovery. While Flo described her bad day to involve "indulging in food and wine" and feeling "yuck" as a result, Flo distinguished the difference of this bad day to her former thinking. Flo recognised

the great progress she had made in relation to previous mindsets where guilt was prevalent when food was described as above. A good day can be understood as multi-dimensional: defined by thoughts and feelings about food and body reflected by neutrality and an absence of guilt, or a good day described by recovery-aligned food and eating.

> "There's no guilt. That's the big distinctions. I'm not like 'I shouldn't have eaten that' it's more like 'I'm looking forward to eating some broccoli'. I can tolerate fluctuations in healthy behaviours based on the context because I know that me having an objectively less healthy weekend doesn't mean that I'm an unhealthy person who will continue to do that" (Flo)

This quote speaks to the idea that every day can't be a "good day", and instead, there will be "bad days" related to food and eating, and, extending the analysis deeper, there is a shift from viewing certain foods as either good or bad. Flo recognises eating is not neutral, however, the goal is no longer perfection. For Flo, tolerating the "bad days" involves appreciating them for what they are, knowing that the practices within it are not indicative of her recovery. Instead, these practices are understood as one small part of a larger picture, where flexibility in mindset and eating reflects neutrality and normal eating.

Ivy also explicitly articulated neutrality as an absence of excessive attention or focus on food or eating, instead living a "typical" life where she was able to manage both eating-related distress and distress related to autism concurrently.

> "Recovery is just a "thing" it's the same reason I'm not actively trying to solve my autism or something, it's just something you can't change instantly so just being normal and trying to act like other people, living your life as other people do, it doesn't have to be a big black hole in your life. And that's how it was for so many years *so I think that's why I have this kind of neutral approach"* (Ivy)

For Ivy, recovery and neutrality were intrinsically linked; recovery was not a concept to be solved, or a notion held separate from her existence, instead, recovery was reflected in everyday decision making eliciting a sense of normality and neutrality. The idea of recovery being a process is reflected through her story “you can’t change instantly”, communicating a level of acceptance to the journey. It was through a daily life interviewing approach that the insight of recovery being in everyday life was fully developed. Ivy described her good day to reflect a day where she was busy and distracted, and thus unable to think about eating. Despite having more to deal with on this particular day, Ivy identified this as a “good day” in recovery due to the regularity maintained with her eating despite the challenges related to autism. Eating was neither neglected or in excess but instead reflected as neutral, neither good nor bad.

Ivy chose the day of the interview as an example of a “bad day” as she had not eaten anything up until 3:00pm. For Ivy, a bad day was one where she avoided food completely as a byproduct of emotional challenges. Ivy described feelings of anxiety and fear where avoidance behaviours interfered with her routine more than usual. After calling in sick to work, she spent the morning journaling and engaging in self-directed psychological learning. By journaling and engaging in self-development within her "bad day”, Ivy demonstrated intent to improve or shift her day by doing the things that make her “feel good and productive”. Ivy also described going on a short bike ride as a form of nourishment for herself. Despite the sensory related challenges that were experienced from navigating the city in the rain, Ivy described a nourishing afternoon where she did not feel compelled to be anywhere or stressed by time. Ivy described the slowness of her day as a positive point of difference to her typical “productive, fast paced” routine. Upon recalling this “bad” day, I probed for further meaning as the events described reflected one that appeared “good” and “nourishing” in nature.

> INT: “The day you just told me about, I'm hearing elements of good in there but in terms of eating you haven’t eaten till now, is that correct?
>
> IVY: No, I haven’t eaten anything. It’s hard when I'm feeling anxious because food has so much loading for me. When I'm feeling emotional, I just avoid it altogether because I don’t want to have to deal with managing any distress or thinking about what I have to eat…so it just happens that way sometimes and I try not to judge myself too much for it”

It was upon further exploration that I was able to understand where and why this day was identified as a “bad day”, in terms of eating related distress. Where avoidance perpetuates distress, it also helped her manage distress in the short-term. This quote illustrates the nuanced meaning behind the words “good” and “bad”, representing more than a dichotomous categorisation, where Ivy’s “bad” day reflects behaviours and attitudes that reflect elements of "good”. Ivy spoke to holding self-compassion and grace for herself on these days when it comes to eating, while putting effort into other activities such as journaling and biking that improved her day in other ways. It is important to consider the interaction of concurrent distress, as eating-related distress does not often exist in isolation. Many participants spoke to feelings of anxiety, stress, or significant life events influencing their “bad day” across narratives, while also managing other mental health difficulties alongside eating distress. This may complicate how a person views a good/bad day and limit the usefulness of such a binary categorisation, where a day may be considered “bad” for eating-related distress, it may be “good” for other difficulties experienced. Across recovery, an ongoing challenge for Ivy were days where feelings of anxiety and avoidance preoccupy a state of neutrality and balance.

Ivy co-constructed meaning with me, where her “good day” was better due to having “more to deal with”, in turn, reducing preoccupation with food and eating. In contrast, her “bad day” was defined by the decision to “cancel everything and amble about…”, identifying

this as atypical to a day in recovery. This highlights the importance of exploring the meanings the participant makes as a "good" and "bad" in recovery may contrast with what the clinician or interviewer may presume. There is interconnectedness between neutrality and nourishment, where nourishment through daily practices here buffered, the effects of a "bad day".

Neutrality can also be understood as a framework, a goal, or state of being when re-appraising body image focused on body acceptance and liberation (Clark, 2022). While some participants described content promoting body positivity as central to their recoveries, others chose to intentionally disengage from all content in general, moving towards body neutrality.

Flo and Ivy described that while they transitioned from viewing content that was negative to their sense of self, content that was also overly body positive exacerbated distress. It is perhaps thought that a focus on body positivity may suggest or over simplify that negative feelings are dealt with easily and that it is a personal responsibility to work on oneself, from a post-feminist perspective (Riley et al., 2023). Having engaged with both ends of the continuum, some participants found having a middle ground essential in recovery. Body neutrality was a state of being that progressed from an initial pursuit of body positivity towards full recovery defined by neutrality, a focus on the ability of the body.

> "I used to also follow lots of body positivity pages but I ended up unfollowing them too because the fact that I followed them was the thoughts associated with someone who needed to follow them to feel better…but part of my recovery is that those thoughts don't exist in my head I was like 'you don't need to follow those people, you don't need that anymore" (Ivy)

Reliance on body positivity content signaled a previous stage of recovery she felt she had surpassed. While Ivy identified as being "in recovery", she also described a shift from being body negative, to overly body positive, before deciding to intentionally remove body

positivity content to reflect neutrality. For Flo, unfollowing body positivity content signaled a turning point in her recovery. Presently, Ivy positions herself as body neutral, without excessive or forced engagement with any forms of body related content. Participants discussion around body neutrality points to the process-driven nature of recovery, where body image is not a destination or an endpoint, but a continuously changing space in recovery.

Extending Nourishment into Embodied Experiences of Eating, Hunger Cues, Affect, and Social Eating

Participants spoke to various ways of nourishing themselves in recovery. Participants endorsed food and eating practices that aligned with the functional role of the body. By shifting disordered eating behaviours with intentionality, evidenced through daily life descriptions; participants engaged with food differently and in ways that worked uniquely for them within their contexts. Embodied examples include eating intuitively aligned with hunger cues, viewing food as fuel, eating "healthy", eating socially, and eating without negative affect. Participants described negotiating food and eating practices that aligned and overlapped with a re-appraisal of body, image, and identity, to some extent. Participants also spoke to wider forms of nourishment including the relationships that sustain and nourish recovery and prioritising themselves within "self-care" practices.

Several participants referred to the concept of Intuitive Eating, taking it up in different ways. While intuitive eating held different meanings for each participant, broadly speaking, intuitive eating involved allowing oneself to respond to hunger and satiety cues while holding awareness and intention over former restrictions imposed. Zaza spoke to having an awareness of former disordered eating habits as the start of her journey towards intuitive eating.

> "I am a lot more aware. Now it's really nice because I am like 'Oh I'm actually hungry again', when before I was like 'okay we are going out for dinner tonight, so I won't have this…or I won't have that'. I really do what my body needs now. I think I am good at that. I am healthy, I really care about my body, and I really care about the planet" (Zaza)

Zaza described eating in response to her hunger signals, maintaining a "healthy" diet, and holding care towards the environment with the food choices she makes. A marker of Zaza's recovery is her excitement for dinner and her ability to intuitively eat chocolate depending on her day-to-day desires. This contrasts with rule-bound eating, where chocolate previously was structured, planned, and limited, at best. Themes of trust and flexibility transcend this shift in nourishment practices.

The turning point in Tegan's' recovery story was discovering the concept of intuitive eating through Instagram, in January 2021. From this point onwards, Tegan described regaining control over herself and her "eating disorder" through the intentional daily incorporation of intuitive eating practices.

> "I started practicing intuitive eating. Where your more aligned with your body […] I started becoming healthier, getting better, eating when I'm just hungry and I don't think of food anymore unless I'm just hungry. Listening to my hunger cues […] not punishing myself anymore. I learnt about this from the Internet, Instagram especially" (Tegan)

Intuitive eating was evident through her daily practices, where for example, Tegan only ate breakfast and dinner dependent on hunger levels. Described within her "good day", Tegan chose not to eat dinner after still feeling full from lunch. While skipping meals may be characteristic within disordered eating and may raise questions, this choice must be understood specifically within Tegan's context, across her experiences and meaning making.

For Tegan specifically, skipping dinner was described as intuitive as she was feeling nourished and satisfied from a previous meal, simply being led by her hunger and satiety.

Mary continues to work towards her self-identified recovery goal of intuitive eating, defined as putting "the finishing touches" on recovery. She spoke to the realistic nature of recovery, where despite awareness and motivation to reach this space, some days in recovery are marked by an internal battle against disordered practices, such as calorie counting. Mary recognised that while restrictive eating no longer plays a part in her recovery, logging meals on My Fitness Pal has been a longstanding way in which she feels a sense of control, a habit yet to be abolished despite best intentions. Mary's daily practices of nourishment depend on whether intuitive eating is practiced, or if food is counted and controlled, changing day-by-day dependent on Mary's ability and capacity to choose recovery. Relinquishing control is understood as part of the recovery process, one where in contrast to Zaza above – previously played out in similar but different ways through rigid meal planning and compensation.

Another way participants re-appraised nourishment and embodied new experiences of eating was by adopting the mindset that food is fuel. With this view, food is required for activities that require energy, embodying a functional view on both eating and one's body. Jenny chose a recent tramp as an example of a "good day". This "good day" depicts the interplay between food and fuel needed for exercise, nourishment in a functional form.

> "We walked for two hours and because I felt pretty full I didn't need snack breaks. When it got to lunchtime my body was like 'I'm hungry' so we stopped at 11:30 after 4 hours of walking […] It was nice being in the bush and I felt if you eat the right amount, not overeat, it just feels good in your tummy after being hungry, I had the energy to walk till we got out" (Jenny)

Eating in tune with her hunger signals, Jenny described feeling energised physically, enough to sustain her activity. Jenny's dialogue illustrates flexibility in her eating, aligning with the

concept of intuitive eating. Food as fuel and hiking as an energising activity links back to the importance of strength and stamina across Jenny's narrative. Energy generated from food holds a bi-directional role with activity. This is clear across Jenny's "bad day" in recovery where an absence of fuel had flow on effects on energy, leading to a reduction in exercise and activity, and less success with intuitive eating practices. While food as fuel is integral to activity, activities by themselves also hold importance on "bad days".

> "Activities are a reset point […] I really like climbing so that was something I could look forward to, to be happy again, while im experiencing this set back. So I organised that. The next day I headed out to Long Beach, learnt how to abseil, and learnt how to do new stuff and it was just a highlight and I felt quite happy again" (Jenny)

On days that are harder in recovery, Jenny described activities such as rock climbing and abseiling to re-set both mood and eating. By engaging in activity, Jenny was able to re-appraise the functional purpose food holds as fuel in her recovery. Here, food is both fuel and functional nourishment, where activities that energise also offer a form of mental and physical nourishment.

Rudy's story also strongly illustrates the notion of food as fuel, where energy from certain foods is central across both her "good" and "bad" days in recovery. Understood at the intersect of gender and occupation, food fuels Rudy with the strength and stamina required her job. This mindset was demonstrated within a "good day", a contrast to distress where food filled an emotional void.

> "I would have probably had chicken wings and some fruit. I probably had a coke, but when I look back I think 'shit 10km', I would have thought I would have had to stuff my face! Then I ended up having takeaways the night, Asian food… noodles. I

> thought I would be shattered the next day but I felt great. I went to spin class the next day after work as well" (Rudy)

Completing a 10km job requiring significant strength and energy, Rudy reflected on eating less than she thought would need to complete this task. Feeling great, she was left with energy to spare that allowed her to attend a spin class the next day. By nourishing herself with specific types of food, the energy generated from this catalysed into more activity. Spin class can be seen as another form of nourishment in Rudy's recovery. Here, food not only provided enough fuel for task completion but also provided a sense of accomplishment. This quote speaks to the inter-connected nature between recovery, food choices, energy, and exercise, each in turn, having flow on-effects for her sense of feeling good and feeling nourished. Her "good day" is best understood in contrast and context to a "typical day" of eating in recovery seen below.

> "No breakfast […] and then I have a smokko at 10:00am. I normally have something high protein, either chicken wings or chicken nibbles with salad or spaghetti bolognaise without the pasta… low carb… unless I feel like I need the carbs for the day if it's going to be a challenging day" (Rudy)

Across both days, there is a clear difference in the magnitude of food eaten and types of food needed for energy. Rudy expected to include carbohydrates and increase her protein intake when undertaking a challenging work task. In contrast to her typical intake, Rudy ate less than expected and of more variety than usual, experiencing positive impacts on her strength and energy. This suggests that while food has a clear functional role as fuel for tasks, when Rudy ate in alignment with her body's needs (which changes day by day from task to task), Rudy re-appraised her own nourishment in line with an intuitive eating approach.

Re-appraising nourishment for some participants involved re-appraising the affect and emotional expressions that came with eating-related distress. For Amy, her childhood

dinnertime context was experienced as “stressful”. She described holding a lack of autonomy over her eating which led to negative associations surrounding food. Identifying as “recovering”, Amy identified being better at managing her inner dialogue around food where she no longer feels the “intense feelings of guilt or high anxiety around eating”. She attributed this to living in a flat and having the freedom to choose what to eat, balancing both control and choice (two features often implicated in distress). Independence and autonomy are two key themes within Amy’s recovery, understood against the backdrop of her distress where she lacked choice and freedom.

For some participants, healthy eating was a central theme to their recovery, elicited for both physical and mental well-being. Flo described that while she does not enjoy “leafy greens” she makes the intentional decision to have this within a smoothie to ensure she is meeting her nutritional needs; similarly, Zaza described having a “celery juice for anxiety”, to look after her mental well-being. Jenny’s typical day was marked by themes of “healthy eating” where her breakfast was used to to illustrate purposeful, intentional choices around this concept in recovery.

> “I brush my teeth, put my clothes on and have a bowl of homemade granola, with yoghurt and a cup of coffee […] we [me and my four flat mates] cook flat meals together and I eat very cheap because I want to spend my money on the things I love and food is just not one of my priorities…but I want to eat healthily. So, I will eat a bowl of granola and it will have the fibre in it, good nuts like almonds and stuff, mix it with brown sugar, peanut butter and yoghurt” (Jenny)

There is a clear theme of “healthy eating” that comes through Flo, Zaza’s, and Jenny’s examples, as they re-appraise nourishment in recovery towards certain “healthy foods” for physical and mental well-being. These foods, and practices, position a “clean eating” or “healthy eating” discourse, a master narrative towards healthism where eating

healthily is perceived as a desirable behaviour and sometimes positioned as a solution for physical and mental ill-health (such as anxiety). Healthism is connected to discourses on empowerment and autonomy as people are expected to take control of their health and well-being through lifestyle management. While nutrition undoubtably plays a large role in recovery, I question what the emphasis on such practices may communicate to those in recovery. With master narratives surrounding healthism, such practices may be a socially acceptable way for people in recovery to continue to control their food and body in a society that values such practices. The literature points to orthorexia (a pathological obsession in pursuit of a healthy diet) as an expression of distress that may present in remission or recovery of an eating disorder, allowing an individual with a previously diagnosed disorder to feel accepted by society again (Parra Carriedo et al., 2020). Such practices raise important consideration given the complexity and nuance embedded within this sociocultural context.

The notion of intentionality was also apparent across participants' daily practices as participants choose foods that specifically allowed them to feel good, and in some instances, simply meet nutritional requirements. Flo and Sarah described deepening or establishing relationships with foods that centre around pleasure, illustrating "feel good" eating or "food joy" as a form of nourishment. The idea of feel-good eating is evident across both participants' breakfasts, understood as important to their daily recovery.

> "A yummy breakfast which always makes me feel good is usually avocado on toast" (Flo)
>
> "I really love my breakfast it is my favourite time of the day so I will poach my egg…I will make my toast and I just sit with that and a coffee and I'll watch something and it's the best 10 minutes ever" (Sarah)

Breakfast goes beyond the food choice specifically, to also include a daily, intentional practice that Sarah finds enjoyable, grounding, and nourishing through its wider form and

function. It is specifically the time taken to eat mindfully, to nourish her body with her favourite foods, and the routine that sets up a catalyst for a "good day". There is a theme of stability and consistency as participants know what brings them joy.

In contrast, Amy's re-appraisal of nourishment involves practicing intentionality where food is viewed as a necessity and eating is purposed for survival, in the absence of pleasure. Evidenced within Amy's daily practices, there is a clear difference from other participants stories that centres around feel-good eating practices. On a typical day, Amy does not eat breakfast nor take a lunch break, instead, she snacks as needed at her desk.

> "A lot of my friends are big 'foodies' and I think being a foodie has become quite trendy now. But I'm not. I don't enjoy eating; I don't like food… I eat it because I have to and I have foods that I enjoy, I like ice cream and stuff, but I wouldn't say I enjoy eating. It's not something that brings me joy as such" (Amy)

Amy's spoke to nourishment in the absence of pleasure. She described a clear dislike towards eating, in contrast to other participants who endorse various food practices that elicit food joy. Amy "others" herself from the sociocultural "foodie" context in which she is situated within, holding disinterest over the "Instagram and brunch food culture". For Amy, re-appraising nourishment involved the small intentional changes made to her everyday routine, implemented over the last two years. Amy does not resonate with the term 'intuitive eating'. Instead, she described a good day as one in which she is *intentional* with her eating.

> "A day where I allow myself to, I guess people say intuitive eating, but I personally don't connect with that because my intuition doesn't really tell me to eat. So for me it's quite intentional eating. I don't usually eat breakfast but like a day where I would get to Uni and go and buy lunch somewhere on campus or like I would bring pasta from the night before, I might eat it with a friend… so like a day where I would meet my best friend for lunch that would probably be a day where eating was good for me

> because it wouldn't be as forced. Maybe also a day where I'm less busy and I have time to come home and make myself a meal" (Amy)

Amy's understanding of her body, specifically the absence of reward mechanisms and hunger cues, was the initial process she worked through before implementing her own strategies and structures to maintain nourishment in recovery. Her experience highlights an important consideration: Is intuitive eating as a dietetic framework assumed too simplistically, perhaps overgeneralised, without consideration for some individuals such as Amy? This good day reflects the themes of intentionality and nourishment, nourishment in terms of broader connection that supports the nutrition in this instance. A day where Amy was able to eat with others meant that food held a social role, as opposed to solely a nutritional purpose. For Amy, having foods that are "safe", predictable, and consistent each week such as pasta, examples the feature of stability and intentional nourishment in recovery.

The Relationships that Nourish my Recovery

Key relationships are thought to support, sustain, and nourish, illustrating themes of accountability, unconditional support, and practical meal guidance. While the person of significance differs across participants, several spoke to certain relationships catalysing and sustaining recovery, and in turn, co-constructing a new sense of nourishment and purpose. Zaza (27 year, NZ European, Female, Heterosexual) examples this idea, explicitly putting her recovery down to key relationships. A particular friendship was pivotal to Zaza's process of reframing her relationship with food, holding a practical role by cooking for her, supermarket shopping, and encouraging "normal eating". This key friend took an unstructured, casual, "tough love" approach, neither forcing her to eat nor highlighting her distress. This approach contrasts with others around her who held a surveillant role which Zaza found to be unhelpful. Over time, Zaza was able to gradually introduce more consistent eating, often just

needing a meal plan to get her through the days. It was in her third year living overseas that she met her current partner, another key relationship that sustains her. Zaza described him as a key figure of accountability and one that holds similar ethical values around veganism. This accountability and "tough love" approach was important for Zaza, as she felt she had not had this prior. The fine line between accountability and surveillance was one Zaza learnt to appreciate, learning to negotiate this within relationships that were helpful to her journey.

> "He's been really good at the whole 'I need more than just eggs' so cooking the meals for him has been really good for me. He very much loves food, so going out places have been a little bit challenging learning how to do that but all in all things are going well" (Zaza)

Zaza spoke to accountability in a relationship as bi-directional, enacted through the daily activity of cooking. Learning to care for others in a socially appropriate way is one way Zaza adopted the social position reflecting normality, where it is the specific yet simple act of making of meals that has allowed her to strengthen her identity as a girlfriend and nourish both herself and others around her. This idea closely overlaps with constructing identity beyond illness, in relation to social roles.

Themes of accountability and practical support thread through Amy's story of recovery, where she similarly described the support of her partner as crucial. Her partner, also vegetarian, helps Amy nourish her body practically by taking the cooking role for them both within the household. A key factor of intentionality was Amy's decision to disengage from people and conversations held around diet culture and fat phobic views, selecting to focus her relationships close and central to her recovery values. It is these specific and intentional relationships that sustain Amy in recovery.

Several participants spoke to the therapeutic relationship with their therapist, ones built collaboratively and mutually around recovery goals. This idea has been well

documented across the literature, where a therapeutic alliance built on trust, hope, and a non-judgmental approach has been identified by lived experience perspectives as one of the most helpful factors to recovery (Venturo-Conerly et al., 2020; Zaitsoff et al., 2015). For Alex, it was specifically the therapist's flexibility, long-term commitment, and belief in recovery that was central to their positive experience. For Zaza, the best treatment she had received was by her long-term therapist overseas, defined by a strong therapeutic relationship that brought forward humour and non-judgmental support. Zaza described therapy as helpful in her journey, however, ultimately puts her recovery down to key relationships. She identified relationships as having a larger impact on the position she is in today and for the identity she has constructed for herself than any form of therapeutic modality.

> "I think to some degree therapy has helped, I love it and I always recommend it. I think I wouldn't have picked a self-help book if I hadn't experienced it… but I think for me recovery, I put it down to my friends. I put it down to a few key people in my life" (Zaza)

This quote demonstrates the specificity of relationships, where friendship and partnership had a greater contribution to nourishment than therapy itself. It may be less about weight restoration or nourishment in its most practical sense, in this instance, but instead, relationships that sustain and bring forth larger forms of nourishment; a place of belonging and a sense of identity, in turn.

Bianca also spoke to relational nourishment in recovery, specifically from her family. Bianca (36, NZ European, Female, Heterosexual) described experiencing eating-related distress for the past year with experiences originating from as young as five years old. Bianca did not recognise her distress until her husband acknowledged her late-night binge eating, the catalyst to her recovery. Until this point, Bianca spoke to being in denial. This point, 6 months ago, is the turning point to her story.

> "He pointed out 'waiting up till nighttime till we all go to bed and munching on 4-5 pieces of bread is not okay? […] This is not good, you need to do something about it'. It was him saying it so frankly that something sort of just clicked. The fact that someone recognised that I have been doing it make it real. It's so weird saying this is now real" (Bianca)

This clear call to action catalysed Bianca's recognition of her binge-eating cycle, increasing insight into the context in which it occurred. This is another example of relationship accountability. As the issue was raised by her husband, Bianca was able to acknowledge and label her distress and in turn re construct both her relational and recovery identity. She identified that her issue was "invisible" when it was not spoken about by others, however it carried a lot of shame and secrecy, and by exposing this invisibility, this catalysed the beginning of recovery. Presently, Bianca labels her current positioning as "I am recovering*"*. This turning point also influenced her social position, improving communication in her marriage and re-focusing her energy towards nourishing her identity as a wife.

> "He said he was sick of it going around in circles and called it for what it was. It was very tough but it was actually… I felt good…it made me feel good after. It made me take some accountability and it made me realise what was going on for me. I had even been to the doctors and prescribed medications and all sorts but even then they didn't put a label on it or tell me what was going on for me. I just went in and said 'I need to lose weight I have been trying really hard' and they would just give me medication. They wouldn't investigate what was ACTUALLY happening here" (Bianca)

Bianca highlights key tensions in seeking help within a medical context, deeply coloured by fat phobic views and management of weight. Weight, when positioned as the "problem", was viewed as something she needed to lose in order to feel good. Bianca highlighted this as an

example of where the clinical model fell short of exploring her context. Here, the root cause and identification of her cycle of over-eating was missed.

The notion of intentionality is evident across Bianca's daily routines, where breakfast is the one non-negotiable meal she has, an arrangement made with her husband. She finds her sugar free Up and Go an important and enjoyable start to her day. A good day is one in which she feels in-control, describing a scenario at dinner where she didn't over-eat her meal when she identified fullness. While feeling in control may hold various meanings and interpretations, in this instance, in-control appears in alignment with trusting her body to detect fullness. Bianca continues to resist eating in secret after her family go to bed by making the intentional decision to not stay up late or be alone, thus distracting herself and utilising her social network as a barrier and support from on-going binge urges. However, some days are harder than others, stress and fatigue are common precipitants to a "bad day".

Jenny described the relational nourishment provided from living within a flat with like-minded individuals, who provide support in preparing food and providing connection.

"I get home to cooked flat meal which is very nice. My flat mates all eat pretty healthily, it will be a nice full meal, I really look forward to these flat meals" (Jenny)

Upon further exploration, I asked "what do you look forward to with flat meals?", Jenny described both the food, the company, and the pride of meal making. Meals made are posted on an "Instagram flat food account". Nourishment for Jenny involves the connection of food and people, fostered both within her immediate flatting context and within her wider Instagram network that highlights the socially connected and relational element of nourishment in recovery. Recovery for her is related to the comforting nature of a "delicious home cooked meal", where nourishment is embedded within the food and context.

Navigating a shift from disconnection to daily practices that centered around connection, is a way Sophia healed and felt nourished in recovery. Sophia (30,

British/Pakistani, Female, Heterosexual), identified as “doing so much better”, where food previously provided a sense of comfort and escapism in the context of grief and loss.

It wasn’t until Sophia understood her behaviours that she was able to create space for other activities that would bring forth the same purpose. By attending therapy, she was able to make a link between the comfort she sought out from UberEats that temporarily masked the loneliness following the unexpected death of her father.

> “I was trying to fill this void that I had, a void I didn’t understand. I just responded hoping the food would fill it but it never filled it, I was never full” (Sophia)

Sophia suggests that food never filled her emotional void, still experiencing loneliness and panged with grief, fundamentally isolated from key supports. This identification led to a re-construction of nourishment, putting her time and energy into finding comfort through relationships and other daily practices. This ultimately led to a reduction in binge eating as well. Sophia re-established relationships with others close to her, putting energy and effort into nurturing her social positioning and taking up all opportunities for connection. Friends provided comfort, and a sense of accountability as Sophia was “too nervous” to use online UberEats in the presence of others. Solidifying and strengthening connections with colleagues at work was also described within her typical day.

> “I was chatting to a few people at work […] I was having a good laugh and chat with my manager and other people in the team I was seeing, left feeling really great. Then I came home and I was texting a few people back home because I just had that time” (Sophia)

Putting effort into connection at work and reaching out to overseas friends is a daily practice reflective of a “good day” in recovery, where connection acts as both a distraction and an opportunity to feel good. Sophia identified a difference between working from the office

versus working from home, where finding a balance of connection and rest is something Sophia continues to construct for herself.

Sophia's experience of the COVID-19 lockdown was described as helpful to her recovery, centering around connection and comfort. Her mother who visited from the UK was forced to extend her stay due to lockdown restrictions. Her mother's presence filled a void of loneliness and brought about a sense of comfort, physical, and emotional support, that illustrates the importance of relationships that provide nourishment.

> "Whilst she was here she would always sort the food. There was so much comfort in that. I think that's what I was seeking. I was already grieving the loss of something so unexpected, so big and so difficult but I was also away on the other side of the world from everyone that I needed to nurture me. I just needed that comfort but I didn't know how to give it to myself" (Sophia)

Food as comfort and food as culture is evident across Sophia's experience, where Sophie achieved a sense of nourishment, in its traditional and relational sense. With mum providing comfort and care, this filled a void that was linked to her distress. While this experience was transient and context bound to lockdown, feeling connected throughout the day is an important part of Sophia's recovery, particularly alleviating isolation, and loneliness and re-appraising nourishment within friendships and social networks in its broader form.

Putting the "Self" in Self-Care

Nourishment in recovery was evidenced through daily activities and practices that participants engaged in to bring a sense of care and prioritisation towards self. Self-care spanned several forms, inclusive but not limited to mindfulness, positive affirmation, food rituals, and daily practices of joy. On days that are particularly harder than others, such as

Ivy's "bad day", Ivy spoke to engaging in alternative modes of nourishment centering around feel-good activities towards herself.

> "I find ways to nourish myself in other ways like buying nice things that make me feel good and spending time doing stuff" (Ivy)

This idea of nourishment transcending food and eating, includes daily micro-moments of activity, connection, and purpose. Buying nice things for herself can be understood as the ultimate act of self-care given her personal challenges with purchasing non-essentials, rooted within a troubled relationship with money and economic restrictions.

> "Buying things are always really hard for me so it also felt like a personal achievement because my dad has big problems with money…so my relationship with money is screwed up […] So I spent over $50 on a few things that I did actually need but I just worked on managing that response […] and I got a nice gift with my purchase so I sat on the bench and opened it up and it felt like a nice gift to myself" (Ivy)

This example of "treating yourself" strongly illustrates the idea of nourishment beyond food, opposing typical connotations of the word "treat" usually describing sweet food. The word treat must be dissected, often used in a way that implies food/activities need to be "earned", as opposed to a normal part of everyday life holding no moral value. As such, "treating yourself" or "buying things" in this context can be understood as Ivy's intentional act of neutrality and nourishment. By purchasing items for herself and managing her response, she actively challenged past patterns and shifted towards allowing herself small daily pleasures. Ivy described taking the time to unbox all her items as an act of care and nourishment for herself. "I started talking to myself like I was doing an unboxing because I had never actually bought so many products at once!". The intentional act of sitting on the bench and opening the gift describes an example of savoring—savoring extending beyond its traditional use in

the context of food and eating. This passage illustrates how eating-related distress recoveries aren't just about food but extend in daily practices of nourishment.

Similarly, Zaza described a "good day" as one that brought a sense of nourishment to herself and her relationship with her partner. On this day she was able to implement a morning routine, journal, read the news, listen to podcasts, and read poetry. A good day was typically a Thursday or the weekend where spending quality time with her partner at their favourite restaurant enjoying natural wines and pizza demonstrated a "treat myself" practice that brought about nourishment for herself and her relationship. A good evening entailed personal and professional administration and the intentional decision to pick up a book to read before bed. In contrast, a "bad day" was one where her morning felt "wasted", experiencing stress, a lack of achievement, purpose, and productivity. Balancing the anxiety between these good days and bad days is on-going for Zaza.

Spirituality and mindfulness can also be understood as a form of mental nourishment. For Rudy, spirituality is a core part of Rudy's on-going journey to find more balance, moving away from religious definition to incorporating energy and passion in daily living. Energy and alignment through crystal manifestations provides insight into her daily recovery practices.

> RUDY: "So I wake up at 5:20am to start work at 7am […] I have coffee with spoonful of honey and either meditate for 20 minutes or have a couple of cigarettes.
>
> INT: How do you meditate?
>
> RUDY: I get crystals for whatever I'm feeling for the day and just the vibe I'm at, what I want to achieve, that kind of stuff. I put it on the Chakras and meditate just following my breathing and generally I have a positive affirmation or use a guided meditation […] energy is a massive thing for me. Not just physical energy for achieving tasks but positive energy too"

Rudy's morning is mindful, and mood dependent, illustrated through crystals, breath work, positive affirmation, and guided meditation. Rudy described striving to implement a more positive mindset and energy alignment across her daily practices. Rudy carried crystals close to her body, holding this energy and purpose across her work. In one sense, this energy may be seen as an aid that helps her to manage the negative energy and derogatory comments she receives at work. Spirituality is a true form of nourishment for Rudy and a key act of self-care across her daily routine.

Similarly, on a typical day, Ann described waking up at 6am and beginning her day with affirmations, illustrating her own act of daily nourishment.

> "One of the staff has me writing down an affirmation and gave me three print outs of self-love affirmations that I stuck on my mirror in my room. I pick one of these a day and I write it down in my mood diary. They also have me doing three things I like about myself today. It's extremely hard I still struggle with it now but I do try to persevere with it" (Ann)

Daily affirmations as a practice and an activity are engaged with to increase confidence and self-esteem. Ann acknowledged that this practice does not come naturally to her and requires external accountability, however, is central to her healing process.

> "Self-care is something I let go in my distress. Staff have picked up on that, that I hadn't had a shower in two weeks so they made a little check sheet which had the day, the date, tick box for shower, wash hair, and brush teeth… this sort of got me in a better routine with self-care" (Ann)

During distress, self-care practices can be neglected. These are the daily aspects of recovering that often also go unmentioned, however, it is important to illustrate the importance of re-building such formative habits with support from others. Having wrap-around staff support within an alcohol residential recovery context supports Ann to build self-care and hygiene

habits. Ann attributed her recovery from addiction, eating-related distress, and past trauma to this context, specifically. The practice of journaling and reflecting on one's mood shows the value of such practices for Ann when managing the daily variations of recovery.

For Eleanor, Flo, Rainbow, and Zaza, reductions in daily screen time were closely linked to intentional, daily sleep hygiene practices. With a deliberate effort to reduce screen time and put the self into self-care, participants engaged in other activities to wind down such as reading, yoga, and journaling. For Rainbow, her phone time was physically distanced from her bed, her place of rest, by sitting on a separate chair that physically associated screen time as a recreational activity. For Flo and Zaza, social media was deliberately avoided in the late evenings and early mornings. Instead, Zaza described her mornings to begin with purposeful media engagement, such as reading the news on her phone on a good day. On a bad day however, Zaza would spend time on Instagram at the expense of productivity. These participants described how implementing simple changes in their day not only helped with their recovery and eating-related distress, but improved sleep quality as well, highlighting the links between sleep, diet, and physical activity on mental well-being (Wickham et al., 2020).

Summary. This chapter explored the narrative of neutrality and nourishment across recovery. Participants described a stage of acceptance and stability surrounding neutrality, where "good days" became synonymous with "typical days", and nourishing practices showed us the wide and varied ways people nourished their body and soul. Nourishment involved the re-negotiation of food and eating practices, and a wider relational form where connection and belonging nourished recoveries. Putting the "self" into self-care was an integral practice for many, where self-care transcended activities to include healing, balance, understanding, and re-connection to former and future selves. Overall, daily decisions aimed to move towards stability and feel-good activity, highlighting the many ways in which participants looked after themselves across food and eating practices and beyond.

3. The "Routine and Structure" Narrative

In the "Routine and Structure" narrative, recovery was constructed through the formation of new routines that provided a sense of order, structure, and ritual, while balancing flexibility. Participants spoke to intentional, pragmatic, daily decisions and habit formation across morning and evening routines, exercise, food, study, and work. Most participants spoke about recovery encompassing a new sense of structure and organisation across their lives. For some, this structure and routine afforded an inner sense of control, while others experienced a sense of flexibility, autonomy, and mastery over practices and activities. While the purpose structure and routine had for each participant differed, a day in the life focus offered nuanced insight on a micro-level at the ways in which people organised themselves and their personal recoveries.

Most participants spoke to elements of their recovery that were encompassed within this narrative type. For some, weekdays were a particular distinction from weekends, while for others, a structured morning or evening routine demonstrated recovery practices. On a micro level, participants endorsed various intentional food and exercise practices. While most participants described structure and routine as a positive allowing them to feel a sense of control, independence, and predictability over their days, a disruption in routine was often spoken about as a "bad day" in recovery, as previously highlighted. Uniquely, one participant spoke to the shift from a structured lifestyle to an unstructured lifestyle as pivotal to her recovery. This speaks to the role of structure and routine being nuanced; for some participants structure and routine was most important, while for others it held them back in recovery. Participants also spoke about the ways in which COVID-19 helped or hindered their on-going recovery, where routine was either implemented or disrupted.

Across each of these narratives, recovery was described as on-going process of self-discovery, a fine balance between routine and flexibility. Overall, the "routine and structure"

narrative was characterised by a tone of intentionality, progressive habit formation, and daily decision making that aimed to elicit a sense of predictability.

Balancing Flexible Routines and Building Social Activity is On-Going

Rainbow, Zaza, Sarah, and Mary spoke to the contrast in structure and routine between the weekdays and the weekend, and in turn, the impact this has on their recovery. Rainbow spoke to the balancing act of intentional routine and structure versus flexibility and spontaneity, two core features that required re-appraisal in recovery. This process is on-going for most participants, neither perfect nor consistent across daily life.

> "Making conscious decisions on everything you do without it becoming obsessive as well because that's the risk" (Rainbow)

Alluding to former disordered eating cognitions, obsessiveness and rigidity are common traits within eating-related distress. Due to the obsessive nature of certain routines within eating distress, routines need to be re-formulated in recovery with an awareness of the tensions between rigidity and flexibility, where balance is important. Rainbow identified her best days in recovery being Monday to Friday "because there is structure and routine and consistency during the working week". She described her weekdays with great precision spanning intentional daily practices and decision making around food, exercise, and work, down to the scheduled break culture within her job. In contrast, Rainbow identified her "bad day" as "every Saturday and Sunday…and Friday night", marked by social plans disrupting routines.

> "As soon as the routine and structure is gone it's so bad, I just can't afford that now" (Rainbow)

Rainbow's awareness is an important part to her intention setting process, utilising routine as an aid in daily recovery that can be brought into days that are harder, such as the weekends. Rainbow spoke to "actively choosing every single day to engage in recovery", enacting this

intention by implementing structure on the weekends and creating time to eat with her son. While routine is helpful to her recovery to some extent, a level of spontaneity and flexibility is required to eat and live socially on the weekends as well. This unstructured flexibility is a part of recovery that Rainbow continues to navigate, one that is not perfect nor polished, a continued process. The idea of on-going flexibility is evident across a typical Saturday chosen as her "bad day". A Saturday begins with a morning ritual of "quad shot coffee", followed by grocery shopping, and physical activity in the afternoon. Rainbow identified this as a "bad day" as the first meal was not until dinner, in contrast to a typical day where regular snacks and three meals are consumed.

> "I put in the structure of having a coffee…but I'm like why don't I put in the structure of eating food at the same time, but I tell myself I don't want to ruin the coffee because Monday to Friday I don't see the need to buy, so I go to my favourite café and it's an experience having a nice coffee or sitting on the couch gas bagging with the café owner…I just can't have the two together and that's why breakfast gets cancelled" (Rainbow)

Where structure is integral to Rainbow's recovery, this quote demonstrates the rigidity when applied to the weekend, at the expense of missed opportunities of social and flexible eating. Rainbow described the importance of coffee as a Saturday morning pleasure, a form of "food joy" that she intentionally keeps separate to breakfast. While this has become routine for her, Rainbow also recognised that the structure works against her eating.

> "There is no nutrition on the weekends […] Basically, instead of having food in the weekend I have caffeine, caffeine fuels my weekend and that's why I'm aware of it being bad" (Rainbow)

Despite the structure applied to Saturday, Rainbow held insight into the ways in which food is missed, identifying this as an on-going area of re-formation in her active recovery.

Where weekends bring opportunity for greater social activity and rest, some participants described social activity as a disruption to recovery while others struggled without social plans. Participants spoke to forming new routines that required a balance of flexible structure on the weekends allowing for social activity. Rainbow described the impact of social activity on her sleep, a routine strictly maintained and structured across her weeknights but one that is flexible on the weekends to make space for social activities.

> "Usually if I have been out I might get three hours of sleep… but then I will binge. Going out impacts on the 'when am I going to binge/purge' cycle. The weekends are the only not so great part of my eating structure" (Rainbow)

Through a disruption to typical routine, both sleep and eating are impacted when social activity is prioritised. Recovery is more than creating structure that allows for regular eating, but instead, a process of re-evaluating a balance between flexibility and routine that also allows for social activity whilst managing eating-related distress. In contrast, Zaza found weekends difficult if there was too much flexibility and open structure. Social activities are an important part of recovery, however, balancing social activities and flexible routines is an on-going process for several.

Sarah and Mary are both university students who, like Rainbow and Zaza, typically see a change in structure and routine when it comes to the weekend. Alcohol plays a large part, impacting both well-being and recovery. Mary described her "bad day" as one where she succumbs to the pressure to drink with her flat mates, within a university context where drinking is expected and encouraged. Mary described herself as a studious student who prefers a structured lifestyle with a focus on study and physical activity. However, on the rare occasions she goes out, she holds an "all or nothing" attitude about drinking. On this "bad day" identified, Mary described "saving" calories throughout the day to make up for the caloric intake of alcohol in the evening. This day was identified as a "bad day" in recovery

due to a disruption in routine which led to restricted eating and compensation. Similarly, Sarah described a similar scenario wherein which "over-indulgence" in food and wine left her feeling guilty, increasing her likelihood of purging than that of a typical day.

> "I'm kind of safe during the weekdays but weekends… I think about it a lot more just with alcohol because Saturdays are always a big one so I am aware and also just not wanting my body shape to change like I don't want to look bloated" (Sarah)

Sarah and Mary's recoveries are embedded within a strong drinking culture which likely impacts the way they navigate flexibility and routine across the weekend, comparative to the weekdays. An awareness of the impact alcohol has on distress is a large part of Sarah's recovery (self-identified as "doing better" presently). While compliments from friends and family around weight loss perpetuated the cycle of restriction and over-exercise; it was the introduction of alcohol that led to purging at university. With this came the realisation that "if you have 10 drinks, that's 1000 calories! That means I couldn't eat that day"! Sarah speaks to the cycle of restriction, bingeing, alcohol consumption, and further restriction, where the effects of "getting smashed" were an addition to her eating distress.

> "What I liked about drinking is that I could be sick from it. When I was drinking I kind of had a bit of courage…that first year was when I realised that, although I TRIED that in high school I was just fearful of vomiting like I would try but I would cry and I just couldn't make myself vomit. It was only when I was drinking I COULD do that so I just abused it for what it was worth... and *that was kind of a way I felt a wee bit of comfort*…and it was only really last year that I learnt how to do that off drinks, but before then I was also quite proud of the fact that I didn't make myself sick because I always thought that was just 'being stupid' and that 'I would never actually let myself get to that point…that's when you've actuuuallly got something'…*that's just so stereotypical private school girl who I would actually*

> *expect to have an eating thing'* but then it got to that point and that became 'this is so good, I can eat whatever I want I can actually enjoy food again and then go oooop'. You get the *hugest rush and sense of relief* after you do it…it really is like a drug, it's just so satisfying, and I felt really content. *I became really good at hiding it* [...] it was just so easy when you're drinking because people just expect that as well…even the next morning, 'oh I'm just really hungover' (Sarah)

This passage highlights various complexities to Sarah's distress, changing shape and form across her journey. Sarah described strong thoughts and emotions; feelings of comfort elicited from purging, the point of relief and the likening of this to a drug rush. However, formerly, she viewed her inability to purge as what kept her separate from having a "real disorder". Upon discovering that she was able to make herself sick after drinking alcohol, she spoke to feelings of pride when able to successfully hide it from people around her. The theme of secrecy is strong in this passage, hiding from others, hiding from herself, and hiding from identifying as a stereotypical private school girl. Part of building routine involved shifting from hiding weekend routines to visibility and acknowledgement of eating-related distress when navigating social routines in recovery.

Recovery for Eleanor involved letting go of the structure and control she had previously afforded in her lifestyle and moving to a more unstructured, flexible way of living. Eleanor described a typical morning with reference to her mornings prior to recovery. The significance of her current wake up time can only be understood in the context of her previous routine.

> "Lately I don't wake up at any specific time at the moment…which I didn't actually think about until you mentioned the parallels but I think it comes into play with the strictness just in general for how my days used to be. I used to have the same attitudes of strictness, getting up early and getting things done…I would make lists. Just the

> same sort of mentality with dieting. If I don't finish everything on the list or if I'm not doing something productive throughout the whole day…so I didn't actually think about this until just now. Now I'm not super strict about it and I can let myself sleep in to 8 or 9am, instead of 5 or 6am" (Eleanor)

It was upon realising the stark difference to her previously structured life that she began to reflect on some of the progress she had made where a typical morning is now described as slow in pace. There is a master narrative around the notion of productivity culture, creating unexpected and unrelenting standards of living across societal structures. It is the specific decision to let go of the strictness that allowed Eleanor to move beyond Eurocentric notions of time, slow down and be intentional with the purpose behind activity. This in turn opposes societal narratives where success and worth are tied to a strictly productive lifestyle (Shahjahan, 2015). Themes of family connection and feel-good activity marked her typical day, where mealtimes are unstructured and dependent on what she is doing and how she feels. In the evening, Eleanor reads out family favourite novels, intentionally spending time away from screens. On its surface, reading as a family evening activity has reduced Eleanor's bingeing episodes at night which was previously a large part of her distress. On a deeper level, what matters most to Eleanor is family and a shift towards purposeful engagement. Eleanor's focus is no longer on herself and her rigid routines, she has created space for a more flexible way of living that allows to prioritise connection, with no urgency or rush to achieve anything. Eleanor can be positioned as the narrator of her own story, given the opportunity to slow-down, re-tell, and connect.

The engagement with hobbies such as music, basketball, and reading, illustrates ways Eleanor prioritised building social activity. The shift from activities for accomplishment to activities for pleasure is strongly evidenced. Activities no longer serve a purpose of distraction from thoughts around food and weight, but instead bring about an inner sense of

fulfilment. A “good day” was described as unstructured, with a focus on spending time with family and engaging in hobbies with no time commitments. Where an unstructured sense of living is a large contrast to Eleanor’s eating distress, it also offers a point of difference to societies socially enforced culture around structure and productivity. Opposing master narratives around productivity, “slowing down” may feel counter-intuitive for some people. Eleanor’s shift in mindset from productivity to relaxation is central to her recovery. On this particular “good day”, Eleanor spent a considerable amount of time braiding her own hair, an activity she has always wanted to do. She felt an internal sense of pride and accomplishment doing this, in turn, experiencing greater confidence in her ability and image.

> “Then me and my dad went for a walk for a good hour or so, and then I played a bit of music. It’s stuff like that that makes my good day now, as opposed to what made my day good before. It’s not like ‘oh yus I didn’t overeat or snack’, it’s me now being focused on other things to actually even have the opportunity to overeat or snack. I was doing it because it interested me, and it was fun. Oh, and then me and my brother played basketball as well. I mean, even though we didn’t do a whole lot yesterday, for the most part it was sitting around reading and relaxing, it probably wasn’t up to my old standards of ‘I have to get some significantly important things done or I don’t feel like I’ve done anything’, it was quite calm and relaxing, and I wasn’t stressed that I wasn’t doing much more. I think that’s what made it good. It’s just a mindset, that I wasn’t disappointed that I wasn’t doing a lot of things” (Eleanor)

Eleanor reflected on strong parallels between productivity before and during recovery, no longer measured by tasks achieved. Feeling content, calm, and relaxed comes from a place of flexibility in her daily activities. This change in mindset and attribution is core in her recovery narrative and strongly evidences how letting go of structure is productive. In contrast, Eleanor described a “bad day” where eating outside of conventional mealtimes and

eating more than usual, against intuition, snowballed into a day of "over-eating" and a "loss of control". This bad day depicts the importance of understanding distress and recovery within a person's context, where for this day, eating-related distress got in the way of full participation in socially enriching activities.

Routine and Rituals Provide Me Comfort and Control

Several participants implemented structured morning and evening routines and rituals integral to their recovery. For these participants, maintaining greater structure and routine provided a sense of comfort and control, as opposed to the flexibility that was crucial for others. Across both groups, there is a sense of intentionality in re-forming routine and structure, a process that is on-going. This process was further catalysed by the experiences of navigating a global pandemic, which led to both routines being both rattled, and re-built.

Participants described focusing on morning and/or evening routines, as a place to begin when creating rituals. Zaza described her typical morning to hold routine during the week with a strong emphasis on structure providing energy for the day. The intentional focus to "get a better morning routine" is a daily goal Zaza sets for herself in recovery.

> "I'm really good in the mornings. […] I'm trying to limit coffee and that actually feels like a thing. Whilst I'm getting ready, I'll make a smoothie it's a fucking wellness smoothie it's got everything in it, I love it. I'll make coffee at home and take it to work. I'm not a breakfast person on the weekdays really. I'll get to work, I would have drunk my coffee by this point. Feeling good, feeling really good I don't have the energy stall in the morning my energy is going. Probably have a rice cracker, or some almonds and then at 11 I will have that smoothie […] Typically my work days are pretty healthy and I like that, its routine" (Zaza)

Zaza's morning routine allowed her to look after herself and her well-being; routine afforded her control and structure and alleviated on-going experiences of general anxiety. Contrastingly, a disruption in routine precipitated distress.

> "I just need my mornings to be put together […] So that would be a bad day when things are becoming a bit rattled in the morning, or typically when I have no plan or nothing to do. That's what I would constitute a bad day for me, I'm not a relaxer, I need structure" (Zaza)

Scheduling and planning were described as her "superpower", a strong metaphor for the importance structure and routine provides her when balanced tightly with the need for flexibility and balance to create room her social activities.

Others spoke to implementing structured morning routines that centered around sleep and eating practices. Mary described a typical day to be a good day, one beginning with breakfast and two glasses of water. Intentionality over her sleep routine was described with the aid of an alarm that was carefully set to her circadian rhythm. She described this, and many other daily practices, in detail.

> "I have this new alarm that wakes me up in the peak of my sleep cycle which is my new favourite thing and it definitely helps… then I'll stay in my pjs and the first thing I do is go to make breakfast because I love breakfast it's my favourite meal and usually I'm pretty hungry in the morning [...] So I usually have baked oats, I blitz up my oats and a banana and some almond milk, some baking powder, put it in a bowl… sometimes I put fruit in it, sometimes chocolate chips and then put in a microwave. Cook it, put some peanut butter on it… maybe sprinkle something on it to make it look pretty" (Mary)

This structured, stepwise process aligns with her intentionality around "healthy eating" and towards her recovery goals. Mary listens to her hunger cues, eats with purpose, and enjoys

her daily morning practices and breakfast rituals. A good day for Mary is one that upholds routine and structure across eating, exercise, and study. The notable feature of a good day is when she has gone to the gym "because I feel like I have done something", linking exercise to accomplishment. Maintaining structure, routine, and in turn productivity provides an element of control while alleviating distress. Where control is understood as a central feature of eating-related distress, it is the re-direction of control towards other activities and daily practices that illustrate a shift in distress to recovery.

Tegan spoke to choosing to live a busy lifestyle, a helpful distraction from thoughts around food. A "good day" is one where structure affords control and clarity, where eating is intuitive and social activity is scheduled. In contrast, a "bad day" was described as a day where Tegan woke up late and ate a "really big breakfast", experiencing a disrupted schedule, leading to a later lunch than usual, increased hunger, and over-eating. This day is markedly different from her typical/good days marked by routine and structure which is central in her recovery. A bad day demonstrates the impact a disrupted routine may have on hunger and satiety cues, as well as the importance of regularity in Tegan's recovery.

Ann described a routine that is predictable and consistent, one that she believes she will be able to carry on implementing in her life following residential treatment. Ann's daily recovery is highly structured, created by the programme and followed accordingly. Like Mary, Ann described finding comfort in routine food practices, specifically, meals that have been carefully tailored to nutritional needs, eaten at the same time each day. Ann also spoke positively to the structure that comes from a daily house walk, allowing for routine movement and social connection. She described these walks to have led to subsequent weight loss and a positive sense of self. While framed as important to her recovery, it is important to consider the context behind the physical activity, cautious where the link between weight loss and "feeling good" may be unidirectional depending on the motive behind the exercise.

While weight loss is valued in this instance, healthy exercise in recovery is one that is not driven by goals around shape/weight. On a "bad day" Ann described the structure of the residential treatment programme as a challenge, particularly following an imposed structure as opposed to holding autonomy over one's own structure and routine.

> "If I had been at home I would have got a couple of packets of chocolate biscuits and scorched almonds and then stayed in bed all day. Whereas here, I had to challenge myself to engage in the community and to do structure. This particular day I didn't make my bed, I didn't shower, I didn't put away my clothes from the night before. I had porridge and two extra pieces of toast which I normally wouldn't do. I felt guilt, I felt bad, I felt worse than I was already feeling. I asked to be excused from the morning walk […] Then we had lunch and I wanted seconds but I didn't have seconds I just went and had some fruit, which I normally wouldn't do…and then after that...I was craving sweet food" (Ann)

Ann described the contrast between a bad day to a typical day, where the structure is helpful, food is contained, and activities are engaging. On a "bad day" however, structure no longer affords comfort, activity is absent, and food cravings are denied. While Ann's narrative is specific to an addiction's treatment programme, imposed structure as a feature may also be considered within other residential programmes, including those for eating-related distress. Within a social constructionist view, imposed structures depict power imbalances and encourages us to analyse the power relationships embedded in our societal structures. On this bad day, feelings of guilt and low mood were described, heightened by the imposed structures present. This snowballed into irritability, and in turn, isolation, with thoughts of wanting to give up on recovery. While structure and routine are identified as most helpful to Ann's recovery, days where distress is higher than usual, Ann feels like retreating to an unstructured way of living. Finding a balance between structure affording accountability and

flexibility while allowing for rest and recovery, is crucial to Ann's re-appraisal of how structure provides comfort when individually imposed.

Some participants spoke to the challenges they navigated across the evening, leading to intentionally constructing evening routines in recovery. For Rainbow and Bianca, evenings were described as a daily difficulty combatting urges against bingeing and purging. Despite a highly structured routine, Rainbow described on-going difficulty.

> "I come home and try eat dinner, 9/10 times it doesn't stay down so that would be the first time during the day that I would purge because I haven't quite learnt how to sit with feeling full at night…I don't quite understand the concept yet, *and I say yet, because it's something I'm working on* […] I'm a toddler learning how to eat. The bulimia is present every day, same with the bingeing but at the same time *I'm pushing myself every day to learn how to eat.* And that's by choice" (Rainbow)

This speaks to the idea of recovery being "active" for Rainbow, while her struggle is on-going, her efforts to counter this also reflect a work in progress through intentional daily choices and practices that buffer distress. It is specifically the point at which medication is taken where Rainbow makes an intentional decision whether to purge.

> "After I shower and get into bed, this is when I binge. I binge after I have done my meditation and I'm relaxing…because I meditate every night because I have learnt that's really helpful…I use my Shakti mat […] Before I take the medicine every night I make a conscious decision on whether I am going to purge or not. The reason this is before my medication is because its pain, sleep, and anxiety medication, and I need to decide, is it going to stay in or is it going to stay out. 9 out of 10 times at that point that's when it will come up, but then half an hour later I will purge again" (Rainbow)

Rainbow implements mindfulness as a strategy to alleviate feelings of distress and as an activity that creates temporal distance between eating and purging. By intentionally engaging

in meditation after dinner and before medication, an active choice is made to get out of the "mind space where I have just eaten", to counteract the urge to purge through distraction and delay tactics. It is the daily decision making around medication that influences what follows.

> "Trying to do something that's not 'oh my god I have just eaten dinner' or 'Oh my god I feel full I don't know what this is what is this feeling what is my body doing, why are we doing this', that's something I actively work on every day. That's my typical day" (Rainbow)

Rainbow's story demonstrated the lived reality of recovery, a process requiring active awareness and dedication, despite on-going distress. The decision to actively work on implementing activity and routine that buffers distress is daily and on-going. Similarly, Bianca described greater susceptibility to bingeing when alone during the evening. Bianca described typically watching television and feeling the "creeping" begin, thoughts such as "oooh there's really fresh bread in the cupboard".

> "I have to train myself to not stay up too late because it's the late-night binging I really struggle with once everyone has gone to bed. About 50% of the time, I can say no, but it's the fact that *no one is around* and I'm not always strong enough to hold myself accountable 100% of the time. It's *making that conscious decision* about missing out on a couple of hours of me time because I know where that goes. […] The evenings I have to be really strong" (Bianca)

Like Rainbow, she speaks to daily decision-making implementing routine. Bianca makes the choice whether to stay up late and binge or go to sleep earlier to minimise the opportunity. While going to sleep earlier comes at the cost of time alone, it is specifically this intentional decision that is reconsidered and re-appraised in Bianca's recovery. On a "good day", Bianca resists the "creeping" thoughts by putting in intentional practices such as having a hot drink with her dog on her lap where she is less likely to get up from the couch or more likely to

sleep early and avoid the situation altogether. Being able to remind herself on a good day that "I have had such a good day, I am not doing that today" when it comes to the evening was also described as protective and intentional in mindset.

> "Having that control makes me feel very positive, like its achieving something and not falling down that black hole. This is something I look forward to, I look forward to having more and more and more good days like that" (Bianca)

The idea of "resisting" certain types of food positions food as either "good" or "bad", implicitly moralising food that is inherently neutral. The notion of control in this instance is closely tied to the ability to resist urges. "Good days" for Bianca are described as days "in control", reflective of her personal recovery. This notion highlights a master narrative around control as a socially prized construct where resisting food is praised and valued. It is important to note that in this instance where managing urges is successful and celebratory for Bianca, having control is complex, multifaceted, and somewhat contested in this space.

Zaza and Bianca spoke to navigating new routines around dinner, a significant accomplishment in the context of their distress. Zaza described a gradual and intentional refocus away from restriction towards eating dinner as the one non-negotiable meal eaten per day. Participants described the help of meal kit services making dinner easier in recovery.

> "I'm so amazed at myself at times, I'm like 'look at what I have made for dinner I would have never done this before'. Dinner is my happy place, we make My Food Bag typically […] I was very anti My Food Bag initially but it's been really good in multiple ways. Big help for the mental health side of things. I would have never chosen to make a meal with multiple carbohydrates, multiple things going on, would have been in the too hard basket… but its soo good. It's been a gamechanger. Where was this when I was asking for nutrition help?" (Zaza)

Zaza reflected on the practical and nutritional support My Food Bag has offered in recovery. Assisting Zaza with the ability to integrate multiple components of a dish while still feeling in control over the process, this food kit offers assisted control. Zaza still makes the ultimate choice to create the food and spend the time creating this structure and routine in her evenings. As a result, dinnertime has become a routine to look forward to, an activity that sparks joy and pleasure. The powerful rhetorical question, "where was this when I was asking for nutrition help?" was asked by Zaza through a tone of frustration. This quote can be analysed in the context of former treatment experiences where Zaza described a lack of practical, nutritional meal support when she arguably needed it the most. She provides an important perspective on the need for individualised, dietetic support with foods that match where the person is at in their recovery journey.

Like Zaza, Bianca also spoke to the usefulness of a meal kit as she navigates establishing structure within her evening routine. Hello Fresh was described as a "stepping stone" to cooking herself, equipping her with the skills and confidence in establishing a dinner routine, an on-going practice in recovery.

> "Structure is huge for me! And that's where Hello Fresh has been helpful […] I don't need to think about it too much…it's not stressful…because it got to a point before where dinner time was so annoying, and it would get so stressful that I would just order something […] and trying to train myself to go to bed early and trying to put in that structure but you know they say babies really strive off routine and structure, so why would that ever change!" (Bianca)

Structure, as a theme, is strong across Bianca and Rainbow's narratives, specifically around food. Both participants described recovery as re-building routine practices and rituals akin to that of a baby needing structure across development. Bianca compares recovery to that of a

toddler, where she learns to eat without purging, while Bianca sees the benefit of structured meals and sleep routines as integral to her recovery.

COVID-19 Hindering and Helping Recovery. An awareness of how a disruption to routine was strongly linked to distress was interconnected with navigating a global pandemic. With reference to the level four lockdown in March 2020, several participants spoke to their experiences of lockdown disrupting their structure and routine. While this affected people differently, several participants discussed a negative effect towards recovery. For others, lockdown provided an opportunity to take more time for self and implement new routines that provided comfort and control. Described as both a routine builder and breaker, navigating COVID-19 was both a hinderer and helper across recovery journeys.

Ivy, Mary, Sarah, Eleanor, Zaza, and Tegan spoke to various ways in which lockdown disrupted their typical routines and practices, impacting a sense of control which in turn increased distress and hindered recovery. Participants described difficulties living with other people during this time and adapting new routines around food and exercise.

Mary identified returning to her family home for lockdown as a trigger to her eating-related distress. Through a disruption to her typical exercise and eating routine, Mary struggled with the lack of autonomy and independence. She found it difficult to maintain "healthy eating" in a family context with a preference for "pasta dishes and pies". This in turn led to greater preoccupation around food consumption and restrictive behaviours, in a context where Mary experienced less control. Consistent with the literature, several people with eating-related distress experienced a loss of control at the start of the pandemic; consequently, turning to disordered behaviours such as food restriction as a way to elicit a sense of control to cope with diminished external control (Branley-Bell & Talbot, 2021; McCombie et al., 2020). Being with family over lockdown was also a challenge for Sarah,

disrupting her usual university lifestyle and reducing her choice over food and eating. A lack of control and autonomy were present across both Sarah and Mary's experiences.

> "It was quite hard because I was constantly with my family, I didn't have control over the food and I just know that all of our families ate curries and stuff… everyone was indulging quite happy to put on weight like we were going all out because there was nothing to do really apart from make food…so I found that quite distressing" (Sarah)

Understanding Sarah's family context illustrates how a lack of routine and loss of control over food choice led to greater eating-related distress during this time, as the role of food and culture is integral to Sarah's story. Indulging is seen as a form of social connection and way for food to provide comfort, in times of unpredictability. However, it is clear the ways in which Sarah elicits comfort is different to her family, down to the types of foods she enjoys and the rituals that provide her a sense of control.

While Eleanor's family are seen to have implemented lockdown-specific routines and rituals, to elicit a sense of control, it is clear from Eleanor's story that the *type* of ritual is important. Between strictly adhering to the Keto Diet and running daily with them, Eleanor described experiencing low energy and fatigue. While building a routine around physical activity may be in alignment with master narratives, this routine became self-destructive for Eleanor, in turn, impacting her mindset, distress, and recovery. While exercise routines are more nuanced than good or bad, the meaning they hold can only be interpreted within a person's context. For example, for Bianca, lockdown facilitated the implementation of more structure across her exercise, which she described as positive to her recovery.

> "I got into really healthy habits with exercise, I started noticing my body changing in a positive way and being quite happy and confident" (Bianca)

This quote suggests that confidence and happiness came after noticing changes to her body, where positive body image is directly linked to weight/shape. While this was helpful for

Bianca's recovery, another way exercise routine may be viewed as positive to recovery is through the functional re-appraisal of body and movement. The concept of exercise as energising is central to Jenny's recovery. Against this backdrop, she experienced a disruption to her typical exercise routine when moving back in with her mother during lockdown. Where running as an activity is central to her recovery, with a reduction in this daily practice, Jenny found herself susceptible to diet culture messaging and restrictive efforts, describing lockdown as "pretty horrible" overall, due to a disruption to this specific routine.

In contrast, living alone increased Tegan's eating-related distress during lockdown where an increased amount of time was spent on social media, specifically TikTok. The effects of such content were insidious, becoming a routine and ritual that Tegan struggled to disengage from. Specific routines are best understood within the COVID context, for example, "lockdown baking", one of many socially media influenced rituals that Tegan adopted. Understood as a routine that increased vulnerability, it also elicited a sense of comfort for Tegan. However, when Tegan found herself baking beyond her consumption, eating-related distress increased. While this phenomenon was socially normed, within Tegan's context it became damaging to her well-being and recovery.

While COVID-19 affected us all in different ways, for Rainbow and Sophia, COVID-19 was described to positively impact recoveries by eliciting a sense of routine, comfort, and control. Perceived control is thought to be a significant factor in recovery (Branley-Bell & Talbot, 2021), where routine and rituals can be a way of feeling in control and meeting this need, particularly in a context where participants faced increased unpredictability.

For Rainbow, lockdown brought about a positive opportunity through redundancy. Through this, Rainbow was presented with the opportunity to join a weekly eating disorder recovery Zoom group which allowed for intentional structure to be placed across her weeks. During lockdown, Rainbow described implementing new routines around food and eating,

routines that provided her with a different sense of control and comfort, to her typically highly routine work weeks.

> "COVID was one of the best things that ever happened for me. Maybe it's the optimist in me but I started eating really nice lunches because the kitchen is right next to my home office… I made a frittata each day, you take the time out of your day to do these things because you can! I was probably purging a lot more but I was eating better quality food, eating a lot more nutritionally beneficial food […] I have taken my learnings from that being like 'those foods tasted really good, 'and now I want to get that to stay down…" (Rainbow)

For Rainbow, seeing the cup as half full as opposed to half empty was a mindset she chose to hold. This allowed her to build routines around food where lunchtime became a joyful routine and an opportunity for growth. While purging behaviours increased, Rainbow illuminates the various shades of grey that recovery holds– moving beyond the simple cessation of disordered behaviours to include mindset shifts and motivating factors that she brings forward into every-day living, such as food preferences and the goal for greater variety.

Similarly for Sophia, lockdown was experienced as a routine builder. With the extended stay of her mother, Sophia found comfort through the routines they built together around food and fitness. Sophia described maintaining routine for the both of them by keeping consistent with physical activity, enjoying food together, and feeling an overall sense of nourishment from connection and comfort. Parallels can be drawn with the nourishment narrative, where relationships that sustain recovery are also included.

> "I had to feel the pressure of looking after mum so I kept routine for us both, to keep us both well. I was like, I got to keep her on track. So I kept really fit during that first lockdown, we still ate and enjoyed food and I still ate lots of baking. I kept really on top of my fitness" (Sophia)

At the intersect of grief and loss, themes around the function of culture, connection, and familiarity, are also apparent within Sophia's recovery and lockdown routines. While lockdown has been, and continues to be, a point of distress for many, lockdown can also provide an opportunity to establish new routines, rituals, and structures, maintain and improve existing routines, and pursue an adapted sense of comfort and control in recovery.

Summary. This chapter nuances the subtleties across structure and routine, exploring the micro-daily practices illustrating the how and why. Some participants described balancing flexibility and social activity as an on-going way of navigating recovery, while others turned to routine and rituals for a sense of control and comfort. Participants described on-going challenges nuanced within contexts and even times of the week, for example, vulnerability factors that pertain specifically to the weekends, the evenings, mornings, and weekdays. Interestingly, COVID-19 acted as both a helper and a hinderer in recovery, with individual meanings ascribed to personal contexts. Overall, the notions of control, comfort, flexibility, independence, and autonomy, depicted different meanings across daily practices while encompassing key themes within the narrative overall.

4. The "Media and #Recovery" Narrative

In a digital age where access to information is at our fingertips and people are more reliant than ever on technology, it is important to understand the impact and implications of media use. In the "Media and #Recovery" narrative participants made intentional decisions to understand, shift, reduce, or alter, their social media usage in recovery. Participants described engaging with various media platforms and online content related to eating, dieting, weight, shape, and exercise. For some, media consumption increased eating-related distress and either subconsciously or consciously changed behaviour. It was against this digital backdrop that participants endorsed new meanings and modes of engagement, typically shifting towards seeking diverse representations of beauty and body positivity, seeking educational and scientific content, reclaiming power by unfollowing accounts that promoted self-comparison, posting lived realities, and re-appraising their ideas about form and function of media consumption. For some participants, media evidenced the gaps in treatment accessibility and as such, media was central to treatment journeys.

Social media was a key topic across all participant stories, to varying degrees, across varying platforms, notably TikTok and Instagram. Recovery was described as an on-going process of self-discovery and development, characterised by pragmatic and powerful daily decisions around consumption and content. Understanding how participants harnessed social media in recovery demonstrates the power of media, both positive and negative to recoveries. Overall, the "Media and #Recovery" narrative was characterised by a tone of intentionality, growth and development, authenticity, and empowerment and control.

Seeking, Shifting and Stepping Away from Social Media

Several participants spoke to the influence of Instagram, TikTok and YouTube on both their distress and recoveries. Most participants endorsed the need to shift the form of

media they were consuming in recovery. Participants spoke to unfollowing disordered eating content, fitness, and model influence, seeking out diverse content and navigating body positivity, reducing screen time for sleep, and for some, deleting social media altogether. This was integral in a sociocultural context where social media invites an evaluative gaze on women's bodies.

Reclaiming Power and Shifting Visibility. Intentionality across social media use was central to participants navigation of online platforms in recovery. This included unfollowing accounts that promoted content resembling eating-distress and unfollowing people who prompted self-comparison; two acts that represented a shift in power distribution and control. A representation of beauty that illustrated diversity across body shape and size was also described as helpful to participants' recoveries, shifting visibility from dominant prescriptions towards intentional content.

Flo, Sarah, Mary, Zaza, and Amy all spoke to intentionally unfollowing influencer, fitness, "foodie" and body image accounts to various degrees, choosing to make Instagram more selective to their values and recovery identities. Flo's intentionality with Instagram is an important part of her recovery. It was specifically the active decision to remove not only social influencers and weight loss content, but to also remove peers "followed" whose content created a space for critical self-evaluation and comparison. The significance of this decision can only be fully understood in the context of her distress, where daily self-comparison to her friends led to experiences of low self-esteem and body dissatisfaction. Similarly, for Sarah a large part of recovery was "unfollowing" those who promoted self-comparison, while also acknowledging her roots of distress. Like Flo, Sarah noted the onset of her "disordered eating" was largely influenced by media. Consuming media was described as a "hobby", where Sarah described herself as impressionable to diet culture discourses. Themes of wanting to be liked, popular, and attractive throughout adolescence were

prominent against a developmental trajectory of becoming and belonging, leading to body image dissatisfaction and peer comparison.

> "I guess I had always wanted to be desirable, hate to say it but it was a huge part of wanting to lose weight. It was a huge force and even since year 8. It's so cliché and its embarrassing but, I always thought guys just really like skinny girls" (Sarah)

Sarah's understanding of her body was largely influenced by the patriarchal views on beauty she was exposed to. Online images were formative influences on the ideals she held around body and beauty. Sarah's understanding of desirability was strongly linked to one version of attractiveness, the thin-ideal. The thin-ideal, its social reinforcement, and the behaviours targeted at achieving this body can be understood as a complex assemblage of aesthetics, desire, morality at the intersect of dominant sociocultural narratives around beauty and health. The narratives surrounding the female body image is part of a complex use of power over women in postmodern society, where narrow definitions around beauty and desirability are oppressive to most of the population. This awareness was the start of Sarah's intentional decision in recovery to unfollow those who represent or promote a singular view of beauty and intentionally seek out body positivity. By seeking out content that reflects unfiltered realities and recoveries, Sarah's daily media practices can be seen as a way of reclaiming power and shifting visibility.

Sarah described the positive impact that realistic content has had on her recovery journey through normalising lived realities and challenging society's expectations of beauty, body, shape, and size. By engaging in videos such as *'what I eat in a day as a chubby person who doesn't want to lose weight'*, Sarah describes no longer seeing videos that encourage or glorify eating disorders, such as *'what I eat in a day with an eating disorder'*. Trending content on TikTok contrasts traditional "glow up" representations. Videos now reflect "before" positioned within eating-distress and "after" images of weight gain positioned as

health and recovery (Herrick et al., 2021). This is particularly significant in Sarah's story of "doing better" as her disordered eating was marked by popular diet phenomenon across YouTube that was consumed as both a "hobby and skill". Now, Sarah no longer uses YouTube. Sarah described Instagram's curation towards diet culture and fitness as "depressing" with a preference for video-based content, such as TikTok. Preference towards TikTok reflects a growing trend to this newer platform, interpreted as both a creative and social media outlet (Bresnick, 2019). However, at present, ED recovery on TikTok has been overshadowed by pro-ED content. The potential for this platform to be used as a tool to assist in recovery has been neglected (Herrick et al., 2021).

Like Flo, Mary spoke to her body image concerns arising from the constant self-comparison to others on Instagram, particularly models and "influencers". Social media influencers may combine "clean eating" and plant based diets with fitness and exercise, to create lifestyle scripts influencing body image narratives through a healthism lens. Mary's intentional decision to disengage from disordered eating content and only engage with people who represented diversity (across beauty and body shape and size) represents a shift in her Instagram usage. This shift allowed Mary to re-frame her view on beauty, where visibility of plus sized models reminds her that women's bodies come in a variety of shapes and sizes.

> "I think the one thing that is really interesting is having a more diverse group of models. There's plus sized people on TikTok and even in movies and no longer is there really skinny actresses. Seeing that I'm kind of like, in my brain going 'these people are still considered pretty and are not super super thin" (Mary)

Mary speaks to the impact of re-framing beauty standards in recovery to reflect visibility of diverse bodies. This aligns with the powerful body positivity movement that has become more prevalent on social media. Unattainable, narrowly defined beauty ideals are rejected and individuals are encouraged to challenge societal messaging towards visible diverse

representations of beauty (Cwynar-Horta, 2016). With mobile devices increasing access to images relative to traditional media, there may be a stronger link to body dissatisfaction but there is also a greater opportunity to change the narratives around beauty. As such, by changing one's social media feed to reflect greater diversity, these images depict greater visibility and power. Mary presently engages in pockets of media consumption, across her daily practices. The form and function differ, where TikTok provides some respite during her study breaks, and YouTube is watched for inspirational content between tasks, during her evening routine.

Body positivity accounts on Instagram also helped Jenny develop a more realistic, reframed view on bodies, in turn, a positive tool in her journey.

> "I discovered those Instagram people. Some people are really into body positivity, like those relaxed poses versus posed photos, and I was like ahh interesting I really didn't know that those people who look so slim when they sit down they also have a wee tummy…*it's so natural*…and that was just *so great seeing posts like that, it's like positive reinforcement*. I started following more people on social media. Sometimes I'd look at my tummy and would be like I want it gone but then looking at these photos, it would just reinforce me in a positive way and I would be like stop the bullshit, it's not worth your effort and time…focus on something else. *I'm just trying to maintain this positivity by what kind of information I'm exposed to*" (Jenny)

Jenny described finding realistic content that promotes natural variation and diversity across body types helpful in order to make peace with her own body and its normal daily fluctuations in shape and size. The representation of such accounts shifts visibility away from the thin-ideal and unrealistic standards, moving towards normal people and normal bodies reflecting greater similarity to her own. In recovery, Jenny is intentional with the media she engages with, empowered amongst realistic, unedited, body positivity content. In alignment

with a post-feminist view, there is an emphasis across accounts towards personal choice, agency, liberation where re-appraisal and engagement in body image representations is freely chosen rather than culturally demanded.

Posting the Real Me Reflects My Lived Recovery. Amy described the active autonomy over her media consumption and output by having two accounts, one for selected friends, and one for a wider audience. Themes of intentionality, visibility, and authenticity transcend this intentional example of media usage, positively influencing Amy's recovery.

> "I have an account where my family and friends follow and its very filtered, my body looks a certain way in those photos and I'm like mm that doesn't reflect how I truly look… they are posed photos, they have a filter on them, and my skin looks totally different to how it looks in real life. Then I have another account *which I'm using a lot more these days*, where I have made a conscious effort to post real stuff! Like unfiltered photos, or ones where I feel like my body looks bad… and on that I don't follow any influencers… I don't follow any fitness accounts, ugh, I don't follow any foodie accounts because I don't want to see food on my timeline… so yeah I have definitely been intentional about how I use social media and that has definitely contributed to me having a better relationship with food" (Amy)

Amy highlighted a key difference between what is typically posted on social media, versus, what she now chooses to post more of; content that is unfiltered and realistic, content that is typically omitted. Amy's intentional decision to display her "real self" through her public account rejects master narratives on social media, changing the "rules" around the lives we display online. Amy described the contrast between "real life" and Instagram life, speaking to the wider sociocultural notions around beauty on the internet often being a perfectly curated, photoshopped, false version of reality. By tailoring content based on the audience and purpose allows Amy to hold a sense of control over how she is represented and what

messages she promotes. Amy's public account aligns with the body positivity movement, as she uses her own lived reality to actively reconstructs the definition of beauty. The careful control of her content displays intentionality based on her mood and context.

> "I don't follow any friends on my private account because it's nice when I can switch. Like if I have a day where my friends are hanging out without me but I'm studying in the library, I just don't jump on that account. So, I have different timelines and so when I don't want to see it, I don't have to see it" (Amy)

The significance of autonomy over media can be understood in the context of the limited freedom and choice she had growing up within her family context, where device time was monitored and strictly limited. Now, Amy is an active creator of body positive content and uses media both intentionally but also freely within her control. There is a sense of empowerment that Amy holds for herself, through the choices she makes and the context of freedom she creates. Where these choices are made by Amy, there is a shift in control – resisting control imposed from sociocultural pressures, as well as family.

While many participants spoke to reducing or altering their social media usage in some shape or form, others ascertained a sense of empowerment and control by deleting social media altogether. Themes of empowerment and control align with a post-feminist view on re-appraising social media practices. Tegan no longer uses TikTok or Instagram, platforms that previously introduced her to calorie counting and restriction. She spoke to the influence of the social media algorithms across platforms, where content in one application soon saturated all applications, in turn, influencing eating distress. Now, Tegan described using her time more "wisely", using Twitter to keep up to date with current affairs. Similarly, Sophia deleted several social media accounts, extending to applications that promoted convenience and comfort. For Sophia, the accessibility and ease of having food delivered through

applications such as Uber Eats and Deliver Easy is one that increased her binge eating. By physically deleting these applications, Sophia reduces contexts for eating distress.

While media plays a significant role in both distress and recoveries, there is no "one size fits all" recommendation that can be applied. In a world where guidelines and recommendations around social media consumption are publicised, like each participants' individual story, self-empowerment, autonomy, and choice over media use is unique, individualised, and part of the recovery *process.* Like recovery, it is an ever-changing landscape that requires frequent re-appraisal and decision making.

Utilising Media to Evidence the Gaps in Treatment

Social media can act as both a help and hinderer to recoveries. Help may be offered through these platforms that allow knowledge and information to be accessed in the absence of professional support and/or clinical treatment. Situated within a context where systemic barriers dictate who can and cannot access support, there is a power distribution in which stories are told and what marks recovery. For many participants, turning to media to access care and support was critical to their recovery, often evidencing the gaps within the system itself when treatment was not accessible. Media use facilitated practices that allowed participants to seek out knowledge, power, and support. With themes of accessibility, education, relatability, and a sense of community, the merits of media are viewed as a substitute for treatment, additive to treatment, and/or crucial to post-treatment on-going self-help and development. However, given the plethora of information that is readily accessible online, media use evidencing the gaps in treatment can also be considered harmful. With risks of misinformation and the rise of influencers promoting messaging without accreditation or limits (Chou et al., 2018), knowledge is continuously shifting, where misinformation becomes integrated generative of new knowledge (Bautista et al., 2021).

With this view, media may evidence the gaps in treatment but there is the need for increased media literacy when carefully choosing *who* and *what* to engage with in recovery.

Knowledge is Power. Using media to access information was a turning point in Mary's recovery story, a shift in power and self-empowerment. Mary spoke to finding the "good side of YouTube", viewing nutritional based content from dietitians and strength trainers she "followed". Educational content was described as invaluable in Mary's recovery. She obtained knowledge on recovery eating and exercise practices represented by individuals with lived experiences, in the absence of any professional face-to-face support.

> "I think I finally got on to the good side of YouTube; a lot of fitness influencers who are more like intuitive eating, the idea that you need to fuel your body and you are allowed to have these kinds of foods, you need to be eating like a decent amount […] Abbey Sharp…she does a lot of review of peoples "what I eat in a day" and it's kind of eye opening being like "she's not eating enough" or "she's eating this but she hasn't treated herself" it's like *ohhhh.. that was really refreshing*. Another one is Stephanie Buttermore…she's like a strength trainer but she recently went and did an 'all in" journey which is really interesting from a *science perspective and that was quite helpful to see*. And also, she gained a lot of weight doing that, and just seeing someone gaining weight and not being afraid of that was really *helpful to remove this idea that you have to be skinny*. And then my favourite one is Natacha Oceane, she has one video where she eats 1000 calories over her maintenance calories for a week and is like "look I haven't changed, you can do it its fine" and literally *when I have a day where I think I've overeaten I will watch that video and it makes me feel better*! […] So from there I have been trying to just eat like enough, build it up to have more of a normal relationship and just, more intuitive eating which is my goal, which I'm still working towards" (Mary)

This passage speaks to people of influence for Mary, media evidencing the gaps in recovery. Mary finds value in material that is *refreshing*, *scientific*, and *inspiring*. She described implementing this knowledge into her daily routine on days where she feels as if she has overeaten, to remind herself of her inspiration and purpose. By choosing to intentionally engage with content that reflects lived realities of recovery, she learns from people who have lived their own journeys and have a lot to share around weight gain, nutrition, adequacy, and intuitive eating practices. There is a sense of relatability and visibility in topics that are not commonly promoted on social media, and a sense of power reclaimed as she takes learning into her own hands.

Similarly, Eleanor described finding meaning in the content she follows on Instagram, particularly, content within a scientific framework by credible sources.

> "Following people online really helped because it was this one main account, and she does *intuitive eating* and talks about the *science behind it*. She talks about how restrictive just makes you want to eat more, just how ridiculous all these sorts of diets are. She would be like "what if we had the same mentality about diets as we do with sleep", like "you can only sleep from this to this time" or "you can only go to the bathroom this to this time". I was like oh, when you put it like that it does sound ridiculous! […] Always having that sort of reminder that comes up on Instagram, I'm like "oh that's a good point". It makes me feel better and takes it away from me to a more universal thing, I'm like obviously other people are struggling with this too otherwise accounts like this wouldn't exist. I always felt like if I saw just feel good kind of positive things, I would be like "well that's easy to say but you don't know my situation", but having that science aspect… like "this is actually how the body works and this is why you need food" really helps" (Eleanor)

This quote speaks specifically to the merit of accessing information online, debunking popular diets and grounding evidence-based literature within commonplace language. Eleanor highlights some important points such as the normalisation of diet habits and food restriction that would not be considered "normal" for other life essential functions such as sleeping and toileting. Snippets of information accessed online has allowed Eleanor to language an area that she was able to research into further, understanding the myriad factors that go into weight regulation from a physiological standpoint. What was important about this content specifically is the evidence-base behind it, the power of science made simple debunking common myths and sociocultural messaging. Eleanor speaks to the value of lived experiences, removing feelings of isolation and difference to others, making what has felt like a private experience an experience shared and validated by others. Tegan similarly reflected Instagram as her platform and gateway to learning more about herself, her body, and her nutritional needs. For both participants, this allowed greater perspective and motivation to continue learning about the body and nutrition.

Sophia described finding motivation to seek further knowledge online, additive to the psychological treatment that afforded an initial understanding of the function of binge eating within her context. In this instance media was crucial post treatment, as an accessible platform for further self-development.

> "There's this girl called Banana bread to Burpees…she's an Indian girl and she's got a huuge following. I saw she posted something about her binge eating and her emotional eating. I messaged her on Instagram and she replied and we had a bit of a chat about it and I remember that really helped…someone who I could see myself in, she comes from a similar cultural background, same kinds of foods […] You can familiarise yourself with them and they are coming from experience and I think that

> helps give you perspective and shifts things. I think that would be really good early on having more people talking about it" (Sophia)

When asked what services or supports would be helpful for people in similar situations to her own, Sophia reflected on the need for greater cultural diversity and dialogue around eating-related distress online. The idea of peer support, sharing lived experiences, is one that appeals strongly to Sophia. Social media facilitates on-going accessibility for Sophia to extend knowledge and seek out supportive conversations with others in similar contexts to her own. Media allows for an on-going process of self-development in Sophia's recovery.

For other participants, self-help and development facilitated a sense of autonomy over education. Rainbow described actively working through an eating disorder recovery guided application (Love Your Kite), where Zaza listens to self-help podcasts and educates herself on nutrition, anxiety, and recovery beyond weight restoration. For Ivy, treatment has largely been self-directed as well, inclusive of reading self-help books, articles, completing clinician workbooks, and journaling. Many described turning to the online space in the absence of formal treatment, while others supplemented formal treatment with self-help practices that centred around increasing knowledge and power.

Finding Belonging Among Recovery Communities. Participants described engaging with recovery communities online, finding them to positively impact their recovery through a shared sense of understanding, belonging, and support.

> "One of the most helpful things for me was the recovery community on Insta. I think I got the sweet spot just before the influencers and fitspo started. We just used to post absolute shit on Instagram when I was in school, you know, pictures of your cat or whatever… having a community of people that had to eat as much as me. There were two years where that was useful before all those people who said they were recovering but they weren't" (Alex)

Alex described the strength of sharing lived recoveries on a public platform where comfort was found from others in similar circumstances. Posting "absolute shit" speaks to the content not always necessarily being food and weight related, but instead, recovery support was found within broader aspects to a person's life. This platform was formative to Alex's recovery within a context where Alex was surrounded by school peers who engaged with disordered eating and dieting. Alex's reference to the "*sweet spot*" before the "influencers and fitspo started", can be understood in relation to my earlier points where social media being helpful needs to be closely balanced with the people who make it less helpful, and even damaging – through disingenuous recovery.

Other participants spoke to media being the gateway to accessing online group support. For Rainbow, her connection with Voices of Hope allowed the opportunity to partake in a weekly recovery zoom group. This group was beneficial to Rainbow's active recovery with its degree of flexibility within her contexts and lifestyle. Describing herself as not typically a "group person", she described this experience to be positive through themes of accountability, scientific knowledge, lived experience, and shared experience. In this space, group recovery blends both clinical expertise and lived experience bridging the gaps in treatment that she identifies was crucial to her recovery.

For others like Eleanor, however, despite motivation and the desire to engage in group recovery, she speaks to a lack of accessibility and information about such groups, particularly for diagnoses like BED. She described the irony of not being able to find binge eating support groups online but stumbling across this research advertisement in the local park bathrooms. She described her engagement in this study and her opportunity to share her story as a form of support, a sense of belonging that she was seeking and needing. Sarah also believed she would benefit group support, "an AA type of thing". She wished for an opportunity to

connect with others through an online group forum where people are given the opportunity to share their experiences of distress and how recovery is enacted daily.

Summary. This narrative explores the ways in which Media and #Recovery was interlinked for many participants. Through a daily-life approach, we can see the ways participants sought out new ways to engage through a shift in content and platform, across Instagram, TikTok, and YouTube in particular. While most participants shifted media use with intentionality and purpose, some stepped away from social media altogether. Overall, there was a theme of reclaiming power by unfollowing accounts that increased eating distress, seeking out diverse content to re-appraise body image, and posting lived realities in resistance of master narratives. Social media interweaved through most recoveries in some shape and form, and for many, media evidenced the gaps in treatment. Social media was used to access knowledge and support through lived experiences and educational platforms that guided recoveries. Knowledge became power and a sense of belonging and community was found among recovery communities. While media is often positioned as negative to well-being, we can see that media use was more nuanced than that – neither good, nor bad, when used intentionally. Participants stories on media invite understandings beyond binaries, into the sometimes less neatly encapsulated descriptions of what these practices and platforms mean to the individual.

Overall Results Summary

By exploring recovery through daily practices and activities, I was able to better understand the progress, challenges, and complexities that impact and intertwine among participants recoveries. For some, a “good day” is understood in relation to a “bad”, while for others a “typical day” is the same as a self-identified “good day”. Overall, looking at how people story their daily activities helps us clarify what recovery/ing looks like, rooted within

a person's wider sociocultural and relational contexts. Across each of the four narratives, intentional choices and changes allowed for an overall re-appraisal of body, image, identity, neutrality, nourishment, routine, and media use.

Within the Re-Appraisal of Body, Image and Identity Narrative, participants positioned their recoveries with an understanding of the sociocultural contexts of beauty, body standards, food, and family norms, ultimately either rejecting such master narratives or learning to live around these dominant sociocultural narratives. The body took on new meanings, shifting from appearance towards form and functionality, where all bodies are celebrated and daily practices such as exercise and clothing choice are re-positioned in a way that promotes energy, excitement, and care. Re-storying identity transcends across all narrative types, moving away from illness identity to nourishing other parts of self that prioritise values, beliefs, and goals.

The Neutrality and Nourishment Narrative described the ways in which nourishment was re-appraised through daily life practices that centered around embodied experiences of normal eating, social eating, self-care practices, and relationships. Neutrality was nuanced, reflecting a process of shifting ideas around food and body where a "good day" was understood within a "typical day" in recovery, and neutrality was illustrated through one's views on body image. The neutrality sub-theme spoke to the importance of generating participants meaning making, as behaviours alone may not reflect the wider context of eating distress. The narrative type overall showcased how participants and recoveries don't exist in vacuums, and a wider contextual lens is needed when understanding recovery.

The Structure and Routine Narrative focused on the balance of flexibility with routine by making time for social activity and social eating, while others implemented routines that centered around comfort and control. There is a particular emphasis on the daily life aspects within this narrative, as newly incorporated activities and rituals came through participants

recovery stories. COVID-19 was also understood as both a routine builder and breaker. The complexities of building routine and structure in recovery was embedded within participants contexts, where for some, shifting away from this construct altogether was central to recovering.

The final narrative, Media and #Recovery highlighted the nuances involved in seeking, shifting, and stepping away from social media use. For many participants, shifting use and being intentional with content and platform was understood as both a form of self-care and nourishment, as well as a routine and ritual in recovery. Participants reclaimed power and positioning through the platforms and people that were made visible through purposeful engagement. For many participants, media was turned to in the absence of treatment, evidencing the gaps within a system not accessible to all. With the power of digital representation and greater accessibility of online platforms, media was neither good nor bad, but instead, a powerful tool when used well in recovery. “Well,” held various shapes and forms unique to lived experiences of distress, mostly involving a shift towards education, diverse representation of beauty, and posting lived realities and recoveries.

Chapter Five. Discussion and Conclusions

The purpose of this research was to explore narratives of recovery amongst adults with lived experiences of eating-related distress, by examining understandings and stories of recovery situated within sociocultural contexts and relationships. I aimed to explore the day-to-day practices of both eating distress and recoveries, by eliciting meaning-making. I also aimed to understand self-identification processes and preferred language for eating-related distress and recovery. This research intended to contribute to the eating disorder personal recovery literature, offering a recovery-close lens into daily experiences of eating-related distress with a recovery "in" rather than a recovery "from" orientation. In this chapter I generate a discussion around my findings in the context of existing literature. Implications of the findings will be discussed, followed by an examination of the strengths and limitations of this study and suggestions for future research.

Self-Identification of Eating-Related Distress and Recovery

Ultimately, no two participants self-defined eating-related distress or recovery with the same language, speaking to the complex nature and possible over-simplification of clinical labels. Self-identification was nuanced. Participants' stories stand alone, individualised to specific contexts, relationships, and cultures. However, participant experiences also share commonalities across interpretations and re-appraisals of master narratives and sociocultural discourses on what it means to be recovered or in recovery/ing. Recovery was largely described as an on-going process, neither defined nor marked by a neat or singular beginning or end. This finding is consistent with recent literature where personal accounts conceptualise recovery as a non-linear *process*, *a journey*, a *path* to recovery that is unique to the individual (Bardone-Cone et al., 2018; Bohrer et al., 2020; LaMarre & Rice,

2021; Patching & Lawler, 2009). For many, recovery was gradual, additive, marked, and coloured by the contexts in which they re-appraised their body, image, and identity.

All participants centred around doing well or doing better. Most refuted the "full recovery" identification, troubling the lines between resisting a diagnostic discourse and aligning with feminist understandings of care and control (Maine, 2008; Malson & Burns, 2009; Matoff & Matoff, 2001). While one participant explicitly identified recovery as "active" aiming towards "full recovery", others, described the end goal in contextual terms such as "getting more balance", or "the finishing touches". Most adopted a combination of the features underlying "eluding a diagnosis" or "struggling to recover" (Shohet, 2007; 2018). Participants felt "recovery" didn't fully capture the complex realities and sociocultural challenges that intertwine with life itself. Several participants aligned with a recovery "in", as opposed to a recovery "from" orientation, speaking to the notion that re-appraising one's eating-distress is on-going, both dynamic and context dependent. Participants embodied a state of being that grappled complex relational and social worlds; a constant process of re-appraisal that was not neatly defined to time or place. Participants had differing perspectives on whether full recovery was possible or even desirable within a diet-culture fat-phobic world, but this did not mean they were "giving up" on their version of recovery. Those who believed full recovery was possible gave contextualised descriptions of what this would look like, personal to their context. Several critiqued clinical definitions of recovery, particularly, refuting weight restoration as the end goal. Instead, recovery was conceptualised as deeply individual to the *person,* within their *contexts*. These findings overall lend support to critiquing clinical definitions of recovery, where recovery is conceptualised in a diagnostic framework defined by an absence of symptomology, "normal eating" and a "healthy weight" (Bachner-Melman et al., 2018; Bardone-Cone et al., 2010; Gremillion, 1992; Slade et al., 2008). It has been shown that recovery is broader and more nuanced than that, where for

several participants life in recovery involved symptom management, an on-going journey towards normal eating (and in some cases Intuitive Eating as the goal), and an active process beyond weight restoration.

Despite most participants using diagnostic language to describe their distress, several of them had never received a formal diagnosis speaking to tensions surrounding not being "ill enough" to have a "real disorder" – highlighting impossibilities and barriers within systemic structures referenced beyond this studies context of care (Eiring et al., 2021; Fixsen et al., 2023). Aligning with Shohet (2018), many were "eluding a diagnosis" – convinced they may not be sick enough, met with diagnostic barriers related to severity, or simply refuting the need for a clinical label. These results are consistent with previous literature where people have spoken to the pressure of having to prove "sick enough" status by reaching a low weight to be recognised by treatment systems. Treatment criteria is distress enabling, prized and privileged where a low weight that meets service visibility may be seen as a "badge of honour" (Fixsen et al., 2023). This has implications for variations of distress that extend beyond AN, possibly overlooking or invoking feelings of shame and confusion in the absence of medical validation which has been found to have profound impacts on help-seeking and recovery (Eiring et al., 2021). There were mixed results on the helpfulness of labelling eating-related distress within a diagnostic framework. Some participants felt diagnostic terminology lacked a deeper contextual understanding of their circumstances. Others found diagnostic frameworks helpful to a certain extent, for example, bringing forth the acceptance that this was a "real disorder" that "deserved" support. Similarly, others found it helpful when recognising the accompanying distress such as depression, autism, and substance abuse. Some were hesitant to subscribe to labels, able to articulate that their distress *was* disordered, and didn't necessarily need to meet diagnostic criteria to be deemed "*real*". The words "*deserved*" and "*real*" highlight the limitations in narrow definitions and the risks of

the reification of an illness diagnosis as the person's reality and therefore when they do not meet diagnostic criteria, their struggles may leave the person feeling un-deserving of treatment and in turn as less "real".

It is important to note that participants' conceptualisations of their eating-related distress were important to storying recovery. While stories of distress were not the central focus of this research, participants held complete autonomy over storytelling where several chose to talk through their distress narrative before storying recovery. Aligning with a narrative structure, there is a clear demarcation of the beginning of the story, before sharing the middle and the end (Dawson & Sykes, 2019). The act of sharing their story for some was described as "energising" and "helpful" in articulating recovery (feedback provided to me when exploring interview experiences). Participants spoke through early life vulnerabilities, sociocultural contexts, relational influences, and cultural contexts, as they had understood and made sense of early experiences. Aligning with the broad narrative type of quest (Frank., 2013), protagonists searched for meaning on what can be learned from the experiences of distress, when constructing recovery. This aligns with theories of Narrative Identity. Rather than "going back to how they were before" participants were more likely to introduce new elements to their lives, holding greater significance to these daily practices that enacted recovery/ing. Like a seesaw, the balancing act of recovery versus eating distress was continuous, and some days the balance tipped (described as "bad days"). It was the overall awareness of where they had come to, the place they used to be, and the path of the future, that kept them on the seesaw navigating this fine line with care and intent. It is important greater visibility is created for these counter-narratives in the literature, creating space and places for participants to speak to these processes to better understand how to support people in recovery.

This study allowed for a deep contextualisation and self-identification, shifting the power to those with lived experiences deemed experts on their experiences. Rather than claiming that stories can be collapsed into one broad conceptualisation, it is about understanding and opening our minds to the wider complexities and contexts at play, allowing space for participants to be the authors of their own stories and the experts on identity. By focusing on "diagnosis" or "recovery" status, without space for storytelling, researchers and clinicians miss out on the rich meaning-making and complex realities within and across recoveries, paradoxically, limiting "recovery" to a categorical construct. It is important to focus on the micro-moments of the here and now, contrasting to daily life prior for a deeper understanding of the overlap, interplay, advances, and differences in storying distress and recovery/ed/ing states.

A Focus on Daily Practices in Recovery

Participants storied the daily practices enabling recovery in several ways. Daily practices across recoveries encompassed themes of intentionality, function, pleasure, comfort, care, control, connection, predictability, neutrality, and flexibility. While participants shared commonalities across some of the practices they engaged in, the way participants approached these activities differed depending on their context and the meanings they made, rooted within a personal understanding of distress. As such, there is an emphasis on *how* daily practices were enacted, extending beyond the practices themselves and the over-arching themes generated. It is the specific re-appraisal within a person's history and sociocultural context that highlights the varying interpretations these practices may hold, the complexities, and the possibilities for the future. Conceptualising recovery within the context of everyday life offers the opportunity to understand daily practices as experienced, with a focus on the meaning rather than the events or actions (Borg & Davidson, 2008). As an example, exercise

practices took on new forms and functions in recovery. Exercise was experienced as energising, beyond a pursuit towards thinness and control with a focus on functionality and strength. This finding aligns with the concept of "joyful movement" where a person engages in movement that centers around moving your body to feel good, physically and mentally (Health At Every Size®; Bacon, 2010). Participants navigated multiple and conflicting master narratives around what is considered "healthy exercise" in recovery, in a culture where obsession towards fitness and physique is considered "normal" and the idea of working on oneself is expected within healthism master narratives (Robinson et al., 2017). Musolino and colleagues (2020) show that accepted norms within health and fitness culture (what they refer to as the "healthism habitus"; Musolino et al., 2015) can easily be categorised by clinicians as "pathological" practices. What constitutes as "appropriate" and "normal" exercise limits in recovery is still driven by professional prescriptions. Excluded across the literature are lived-experience perspectives that describe exercise practices within context. The stories within this research provide support that exercise is energising, affect regulating, and a way to connect with oneself and others, to feel strong mentally and physically. Participants re-defined the purpose behind exercise based on their values systems and identity reformation. While participants practices differed, the focus was on appreciating what the body can do, shifting to embodied ways of living centering around form and function. Such findings are consistent with Calogero and Pedrotty-Stump (2010) advocating for movement that is performed with "attention, purpose, self-compassion, acceptance, awareness and joy" (p. 434). These practices align with reclaiming the view of a body as an instrument, not an ornament (Kite & Kite, 2020), in alignment with theories of body functionality where the body is viewed as process than object (Alleva et al., 2021).

These findings extend the persistent emphasis on yoga as a tool for recovery across the eating disorder literature (Hockin-Boyers & Warin, 2021; Perey & Cook-Cottone, 2020).

Yoga, as a form of exercise can be positioned as a practice that is part of a healthism master narrative, a socially accepted exercise based on gendered constructions of femininity. The social construction of the gendered body positions exercise within a binary of masculinity or femininity. Activities deemed overly masculine (such as those rooted in competitive sport, like weightlifting) sit in stark contrast to the feminised exercise recommended for recovery such as yoga (Brace-Govan, 2004; Hockin-Boyers & Warin, 2021). Examples from this study such as boxing, spin, and strength-training, are often excluded from recommendations in recovery (Brace-Govan, 2004). Clearly, the links between women, exercise, and mental health continue to be "profoundly shaped by wider social agendas and views on women's bodies and minds" (Hardes, 2018, p. 191). These findings extend beyond clinical prescriptions of exercise, highlighting the various ways exercise enacts lived recoveries. Clinical exercise parameters may heighten rigidity, as opposed to creating space for people to discover, re-appraise and find flexibility in movement that enhances physical freedom.

Another daily practice that invites readers to think differently about recovery is the form and function of clothing choices, linked to both body image re-appraisal and identity. This is a specific daily practice that extends beyond the existing literature, with links to both body image, nourishment, and identity. While clothing choice varied, it was specifically clothing that enhanced positive body image, at the intersect of self-esteem and identity formation. There was a shift in visibility from hiding oneself and one's body, to comfortability and clothing that nuanced parts of personality - intentional clothing choices that increased body positivity and positive affect. Clothing choice was also an act of resistance against sociocultural expectations. For example, wearing clothes that reflected gender neutrality was a large part of re-appraising gender beyond the binary. There is a paucity of research investigating body image, eating-related distress and recovery among individuals who identify as non-binary. This research acknowledges the importance of an in-

depth understanding of eating-related distress among sexual minorities inclusive of gender identity, sexual orientation, and their interactions in relation to both distress and recovery, extending findings from Mason et al. (2018).

Prior to discussing each narrative type, I consider the lessons learned across the narrative themes. Across each narrative, there is a strong theme of authenticity, visibility, vulnerability, care, comfort, and control. Each narrative demonstrated intentionality across changes and choices illustrated through a broad process of re-appraisal. Without acknowledging stories of distress, participants may not have had the full awareness of the choices and changes that required re-appraisal in recovery. Resisting master narratives was true across all stories – transcending culture, religion, sexuality, beauty standards, and family contexts, to name a few. What is clear is that eating-related distress is essentially an umbrella term for multi-layered contexts of oppression and trauma faced. Recovery classification by itself is too simplistic when understanding the myriad of influences participants continue to navigate. The narratives do not stand alone. There is particularly overlap with re-appraising identity with a shift towards values, beliefs, and recovery goals. Similarly, media in recovery overlaps with self-care within nourishment and the re-appraisal of routine and structure. Each narrative is best understood as a context, or a layer of recovery, constructed within the interplay between complex relational and sociocultural worlds. Lastly, the neutrality narrative highlights the importance of meaning-making. Participant and clinician definitions of neutrality may differ if a deeper understanding of experience is not explored.

Daily practices illustrating nourishment demonstrated the many expressions of this concept. Nourishment involved negotiating new food and eating practices where participants largely shifted to viewing food as fuel, eating for pleasure, eating socially, and trusting one's hunger and satiety cues. Normal eating was positioned as the goal for some who had accessed treatment, while others rejected and resisted this questioning whether it was even possible

within a diet-culture sociocultural context. Several navigated nourishment through self-knowledge and daily practices surrounding intuitive eating, described within a "good day". Although participants referred to the general concept of intuitive eating as opposed to specific domains, there is preliminary support consistent with the literature that an intuitive eating framework is seen to positively increase well-being, reduce eating-related distress, and enhance body positivity and embodiment (Cheng et al., 2022; Koller et al., 2020). However, the line between intuitive eating and "healthy eating" is a murky one, riddled by rules and societal prescriptions which makes navigating nourishment an on-going challenge. Participants in Erhardt (2021) described intuitive eating as a counter cultural process that involved unlearning and rejecting diet culture. Consistent with my findings, participants described a freeing of headspace in recovery which allowed for the introduction of new activities, interests, and opportunities to develop. It is important to hold space for counter narratives, where in the absence of intuition to eat, for example, there is a shift towards intentionality. This raises the question whether intuitive eating as a concept, may overlook the varied expressions of food freedom people define for themselves. Should we instead be positioning food freedom along a continuum of affect and neutrality instead?

Participants re-appraisals of nourishment centred around themes of healthism, control, and intentionality, alongside or in addition to intuitive eating, however, the balance between these concepts in recovery warrants further discussion. Where there is overlap between these concepts, certain practices border the grey between intuitive, intentional, and controlled. Participants in this study endorsed practices of flexible control with intentionality. Where dietary control is praised in society (Corrington, 1986), evidence of the internalisation of such master narratives and adherence to bodily standards fringed the corners of some participants stories. With an emphasis on "clean eating" within a healthism master narrative, participants practices illuminated the inevitable adoption of some practices in this contemporary culture.

Such practices point to the complexities and contradictions of postfeminist constructs of choice, freedom, empowerment, and agency, the idea that women may take and redirect control towards normative ways of being under a healthism lens which may be socially and morally acceptable in recovery. Resistance to, and through food, is an exercise of power that is culturally normed, which makes teasing out the intricacies of intentionality, choice, and control nuanced and context specific (Cooks, 2009).

Several participants described daily practices of nourishment that extended beyond food and weight into relationships that sustain recovery and self-care activities. Being embodied requires practice, where participants spoke to re-negotiating practices that prioritised self, increased introspection, self-regulation, and positive affect. Consistent with the literature, mindful self-care practices such as yoga and meditation may have a role for prevention (Cook-Cottone, 2016). However, this study extends the concept further – illustrating the various ways participants increased self-awareness, self-compassion, self-love, and physical practices through activities alone. Activities included setting up routines around journaling, listening to podcasts, exercising, reading, reducing screen time, intentional moments of food joy, and keeping up with hygiene practices. While little is discussed in relation to self-care within the eating-related distress literature, self-care culture is saturated with messaging that perpetuates stereotypes on forms of self-care (such as "treating yourself" (Martínez-Jiménez, 2022). Extending beyond the wellness industries articulation of self-care requires appreciating care beyond specific practices to understanding the significance within individual contexts (Martínez-Jiménez, 2022; Wyatt & Ampadu, 2022). For example, while unboxing a gift aligns with the "treat yourself" discourse, when understood within a context of financial insecurity and family structures of control, the act of buying something represents resistance, healing, and a re-negotiation of pleasure, money, and self-worth. Conceptualising self-care as action-oriented items or behaviours, limits the comprehensive,

nuanced understanding of self-care as healing and nourishment. As such, these findings help expand our understandings of self-care beyond behaviours alone (Miller, 2020). Self-care can also be understood as a process through practices that help participants move towards liberation and empowerment. Missing from the current self-care discourse is the need for minority groups to engage in self-care as a means to survive within spaces and places that oppress and impact their distress (Wyatt & Ampadu, 2022). An example of this was the intersect of self-care and spirituality. Rudy's positioning as one of several participants identifying as an ethnic and sexual minority helps us understand the deeper meanings to caring for self. A focus on energy and alignment through the daily use of crystals, affirmation, breathing, and meditation, showcases self-care practices centred around mindfulness. Self-care was also appraised by letting go of religion that opposed her identity as a lesbian. Rudy's experience offers an experience-close lens to spirituality, extending beyond traditional forms that have been documented in recovery, while also incorporating mindfulness and meditation practices considered to increase spiritual connection and recovery (Richards et al., 2018).

While the concept of neutrality has been cited within body image literature (Perry et al., 2019; Smith et al., 2023), this study offers insight into the nuanced meanings to neutrality in lived recoveries. Neutrality was described where food held no affect, seen purely as nutrition. Neutrality was also linked to self-compassion. Recognising "bad days" are inescapable in recovery, participants shifted from a dichotomous view on self and recovery. Exampled by Ivy, neutrality was the approach that defined a "good day" in recovery, as complete engagement in daily life and other activities beyond food, meant that food became a second thought. A "good day" was counterintuitive to my assumed meaning, highlighting to me how important meaning-making is, individual to the person, their context, perception and intention behind activities and events. Neutrality and Nourishment can be understood as

interlinked processes, where for some, neutrality was achieved by keeping up nourishment across daily life. For others, nourishment was understood as a concept that involved re-appraisal, extending into value aligning activity.

Navigating new routines required intentionality and self-awareness, and an on-going process of balancing flexibility while building social activity. Implementing rituals and routines in recovery centered around new meanings of comfort and control. The term control has also been implicated as a feature of eating-related distress, where the literature points to new meanings ascribed by people in recovery. Participants in Patching & Lawler (2009) described the importance of relinquishing control, regaining control, and reconnecting with life through the formation of self-identity. Similarly, D'Abundo and Chally (2004) cited gaining control, thinking rationally, and joining society as factors that decreased distress. The findings in this study supported these ideas, where participants came to an understanding of how former contexts were associated with the manifestation of control, holding self-awareness over new routines and rituals implemented in alignment with identity.

A unique contribution from this study was the nuanced discussion on how COVID-19 was both a routine builder, and breaker. COVID-19 was neither "good" nor "bad" for lived recoveries but nuanced to each participant's story. Emerging from the COVID-19 literature, lived experience perspectives speak to how a lack of structure and purpose led to a lack of control and increased distress, where disordered eating was a way to comfort or distract oneself from the effects of the pandemic (Brown et al., 2021). Recent research points to decreased access to treatment (Rodgers et al., 2020), changes to routine, loss of structure (Branley-Bell & Talbot, 2021; Hunter & Gibson, 2021), negative influence of weight stigmatising media (Cooper et al., 2022; Hunter & Gibson, 2021) and loss of support as contributing factors. For those who described COVID-19 as a routine breaker, recovering was made difficult in the presence of others who modelled their own "healthy eating" habits

or strict exercise regimes. In contrast, for some participants isolating away from support was difficult, highlighting the nuance to relationships. The impact of isolation is greater among minorities, where for example, those isolating at homes where gender identity or sexuality are not known or accepted, may exacerbate distress (Cooper et al., 2022; Watson, Veale, et al., 2017). A limited amount of literature has cited some positive outcomes from COVID-19, such as the opportunity to create new self-care routines, to self-reflect, and for some individuals, increased social support (Frayn et al., 2021; J Devoe et al., 2023). For those who described COVID-19 as a helper in recovery, a change in circumstances catalysed value aligning activity supporting the formation of new habits and routines that supported personal recovery. Similarly, those who felt connected during lockdown described a sense of healing and comfort previously missing. As a result, new routines were considered essential to coping with eating distress during this time.

Lastly, media use shifted in recoveries. Participants elicited a sense of control and power by re-directing their energy to seeking out content that reflected diversity, unfollowing accounts that promoted self-comparison, and posting lived realities. These findings extend beyond the literature that positions social media as a risk for eating-related distress through self-comparison and master narratives around body ideals (Lewallen & Behm-Morawitz, 2016; Rodgers & Melioli, 2016; Sherlock & Wagstaff, 2019). While most participants spoke to the interconnected nature of eating distress and former social media use, recovery involved re-appraising use and representations. No single platform was positioned as inherently helpful or unhelpful – it was specifically the curation of one's algorithm to make social media an intentional, purposeful daily practice in recovery. Through the active re-appraisal, many participants engaged in what Hockin-Boyers et al. (2020) described as "digital pruning". Consistent with the theme of "balancing on and offline engagement" by Nikolova and LaMarre (2023, p. 8), some even described engagement with different accounts based off

purpose and affect. Others described limiting screen time and prioritising in-person activities. New ways of engagement were enacted in recovery. Shifting from self-objectification to utilising media as a tool for on-going self-help and development and a forum for connection. Instagram has been found to aid recovery by increasing knowledge about the recovery process, reducing stigma, and creating a community for social support. However, Instagram has also been found to maintain distress, promote self-comparison, and trigger relapse (Eikey & Booth, 2017).

A unique contribution to the literature was participants narratives around using media to evidence the gaps in treatment, highlighting the power and agency one has over digital information, in the absence of formal treatment. Consistent with Nikolova and LaMarre (2023), participants enacted identities as active engagers, emphasising the on-going modification needed to keep media helpful in recovery. Knowledge is power and as such, participants media use can be seen as a way for them to reclaim power over their own lives. However, it must be noted that while participants were aware of the problematic content and ways to minimise or avoid this, ultimately, a cultural shift is needed from a societal level as change needs to occur beyond the individual consumer (Gill, 2007).

Overall, these four narratives depicted various daily practices that participants constructed and re-negotiated in recovery, illustrating the nuances within everyday life. Moving from here is a discussion on theoretical frameworks of personal recovery and how the findings align, extend, and/or reject the literature to date.

Unpacking and Extending Overarching Concepts of Recovery

Consistent with conceptual models of personal recovery such as CHIME (Leamy et al., 2011), participants supported the importance of over-arching recovery processes such as connectedness, hope, identity, meaning in life, and empowerment (de Vos et al., 2017).

Wetzler et al., (2020) cites additional factors of importance, namely, self-compassion, and supportive relationships. These over-arching factors were consistently supported in this study, nuanced further through the meaning-making made across each theme and best reflected by daily practices. For example, “Identity” extended beyond the understandings within CHIME and will be theorised further below.

Identity was a key theme across narratives. Participants re-storied a sense of self across various discourses, consistent with literature on social identity (McNamara & Parsons, 2016), occupational identity (Kelly et al., 2010), and illness identity (O’Connor et al., 2021; Williams et al., 2016). This study extended understandings to include sexuality and gender identity. How participants developed a sense of self and constructed identity within recovery, closely maps Narrative Identity Theory where storying the past is used to make sense of experiences, providing context for the present (McAdams, 1985). Within a social constructivist lens, identity is understood as dynamic, derived from the interactions of oneself and the environment and established within the multiple social realms (Jackson & Hogg, 2010). Re-storying identity within this research was articulated across the many social positions a person holds as important to their lives. For example, this included social roles (as a mother, a daughter, a wife, for example), recovery identity (identity in/away from illness), finding strength and purpose within professional identity, growth and honesty within sexuality, and cultural identity, to name a few domains. Identity constructions and articulations were complex and interconnected with other aspects of life; there were no clear delineation as participants constantly negotiated and re-negotiated a sense of self based across contexts and time. Identity was reflected and constructed through storytelling. This aligns with the view that identity itself is also a narrative. The ways in which participants positioned themselves within their stories and the wider discourses they drew upon or

resisted, highlighted the different meanings they held for their identity. Identity construction was a journey, a process in itself (Conti, 2018).

Research cites a recovery identity as vital for successful recovery (Federici & Kalplan, 2008; McNamara & Parsons, 2016; Wetzler et al., 2020), only possible based on the extent an individual is able to successfully let go of illness identity and develop a new identity (Espíndolo & Blay, 2009; Federici & Kalplan, 2008). The results of this study both advance and challenge this notion. While some participants spoke to illness identity as distinctly separate to recovered labelling, for the vast majority, illness identity was intertwined with recovery identity, neither separate nor complete but an on-going co-existing intersection. This is important to note. Often, identity is positioned as separate to illness identity; however, for these participants, lived realities reflect a complex process of establishing identity "in" the context of distress, as opposed to separate and "from" distress (Conti, 2018). Part of illness identity involved recognising how eating-related distress initially afforded a sense of belonging and control, where recovery involved finding belonging in other social identities across life. Consistent with Wetzler and colleagues (2020), participants spoke to personal growth and building inner strength and resource, in alignment with meaning and purpose. However, less explicit was the de-identification from eating-related distress for several participants. Linking this back to my initial research question examining individuals' understandings and constructions of recovery, identity, plays an important part in how people story their recoveries.

Social identity was appraised through an overlap with the nourishment narrative, where certain relationships were understood as nourishing to a person's sense of self illustrative of recovery. Consistent with Ison and Kent (2010), shifts in social positioning involve a recognition for readiness to change, influenced by outgroup perceptions of eating-related distress affecting disclosure to others and recognition itself. There was a clear

hierarchy of distress which influenced illness identity, and in turn, identity in recovery. Daily practices engaging with recovery-oriented social groups illustrate recovery as a social process, where individuals not only re-construct illness identity for themselves, but construct identity within a wider community with similar goals, values, and beliefs. Some participants spoke to the meaningful engagement in recovery groups, whereas others found groups to connect with through social media platforms in the absence of formal treatment. Supporting the findings of McNamara and Parsons (2016), these groups center around facilitating hope, constructing a shared understanding that recovery is possible, even when participants believed "full recovery" to be impossible.

For several participants, growth, and honesty in one's sexuality was another way identity was shaped and sociocultural discourses resisted. While there is a considerable literature documenting the relationship between eating-related distress, sexual orientation and gender identity, less is known about the influence of these areas for women, by women (Hepp & Milos, 2002). These findings highlight the importance of exploring gender identity within and beyond the internalisation of traditional gender social roles and responsibilities. Participants differed on their positioning of such roles and responsibilities. Some rejected gender stereotypes and adopted contemporary roles and subject positions within their relationships. Overall, the way in which participants navigated multiple identities across their lifetime and intentionally leant into some more than others within their recovery, answers part of the research question. Here, stories of recovery were articulated through the motions in which people defined themselves and shifted identities across day-to-day life.

Supportive relationships were integral to participants recoveries in this study, where no two relationships were the same. What was particularly critical was *the form and function* relationships played across and within stories, supporting and further nuancing the importance of social connectedness in recovery. Consistent with the literature towards a

relational understanding of recovery, recovery has been cited as a social process (Price-Robertson et al., 2017; Schön et al., 2009). As Lester (2019) states, "eating disorders do not exist *within* people, they emerge *between* people" (p.9). Participants stories align with these ideas, where distress was tied up within social relations, and recovery was navigated by re-negotiating nourishing relationships.

While family has been cited as an important component to recovery and relational recovery (Linville et al., 2012; Patching & Lawler, 2009), some participants resisted this notion. Friends and family who remained preoccupied with diet culture and over-exercise, were not helpful or included. Several participants had to make sense of the origins of pain and trauma they had experienced, rooted within their own family context. For these participants, the healing process involved rejecting abusive relationships and choosing self-nurturance where "family" were re-defined to include colleagues, flat mates, and friends. Acknowledgement of early family traumas and the shift from self-punishment, blame, and shame, to self-nurturance, is a process spoken about in Moulding (2015), similarly, these participants spoke to finding new unconditional relationships that helped them recover. Listening carefully to the stories from people who have experienced trauma and eating-related distress holds significant power to guide a better understanding of implementing trauma-informed care.

While most participants endorsed support from friends or partners, there is a lack of research into other networks of support outside of the family (Leonidas & Dos Santos, 2014). Extending beyond the *who* into *how,* these supporters provided attunement to the needs and desires of participants, beyond a surveillant model into the relational aspects of trust, support, love, and safety (Lester, 2007). For many, recovery was about re-appraising relationships with like-minded people whose values aligned with their own goals and identity; friends who offered "tough love" and practical food support instead of food surveillance, friends who

exercised for energy and did not centre around appearance comparison. Thus, it may be too simplistic to categorise "connection" and/or "relationships" as key to recovery. These findings add greater specificity for relationships to be understood, moving away from a sense of disconnection to connection, articulating specifically how and which relationships sustain and shift participants towards a state of connectedness beyond or amidst distress.

Contextualising Challenges and Complexities in Recovery

Across narratives, participants spoke to the difficulty in adhering to both sociocultural and clinical standards for recovery. Daily variations in both eating distress and recovery reflect the on-going challenges of recovering in a fat-phobic, gendered, patriarchal context where values and practices around "health" (Harwood, 2012), food, and bodies continue to limit and constrain personal articulations and standards of recovery (LaMarre et al., 2015). As Musolino and colleagues (2016) highlight, "post feminism, neoliberalism and healthism represent a constellation of contemporary forces which have created an environment for disordered eating to flourish" (p.2). It is no wonder, that participants stories are coloured by an ever-evolving context of impossibility and complexity. Some of the many complexities, contradictions, and challenges to recovery/ing within this sociocultural and dominant diagnostic context will be discussed below.

Narratives were consistent with research that supports the importance of a broader conceptualisation of recovery, beyond weight status (Bird et al., 2014; Dawson et al., 2014b; Slade et al., 2008; Wetzler et al., 2020). Many participants spoke to the notion of "recovery beyond weight-restoration", advocating for a focus on incorporating on-going skills and understandings to manage daily distress. Participants did not see nor experience weight restoration as the end or marker of "full recovery" (Boughtwood & Halse, 2008), where clinical recovery was critiqued for its focus on recovery for "body" with less emphasis on

recovery for the "mind". Participants' discussion towards this matter highlighted to me how much trust is put within treatment that emphasises weight restoration as recovery. Perhaps, at times, this message is communicated with an absence of psychological recovery as a goal. It is understandable that participants emphasise this component to recovery, when master narratives around eating distress are tied into weight status to begin with. Participants who had received treatment perceived the focus on weight restoration to be inadequate, echoing literature that explores the limited nature of such a focus in recovery (Boughtwood & Halse, 2010; Gremillion, 1992). Recovery beyond weight restoration was absent from the goals set by treatment providers, positioning a very narrow definition of recovery that was not best matched to life beyond. While participants may not have known this at the time, several expressed frustration at this realisation when they had met weight restoration and questioned, "where to from here?". While the process of weight restoration is deemed difficult, when recovery is so closely tied up to achieving this, what does this communicate to those who do not meet the expected weight gain each week? What does this communicate to those who make a full psychological recovery without full weight restoration, or even, those who want more supportive tools alongside weight restoration but are told one goal precedes the other. A recovery "in" orientation was best aligned for most participants, thus, this orientation needs to be considered in clinical framework. This may come with the understanding that full recovery may not be possible, achievable, or desirable for some people. This has implications on how practitioners may engage in treatment, requiring the clinician to re-frame resistance and meet the person where they are at.

Extending beyond these clinical implications and questions, I pose a transcultural feminist lens on some of the implications of recovery being tied simplistically to weight restoration. Rooted within a sociocultural context that encourages self-scrutiny around body and health, fatness is stigmatised and equated with laziness and a lack of restraint (Rice,

2007). By situating weight restoration within a fatphobic world, how are people meant to appraise a recovered identity in a weight restored body within a cultural context that outwardly prizes thin bodies? Participants faced with recovery, and reality, are essentially faced with two sets of incongruous instructions (LaMarre & Rice, 2016b). Considering some of these tensions helps us understand participants' navigation of recovery beyond weight, and the contradictions faced counter culturally. This research aligns with the view that when recovery from eating-distress is defined only by clinicians and researchers, important aspects of recovery may be overlooked. Weight understandings or misunderstandings is a particular point needing advancement (Pettersen & Rosenvinge., 2002).

A discussion on weight is incomplete without consideration for the limitations of a weight-centric recovery approach for people in larger bodies. Weight stigma is rife throughout clinical frameworks, from diagnostic categories to the way treatment is approached. Consistent with this research, participants in Harrop (2019) described receiving weight biased care based on their body metrics, some even put on a restrictive meal at admission based on their weight despite having a restrictive eating disorder. Others speak to the marginalisation they faced due to being in a larger body. People in larger bodies are consistently under recognised within treatment approaches that prescribe "health" within narrow weight parameters. In turn, individuals face increased internalised weight stigma and distress when navigating fatphobic contexts where larger bodies are routinely degraded and stigmatised, with assumptions made on health based on weight (Rice, 2015; Saguy & Ward, 2011). As such, when we explore distress, it is important to consider how people are bound up in such categories that "manage" and constrain bodies to a certain form (Halse et al., 2009).

Moving beyond weight and taking a more holistic stance, a Health At Every Size approach (HAES ®; Association for Size and Diversity Health) advocates for the adoption of

weight inclusivity, eating for well-being, respectful care, life-enhancing movement, and health enhancement. Extending beyond weight-centric assumptions in eating distress detection and recovery involves a deeper consideration of the context in which various body shapes and weights exist, rejecting the stereotypes (Cheng et al., 2019). Where illness identities have been found to impact recovery, participants in this study frequently "othered" themselves from the master narratives that tie weight severity to distress. As such, recovery involved recognising some of these systemic limitations, acknowledging their distress, and shifting towards life-enhancing movement (exercise as energising) and eating for well-being in alignment with HAES. The findings on recovery beyond weight restoration highlights the need for wider representation and visibility of stories across the distress spectrum and among people in diverse body sizes.

A contradiction to the importance placed on relational recovery, some participants described taking individual responsibility (Leamy et al., 2011), particularly within a context where treatment was largely inaccessible. The notion of needing to meet high levels of distress to access treatment was a common theme across narratives, where participants criticised an absence of middle-ground support. Others described negative experiences within primary care settings where they felt rushed, weight defined, and sometimes unheard by General Practitioners (GP). There was a general desire for healthcare systems to be given more education on appropriate and inappropriate languaging and questioning around eating-related distress.

While treatment experiences were meaningful and helpful for some participant recoveries, it was specifically the relational aspects of treatment that were cited as most helpful, consistent with the literature (Bell, 2003; Pettersen & Rosenvinge, 2002; Zaitsoff et al., 2015). Several participants described turning to intentional media use in place of formal intervention. Social media has been thought to offer new possibilities for self-help (Saunders

et al., 2020; Wenig & Janetzke, 2022) and an avenue to engage in identity work that is part of recovery (Nikolova & LaMarre, 2023). For example, recovery stories on Instagram have been described as door openers for further treatment, motivation for therapy and a first step towards behaviour change (Wenig and Janetz, 2022). However, the way social media is used depends on motivation and purpose. An understanding is needed of these contexts and complexities, as well as other avenues such as media for social possibility and support.

Implications

The study's findings deepen our understandings and constructions of recovery, where a daily life approach offers unique insight and innerstanding into the process and "doing" of lived recoveries. This knowledge informs several recommendations that may guide clinical practice. These implications are informed by both the findings and participants perspectives on how supports and services may be improved, to better meet the needs of those with experiences of eating-related distress. As I write this chapter as a registered Intern Psychologist working within the eating disorder field, it is important I reflect on my own positioning and the knowledge I take into my practice, particularly, attuning to some of the systemic barriers when seeking support. Working within the field, I have ability to translate my research findings, to better support the needs of those seeking support. I will hold these participants experiences close to my head and heart, implementing a personal recovery orientation, refuting unhelpful stereotypes, challenging dominant discourses, and advocating where appropriate.

The findings suggest that self-identification of eating-related distress and recovery is important. The language used to position oneself and identity within or beyond dominant discourse may inform practitioners on how the person thinks about recovery. What recovery means to a person is communicated through the language chosen. Without asking how

someone refers to their distress/recovery using an open question, we may miss the essential meaning making that occurs. As no two definitions were the same, there is a lot to understand from language alone. The way participants frame their eating distress helps to inform their view on recovery as recovery "from" or recovery "in". Without situating ourselves within a person's identifications, nuanced understandings and contexts are missed. It is also a way to attune to power dynamics, extend beyond stereotyping, stigmatisation, and diagnostic constructs. Practitioners are encouraged to ask how a person may identify with their distress and recovery, clarify terms, explore meaning-making further, and use this preferred language across treatment and note-taking. Incorporating such language use from formulation to report writing may also dismantle power hierarchies that exist, and create space for an alternate, meaning focussed approach to understanding. Similarly, it is important to note the differing identities and power dynamics with the various terms used such as client, consumer, service-user and patient, perhaps opting for more person-centred languaging overall.

It is important clinicians believe in recovery articulations identified, holding awareness for their own thoughts and positioning for recovery possibilities and impossibilities. A recovery "in" lens not only holds hope for life beyond illness, but focuses on quality life amidst illness, and quality life despite illness (Conti, 2018; Dark & Carter., 2019). In contrast, a recovery "from" orientation matches clinical recovery outcomes and is positioned in opposition to the tenets of personal recovery. While this research is not about the correct perspective, it highlights the idea that there are *multiple perspectives and positions on recovery that may not fit neatly into a simple categorisation or singular understanding.* Recovery understandings must be generated from the person, for the person, where clinicians are invited to sit in the grey or the nuance at times when recovery categorisation is neither here nor there. Where some people may prefer a blend of both perspectives it is a clinicians role to hold space for both, work with resistance and/or simply meet a person where they are

at. Recovery is a complex phenomenon, and this process-driven view beyond outcomes is largely consistent with recent research that proposes a person-centred ecological approach to recovery (Kenny & Lewis, 2023). Based on this idea, I invite practitioners to also consider their own individual perspectives and positions on recovery, identifying any possible biases or dominant recovery discourses they may hold. Ultimately, considering whether they can hold space for clients whose goals may not match that of the clinician.

Another central takeaway from the present study is the importance and centrality of daily practices in recovery. A "day in the life" questioning approach would be a helpful clinical assessment tool to implement. While currently clinicians may use "typical day" questioning styles probing into eating, energy, and sleep, an extension is needed beyond these symptomatic areas into daily living. An open-ended daily life questioning style that allows individuals to narrate a typical day, without any limits or pre-defined parameters, may importantly shed insight beyond symptomatic categories and may be used as a holistic tool throughout treatment as well. For example, asking individuals how a "typical day" differs from a day without/beyond distress, will illustrate the subtleties in recovery framing specific to activities and contexts. It is specifically the day-to-day activities that may seem insignificant at first glance, or by clinical definition, such as daily routine, relationships, commutes, and clothing choice, that reflects the many intentional decisions made to stay well. By probing into these details, there is a deeper enactment of intentionality, hope, and authenticity, rooted within the contexts. However, it is important to note a focus on a "good" and "bad" day specifically without a sense of a typical day, may reinforce dichotomous thinking styles. A blended approach beginning more generally, would be important. A practitioner prompt is exampled below:

- "Can you talk me through a day where you felt good"; (*felt good*, in terms of eating-related difficulties specifically and/or recovery)

    - Further probe suggested: *"Are there any specific people, places, things, situations, practices, or activities that surround the feeling of a good day?"*
- "Can you talk me through a day where you didn't feel so good; a day where eating distress may have impacted you more than usual for example"

Overall, this implication aligns with recent literature. Perhaps, this questioning style can be expanded into a therapeutic tool – integrated with ideas around mastery and pleasure, focussing on an intentional day at a time through daily practices in recovery. It would be beneficial to incorporate this line of questioning in both assessment and intervention.

A cultural understanding is important, and often missed from eating disorder literature and practice. Participants who identified as ethnic minorities spoke to challenges specifically linked to cultural identity, consistent with suggestions that contemporary patterns of migration, acculturation and multi-cultural environments may add further complexity to identity formation (Leu et al., 2011; Manuela & Sibley, 2014; Paradies, 2006). Participants worked through identifying with, or away from culture of origin when forming a sense of self in recovery. Some re-appraised culture by taking the value aligning activity and relationships that sustained them, and leaving behind fatphobic discourses that were pronounced within certain cultures described. Many grappled with the contradictions of recovering within a cultural context where prescriptions around healthy bodies and eating are continuous. Others spoke to intergenerational trauma and accumulative stress best understood within cultural contexts. Participants of gender and sexual minorities also grappled with marginalisation and effects of minority stress. Participant recoveries were deeply situated and influenced by social and cultural contexts, thus, an exploration of some of these contexts is essential in clinical practice. Allowing individuals time and space to be expert on their experiences is imperative to understanding diverse worldviews. Exploring the impact of culturally contextual factors includes a comprehensive exploration of gender, ableism, cultural background and values,

educational attainment, trauma, ethnic identity, acculturation, and the process of navigating multiple worlds. Using a culturally adapted model is one that accommodates and explores cultural factors for food refusal (e.g., complaints of abdominal bloating,) and variations in the thin-ideal, weight ideals, and fat phobia that may drive distress (Lee, 1995). Particularly in the context of pain and trauma as a common precipitant to distress, it is important a "healing is ongoing" mindset is incorporated, where treatment may be best implemented within a trauma informed approach (Breweton, 2019). These complexities nuance our understanding of cultural identity, calling for a deeper exploration of layers to identity formation.

It is important clinicians shift treatment focus from an individual perspective to include interpersonal, societal, community, cultural, and political understandings within care (Alegria et al., 2010). Using a cultural model of health such as Te Whare Tapa Whā (Durie, 1984) could help to conceptualise recovery in a more holistic form. In addition to this, a person-centred, ecological framework by Kenny and Lewis (2023), may aid in contextualising the myriad of systemic and oppressive factors that are missed from traditional treatment models. Both models may act as a starting point for a deeper discussion on sociocultural and relational contexts, to aid in shared meaning making and formulation. Noting the tensions of living and navigating recovery in this world through the discourse of master narratives around health and body, would be an important part of this discussion. By establishing the links between eating distress and the range of oppression and power imbalances a person may face invites a more nuanced way for clinicians to think about precipitating factors within a clinical framework and/or formulation. As identified, recovery is more than the absence of symptoms but better understood as an incorporation of how a person stayed well spiritually, emotionally, physically, and relationally. As such, a contextualised approach incorporating a focus on daily practices, supports a person to live a fulfilling life – beyond or amidst distress.

Understanding the relationship between recovery and identity involves moving towards the view that identity is an on-going process, across multiple domains. Intersectionality is key to this view. Exploring the various constructions and identities a person may hold in both eating distress and recovery, must be translated into clinical practice. An individual's personal recovery goals beyond weight metrics needs to be clearly delineated, emphasised and re-visited throughout. As a key part of re-appraising identity was living an authentic life beyond gender roles and master narratives, value identification may be supportive in treatment. Contextualising a sense of self is understanding that identity is a fluid, social process, one that may include and extend illness identity, but is ultimately unique to each person and re-constructed throughout life. Another key implication is that identity formation may take time and support in recovery, particularly, when resisting or reframing master narratives and sociocultural tensions. It may be of value for practitioners to integrate therapeutic models such as Schema Therapy, Narrative Therapy or Acceptance Commitment Therapy as an adjunct to further explore identity. Adaptation of therapeutic modalities require clinician flexibility and sensitivity, recognising the strengths and limitations of current modalities predominantly used in the field (e.g., CBT-E).

Two further practical implications that can be integrated into clinical practice include the need to explore nourishment and media use in a way that is rich and multifaceted, across both assessment and treatment. Nourishment, defined in a broader sense, encompassed values, and practices that an individual incorporated in their day-to-day life to stay well and feel good. This closely relates to the concept of psychosocial functioning, extending beyond weight and food into alternative coping strategies and connection. Perhaps, a clinician prompt such as the below may be incorporated into both assessment and on-going treatment, as an exploration and renegotiation of daily practices beyond food.

"*How do you nourish yourself – what do you do that makes you feel good?"*

"What would recovery look like to you if you were to nourish yourself beyond food?"

Media use was described as both a factor in eating-related distress, and a platform used in recovery. However, the way social media is used, the content engaged with, and the purpose behind it is as individualistic as recovery itself. Holding a curious, open lens, and allowing the person to speak to their media consumption, is imperative to understanding how distress is situated within and influenced by the digital world. By asking people what content they engage with *and what they make of this*, we can understand the impact this may have. A questioning prompt suggested below.

"What [media] are you consuming" (Nikolova., 2021, p. 122)

This creates a window of opportunity for media to be re-appraised in recovery, through psychoeducation on media literacy and encouragement towards diverse content. Studies have even found that selfies can be used as tool to resist appearance based expectations, exercise free speech (Zhao & Zappavigna, 2018) and counteract fat shaming dialogue and images (Lupton, 2017), as a form of empowerment. Empowerment has been identified as a key construct in reducing self-objectification, and in turn, eating-related distress, moving towards a functional view of the body. However, the term empowerment requires careful consideration, as it can be used to frame practices that might be otherwise understood as disciplinary and oppressive. The women in the study by Saunders et al. (2020) took an empowered approach over one's body through the selfies that were described as helpful to recovery. By taking an empowered stance, these women disrupt and reject the sexually objectified lens placed on them by the patriarchal systems that cause oppression and distress. Integrating post-feminist approaches into treatment through media literacy, may be a way to increase self-understanding and resist gendered prescriptions (Holmes, 2016). Using an empowerment lens, questioning prompts around media use may be of clinical use.

As the form and function of certain relationships were an important part of recovery for many, these findings also translate suggestions for care. Participants valued relationships that provided "tough love", people who were not overly surveillant but instead provided supportive structure and encouraged a sense of normality and expression of self beyond eating distress. Therapeutic relationships that centred around honesty, trust, patience, compassion, and a focus on the wider factors at play, were also ideas brought forward for clinical practice. The importance of building a strong alliance cannot be underestimated. Central to this is a clinician who can install hope, amidst difficulties. We must consider how collaborative relational care can be implemented in New Zealand. It is important while hope is instilled, clinicians also remain realistic about the on-going, process-oriented nature of recovery. Paying particular attention to how a person stories themselves and envisions recovery is key to a genuine approach that conveys a sense of understanding, and desire to support the person collaboratively.

With early intervention and psychoeducation an important implication, greater education must be implemented. Prevention requires an ecological approach for understanding the multiple interacting layers of influence across social contexts (Bronfenbrenner, 1979). At the centre of influence is an individual's immediate surroundings and relationships, including family, where an extension is needed into the community (schools), broader culture, and the economic and political systems of society (Cashel & Braun, 2007). In alignment with the prevention literature, participants believed there is a greater need for all young people, parents, teachers, and school communities to be better educated. Education will not only enhance support but reduce stigma and facilitate greater conversations around help-seeking. For parents to be better equipped through parent-child consults, these need to be more readily available. The findings suggest that education should not only focus on food and eating, but deconstruct diet culture, patriarchy, fatphobia,

contemporary western contexts of beauty and thinness (Musolino et al., 2016, Rich., 2018), sociocultural ideals and oppressions, and the role of social media when portraying "health" (Camacho-Miñano et al., 2019; Halse et al., 2009). There is a need for greater education towards body functionality and acceptance, and cross-cultural perspectives of distress (Pike & Dunne, 2015; Thompson, 1994). Visibility was a key theme across accounts, where services need to be better advertised across various public spaces (including gyms and recreations centres). This perhaps also reflects a need for more public awareness about eating-related distress, like the depression and anxiety campaigns in New Zealand. Reframing messaging from a passive help-offering stance; "*here if you need me"* to *"what can I do to support you?"* is a prime example.

Offering alternative ways to support people is important, particularly for those excluded from services or those who feel they are undeserving of treatment. Participants endorsed approaches they believed would be valuable to implement and advertise from a primary care level. These included peer support groups, self-help online therapy (application or website based), online recovery support groups inclusive to all eating-related distress, and low-cost treatment packages. Where peer support has demonstrated benefits through the normalisation of experiences, inspiration to recover, and sharing of insight, some risks include disingenuity and exposure to triggering content (Lewis & Foye, 2022). With multiple formats, the main feature of peer support is relating and reflecting experience. Given the importance of connection, group-based care was repeatedly identified as a form of support missing within the New Zealand context, despite, group-therapy for binge eating disorder used internationally (Peterson et al., 2009; Safer & Jo, 2010).

There is also a need for the GP and psychology workforce to be given frequent, up-to-date training on eating-related distress, particularly training on screening distress, health at every size, cultural expressions, and the implications of language use. The upskilling of GP's

in ED detection, management, referral, and supporting treatment has been called upon by parents of those experiencing distress, where mixed findings have been found for care received (Cribben et al., 2021). Australian GP's report minimal training in eating disorders, with difficulties in identifying, diagnosing, and managing eating distress (Aouad et al., 2022; Gooding et al., 2017). Similarly, it is important the psychologist workforce is increased and upskilled to meet the needs of those struggling with eating distress, teaching specific treatment models within clinical training programmes and using service-user perspectives throughout (Heruc et al., 2020).

Specific care must be taken to understand an individuals' positioning and power differentials when working as a clinician within the eating disorder field. It is important to note implicit biases and attitudes towards weight, as well as differences in body size between therapist and client and the implications of such positioning. Feminist literature insists on continuous self-reflexive practices, particularly noticing what is not being acknowledged and ways to build layered understandings while reducing differences in power (Ackerly & True, 2008). Utilising on-going and frequent reflexive practice in supervision is paramount to this approach. By naming any imbalances within the therapeutic relationship (where appropriate), the acknowledgement of such differentials can be used as a tool, rather than a barrier in treatment. Naming the "thin privilege", for example, is a form of self-disclosure that may also deconstruct power imbalances based on body size alone (Maine, 2008; Van Amsterdam, 2013). Self-disclosure around "food joy" (foods the therapist and client both enjoy in common) may be another way to increase therapeutic alliance and normalise food, aligning with a feminist and multi-cultural approach that advocates for self-disclosure as a tool to promote equality in therapy (Levitt et al., 2016).

Strengths, Limitations, and Future Research

In line with the epistemological underpinnings of this research, the focus of this study was to deepen understandings and constructions of recovery through a person's daily practices. These results describe the stories of eating-related distress among 15 adults living within New Zealand. A notable strength was participants self-identification of both eating-related distress and recovery. Self-identification allowed for a broader range of experiences beyond diagnostic classification.

This study was innovative through its daily life approach adapted from Del Rio Carral (2014), specifically engaging with a micro-level analysis of "typical", "good" and "bad" days in recovery. A micro-level analysis allowed for a deep exploration of daily practices across recovery, contexts, and across and within participants stories. While this allowed for nuanced insight into participant's experiences and meaning making processes across chosen days, "good" and "bad" also represent a binary categorisation, replicating dichotomous thinking styles (a common eating disorder cognition characteristic of an eating disorder). While participants were skilled in providing extensive detail, this questioning style may also be considered a limitation as it may replicate or encourage a cognitive style that is less helpful in recovery for some participants. For some, having clear structures in recovery was deemed helpful, therefore, this questioning may have also helped them articulate recovery depictions. While for others, a "good" and "bad day" orientation may limit the shades of grey that exist at the expense of a more fluid, flexible construction of lived recoveries.

A key finding was the re-appraisal of body appearance to function. While all participants in this study spoke to negotiating new ways of appraising their body, involving exercise, movement, and functionality, it is important to note that this re-appraisal is limited to able-bodied participants. A limitation of this study was that all participants were able-bodied individuals, thus, the experiences of men and people with physical disabilities were

beyond the scope of these findings. A large body of literature identifies a positive relationship between body functionality and positive body image (Alleva et al., 2015; Bailey et al., 2015). However, more complex is the story of how functionality relates to body image among people with disabilities and bodily differences (Rice et al., 2021). Although one participant in this research did classify as neurodiverse, this participants narrative on functionality omitted a discussion on neurodivergent positioning. Given that functionality was central across narratives, it would be important to explore this amongst people with physical disabilities in the future to see if there are any differences in articulations (Rice et al., 2021; Thomas et al., 2019).

While forty-five people expressed interest in participating in this research, only fifteen were included due to researcher and project time constraints. Inclusion of fifteen participants stories is considered a strength for this qualitative research project, surpassing original expectations of 10-12 participants. What was particularly strong was the varying lengths of interviews (approximately 1.5 hours, up to 2.5 hours) allowing for deep engagement surpassing researcher expectations. While the large expression of interest is also a particular strength attributable to the success of recruitment, this also speaks to the large number of people with lived experiences who want to share their story. This has made me reflect on the position of hope my research may have catalysed for others to share and make sense of their own experiences.

The diversity achieved across the participant sample can also be considered a significant strength. This study included identified ethnicities spanning NZ European, Malaysian, Chinese, Sri Lankan/Indian/NZ European, Filipino/Australian, British/Pakistani, NZ European/American, Filipino, South African, and multiple dual-ethnic identifications. This study had large diversity across sexual orientation (Heterosexual, Lesbian, Gay, Bisexual, Queer, Asexual) and gender diversity (Female, Non-Binary). Across a recent

scoping review of disordered eating and body image research in New Zealand spanning a 43-year time frame, studies often reported all female or mostly female samples with minimal exclusion of males and ethnic minorities (Cleland et al., 2023). They specifically highlighted the underrepresentation of minority ethnicities with the need for future research to increase diversity of sample, which I believe this study has achieved. While participants reflected diversity across sexual orientation, age, and ethnicity, this study was unsuccessful in recruiting participants identifying as Māori or Pasifika, despite prevalence rates suggesting that eating distress is at least as common in Māori populations as non-Māori (Te Rau Hinengaro, 2006; Lacey et al., 2020). While one male expressed interest in this research, no males were included. A paucity in male participants is not uncommon across the literature (Cleland et al., 2023; Johnson & Petrie, 1995; Thapliyal et al., 2018); however, this remains a significant limitation of this research and the field to date. Male experiences of eating-related distress are needed to understand how embodied expectations around masculinity are experienced and found to contribute to distress (Lavender, Brown, & Murray., 2017; Raeuvori et al., 2014). Insight into daily practices related to masculinity and muscularity, exercise, and body image practices, may illustrate an important understanding of identity construction among gendered roles. Similarly, research among males is needed to better inform clinical practice where eating disorders among males remain underdiagnosed and misunderstood (Strother et al., 2012).

Lastly, multiple narrative analytic processes were used to comprehensively and flexibly to explore the research question. As data was rich, complex, and multi-layered, there were still aspects of the data that could not be included in this project, for example, an in-depth discussion on service-user perspectives, treatment experiences, and stories of distress. While included briefly and deserving of more attention, the scope of the research questions did not allow for a more in-depth inclusion of these topics.

While the present research builds on and works towards filling some gaps in the existing literature, it also helps illuminate possibilities for future research. Future research would benefit from exploring lived experiences of eating-related distress and recovery among populations specifically marginalised in research thus far, specifically recruiting males, and/or Māori and Pasifika. Given the under-detection of eating-related distress among both these populations and barriers in detection and disclosure, research may illuminate crucial understandings needed to advance this space. Although it may be more difficult to recruit these groups, engagement of these communities must be considered from the outset, rather than relying on them to present as research participants. I envision careful thought must also be given to the languaging of "eating-related distress", perhaps, not best suited to all populations. I reflect on the learnings taken from my attempts to recruit Māori and Pasifika specifically. A discussion with the Māori librarian at Otāra Library left me reflecting on the importance of language across cultures. She described people she knew who would qualify for this study; however, questioned whether they would come forward needing clarification on what "eating-related distress" meant, a term she had not heard before. Perhaps, language simplification is needed. Future research is needed that is guided by cultural supervision, to ensure intentional and culturally appropriate languaging is considered. Although participants within this study spoke to culture as forming part of their recovery story, this study was not focused solely on cultural understandings of distress and recovery. However, building on this study and focusing specifically among Asian populations living in New Zealand could be an area for future research.

Although this research recruited diversely across sexual orientation, future research focusing specifically within a LGBTQIA+ population is needed to advance study findings. The oversight of gender diverse experiences has been a significant limitation in earlier feminist work. Eating-related distress is thought to be perpetuated by minority stress,

experiences of stigma, and discrimination, with eating disorders more prevalent in LGBTQIA+ individuals compared to their heterosexual and cisgender counterparts (Calzo et al., 2017; Nagata et al., 2020; Parker and Harriger., 2020). This is an area that requires significantly more research, where only recently has research explored experiences of eating-related distress among trans and non-binary individuals.

It would also be beneficial to understand eating distress and recovery in relation to socioeconomic status, given the present sample comprised of participants who predominantly identified as being in a privileged financial position. Situating an understanding of contemporary issues related to economic restrictions, such as food scarcity, is important. Eliciting narratives from adults across diverse socioeconomic positions, this may serve as a useful contrast to this research, further dismantling the myth between eating disorders and higher socioeconomic status (Gard, 1996; Gibbons, 2001). Similarly, while not the primary focus of this thesis but an important area that requires further attention, future research exploring people's treatment experiences (or lack thereof) is imperative. Treatment experiences and the implications this has on recovery and recovery construction is most important, to illuminate and hopefully instil change within the New Zealand health context.

While this research focused exclusively within an adult sample, the typical onset of eating distress begins in adolescence (Volpe et al., 2016). Given the emphasis on an ecological model for prevention, and the interconnected nature of adolescent eating-related distress and sociocultural standards both online and offline (Herrick et al., 2021), future research into recovery narratives among youth specifically would be important. Another possibility for future research would be a longitudinal study that would allow for narratives to be captured over time and developmental trajectories. By interviewing adolescents experiencing distress in early adolescence, early adulthood, mid-twenties, and late 30's, a

rich narrative will emerge across timestamps, development, and contexts. These findings may be enriched with the perspectives of families and/or teachers, situated within contexts.

Perhaps a few of the strongest narratives identified in this research was the re-appraisal of body image to functionality, aspects of identities that extend beyond illness, re-appraisal of routine and structure being individualised, and the influence of media as being both positive and negative. Future research that includes relational influences important to a person's recovery would also shed insight into the strengths and struggles of friend/family/partner/caregiver support, moving beyond an individual lens to a collective relational lens. Lastly, further research on the influence of media and recovery is needed, with the reliance on digital living during the COVID-19 pandemic that continues to change the ways we work, connect with others, and the ways people recover in such a context.

Concluding Comments

Eating-related distress and recovery are complex experiences, active processes, and on-going journeys across multiple contexts, identities, and social realms. This research analysed stories in relation to the contexts in which a person described their process of recovering. Stories transcend from the beginning of distress to recovery identification and present-day living. This research troubled the line between recovering and recovered, opting for a recovery "in" over a recovery "from" orientation. This research shared stories often untold, experiences deemed "not severe enough" for treatment, or diagnoses overlooked. Participants spoke to systems that were not best matched to their personal needs and recovery goals. Participants informed ways in which services and support could be better utilised to support people in similar circumstances. The current mental health system may have to undergo some significant changes to align with a genuinely personal recovery framework, centred around lived experience perspectives.

Attuning to complex social, cultural, and relational contexts, no two narratives were the same. Across all narratives, re-appraising identity, body image to functionality, nourishment, structure, and media was key. Participants formed intentional, active habits and rebuilt a life in recovery, an active process marked by everyday wins and meaningful day-to-day practices. Daily practices were instilled across all narrative types, centring around activities that elicited energy, pleasure, accomplishment, comfort, and control. Practices in recovery were best understood within contexts of distress, where recovery involved the re-appraisal of certain activities and the elimination of others. Some days were described as harder than others, speaking to the complex intertwining nature of eating distress and lived realities. All participants shared important insights, understandings, and constructions deeply situated within unique contexts, offering a counter narrative to the clinician and researcher recovery perspectives that have dominated the literature and guided service provision to date.

I hope that this research has provided reflection for professionals, services, and service-users alike. It is hoped that participants voices will be heard, stories will live on, and people will come forward to share their story in the future. I hope courage is instilled, hope carries on, and recovery is truly held as a possibility for all those who may be suffering. Lastly, may the voices of these participants speak loudly to the possibilities for recovery within treatment spaces, moving in a direction that better meets the needs of those recovering, against all odds.

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Appendix A. Participant Information Sheet

Exploring the Recovery Narratives of People with Lived Experiences of Eating-Related Distress

Participant Information Sheet

Personal Introduction

Kia ora, my name is Natasha Amarasekara and I am a Doctor of Clinical Psychology student at Massey University, Auckland. As part of my research, I am exploring stories of recovery by people with lived experiences of eating-related distress. My interest in this area came from my work experience in child, youth and adult residential settings in Ōtepoti (Dunedin) and Tāmaki Makaurau, I have supported several people struggling with complex eating, weight, and shape problems. I noticed that it was often the simple yet significant day-to-day practices and activities that impacted most on a person's well-being. It is these daily practices I am most interested in hearing about.

Why am I doing this study?

Before I give more details about the study, I would like to share a little bit about me and *why* I am doing this research. I was born in Hong Kong, am of Sri Lankan descent, and grew up in Tāmaki Makaurau (Auckland). I aim to explore the ways in which people make sense of their distress and personal recovery in their own contexts. I am particularly interested in stories that often don't get heard. Hearing these stories can help us get a fuller picture of "recovery" in context, beyond what we already hear about recovery from a clinical/medical perspective.

An Invitation to Participate:

You are invited to take part in an interview about your experiences of eating-related distress and stories of recovery. Participation is voluntary and it is okay if you choose to take part but change your mind later. Before you decide, you may want to talk about the study with your support people, such as whānau/family, friends, cultural advisors, or healthcare providers, in order to make an informed decision about whether to take part.

Who can Participate in this Study?

If you have struggled with eating, experienced a relationship with food, weight, shape and/or exercise that you found challenging or problematic, but are doing better now than you have in the past, I want to hear from you! There are no criteria for what counts as "eating-related distress" or how "recovered" you are. You do not need to have been diagnosed with an eating disorder to participate. "Recovery" involves self-identifying as doing better now than you have in the past. As an ethnic minority living within a dominant western society, I am particularly interested in diverse experiences/people. I extend a specific invitation to people who may be living within underserved, underrepresented communities and groups in Aotearoa, New Zealand.

You must be at least 18 years old, self-identify as having/had experience with eating-related distress, and identify as doing better now than in the past relative to your own experiences of distress. You hold the best knowledge of your needs and experiences, so you are in the best position to make an informed decision on whether this research is something you want to and can do. I am interested in hearing *your story*, how you define distress and recovery, and what this looks like on a daily basis for you.

What will I be doing, if I choose to Participate?

If you choose to participate, you will be invited to a 1-2 hour interview at a time and place most convenient to you either in person (e.g., in a private room in a public community hall/library, or Massey University School of Psychology), or by Zoom. You are welcome to bring a support person along. Prior to the interview you will be asked to sign a consent form. I would like to talk to you about your daily life: a typical day, a day where you felt good, and a day you felt less good. You will guide the conversation with your story, choosing what to share, when you share, with the terms you use. You do not have to talk about anything you do not want to and can stop/pause at any time. The interview will be audio-recorded and transcribed (written out word for word); identifying information (e.g. names and places) will be removed. I will ask you to choose a pseudonym (fake name) that will be used to refer to you in write ups. A few weeks after the interview, you will have the opportunity to review the transcript, where you can add/delete/clarify anything you have said. Reviewing the transcript may take a further 30 minutes. Once you are happy with the transcript, you will be asked to sign a "transcript release form", allowing us to use your interview for our research. As a token of appreciation for your time and participation in the study you will be given a Prezzy Card to the value of NZ$30. Hot and cold drinks and biscuits will be shared at the interview, if you wish.

What are the Benefits and Risks of this Study?

By sharing your experience and knowledge, you will help us learn how to better support and understand recovery. Asking people how they orient to the concept of recovery helps to shift the expert discourse on *whose stories matter*.

I will contact you the day before the interview to check-in that you are still willing and able to participate, in case your circumstances change. You can withdraw at any time before the transcript release form is signed. While I do not anticipate any harm in you participating, it is possible that sharing your story may bring up a range of emotions for you. If you become distressed during the interview, the interview can be paused/stopped at any time and extra support can be facilitated.

What Happens after the Study Finishes?

To protect your information, all digital documents will be password protected. All printed information will be stored in a locked filing cabinet at Massey University for five years. You have the right to access a summary of the study findings and to provide feedback about the study. If you wish to see the results, these can be distributed to you when they become available, I can meet and discuss them, email them to you, or we can talk over the phone.

Who Approved this Study?

This study is being done by researchers at Massey University and funded by Massey University. This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 21/04. If you have any concerns about the conduct of this research, please contact Dr Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43347, email humanethicsnorth@massey.ac.nz

My supervisors for this project are Associate Professor Joanne Taylor, Dr Kirsty Ross, and Dr Andrea LaMarre. They are all part of the School of Psychology at Massey University.

Who do I Contact for more Information, or if I have Concerns?

If you have any questions, concerns, or complaints about the study at any stage, you can contact:

Natasha Amarasekara
Clinical Psychology Doctorate Student
Lead Researcher
natasha.amarasekara.1@uni.massey.ac.nz

Associate Professor Joanne Taylor
Primary Project Supervisor
Email: J.E.Taylor@massey.ac.nz

For Eating Disorder Support: Eating Disorder Associations of New Zealand (EDANZ):
Helpline 0800 2 EDANZ.
Website support www.ed.org.nz

A List of National and Specialist Helplines can be found: https://www.mentalhealth.org.nz/get-help/in-crisis/helplines/: including

- **Healthline** (0800 611 116)
- **Lifeline** (0800 LIFELINE)
- 24/7 support from a trained counsellor (1737)

Peer Support Services: Auckland Central 0508 927 654 or 0508 WARMLINE

Appendix B. Research Advertisement

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

AN INVITATION TO PARTICIPATE:

Exploring the Recovery Narratives of People with Lived Experiences of Eating-Related Distress

Are you 18 years or older?

Have you ever struggled with eating, food, shape, weight and/or exercise?

Have you found a way to limit the impact eating distress has on your day-to-day living?

Do you currently identify as doing and feeling better now than you have in the past?

I would like to invite you to participate in this study

Kia Ora, my name is Natasha Amarasekara and I am a Doctor of Clinical Psychology student at Massey University, Auckland. I was born in Hong Kong, am of Sri Lankan descent, and grew up in Tāmaki Makaurau (Auckland). As part of my research, I am exploring recovery stories of people with lived experiences of eating-related distress.

I am interested in hearing ***your* story;** how you make sense of your eating-related distress and recovery and what recovery looks like for you on a day-to-day basis

There are no criteria for what defines "eating-related distress" or how "recovered" you must be. If you are 18 years or older, experience distress around food/kai, weight, shape and/or exercise, and have found ways to limit its impact on your daily living (identifying as doing better now than in the past), I would love to hear from you! I extend a specific invitation to those of you that may be living within underserved, underrepresented communities and groups in Aotearoa, New Zealand. Hearing stories that often don't get heard can help us get a fuller picture on "recovery" in context.

The study will consist of a one-on-one interview which will take approximately one hour, guided by your story. As a token of appreciation, you will be given a $30 Prezzy Card for your valuable time and input.

If you are interested in this research project and would like to take part, please contact me for further information at natasha.amarasekara.1@uni.massey.ac.nz

Te Kunenga ki Pūrehuroa

Massey University School of Psychology – Te Kura Hinengaro Tangata
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Appendix C. Pre-Interview Questions

After reading the information sheet if you are still interested, I have a few pre-interview questions just checking-in around your ability and willingness to participate. This will give me a sense of where you are at, in terms of your distress and recovery, and this will also provide another opportunity for any questions you might have.

Could you please answer the following questions?

1. What intrigued and/or inspired you to take part in this research?
2. Where did you see the advertisement, or hear about the research?
3. Have you had a chance to read the information sheet, and do you have any further questions before the interview starts?
4. Have you had a chance to discuss the decision of participating in this study with your support network? If not, do you plan on doing so?
5. Could you briefly tell me about your experiences of eating-related distress, and identification with recovery currently?

Appendix D. Interview Guide

Exploring the Recovery Narratives of People with Lived Experiences of Eating-Related Distress

Interview Guide

1. **Whakawhanaungatanga (introduction/sharing process), questions participants may have, informal conversation to build rapport and researcher trustworthiness, option to open and close with a Karakia/phrase/whakatauki**

Example opening blurb: Thank you so much for taking the time to take part, this research wouldn't be possible without your expertise and generous time and willingness to share your story. I'm completing this research as part of my Doctor of Clinical Psychology training at Massey University. I'm really interested in hearing your experiences and stories on what recovery is like from those actually doing the recovering themselves. I am particularly interested in your day-to-day contexts and relationships, what recovery looks like in your day-to-day life through the ordinary yet significant moments that may paint a bigger picture on how distress and recovery play out for you.

Before we begin, there's just a few last things I would like to clarify. The interview is all about what you want to tell me, so it will be more like a discussion with me listening a lot. I will begin by asking a few opening questions, however with the exception of these, the rest of the interview is largely up to you. It is important you know that I don't expect you to tell me any details about your experience that you are uncomfortable sharing. Anything and everything you tell me is valuable, as I am really just interested in hearing your story and learning from your experiences.

2. **Demographic/Baseline Questions**

    1. What pseudonym would you like to choose? (fake name)
    2. What is your age?
    3. What cultural group/ethnicity do you identify with?
    4. What is your gender? Sexuality?
    5. How long have you been experiencing distress and self-identify as recovered/recovering?

6. Have you accessed treatment before. If so, are you currently engaged in treatment or intervention?
7. Have you been given a diagnosis, if so what was this?

3. **Pre-interview questions**

- What intrigued and/or inspired you to take part in this research?
- Where did you see the advertisement, or hear about the research?
- Have you had a chance to read the information sheet, and do you have any further questions before the interview starts?
- Have you had a chance to discuss the decision of participating in this study with your support network? If not, do you plan on doing so?

At the beginning of the interview, the researcher will clarify any further questions or concerns participants might have. As participants have been encouraged to discuss this study with their support people prior to making a decision whether or not to participate, the researcher will informally check-in around this. Each participant will be reminded that they can let the researcher know if they are feeling distressed or triggered at any time, and the interview can then be paused or stopped if they wish.

4. **Semi-Structured, Participant Focussed Interview Schedule:**

Interviews will be conversational in nature to encourage rapport building and to follow participants lead as they share their stories and experiences in manner in which they choose. The interviewer (lead researcher) will ask prompting/clarification questions to facilitate this process, however largely taking the role as an active listener in the interview. These conversations will be guided around the following areas:

1. **Preferred terminology; self-definition and identification of distress and recovery**

e.g.

- “What words would you use to describe your experiences of eating-related distress?”
- “Is there a preferred term you use to define this?”

- "How do you feel you are doing right now, compared to in the past?", "Is there a word you use to refer to the state you are in or the path you are on?"/"What is your preferred terminology?"

[from here; researcher will use informants' preferred language/terminology/definition/identity]

2. **Daily life approach**

The lead researcher would begin with broader questions, allowing the participant to determine the sequence and time spent discussing what is most important to them.

e.g.

- "Can you talk me through a typical day from the moment you woke up until the moment you went to sleep?"
- Can you talk me through your morning routine?

If the participant needs some more encouragement to **elaborate** on their accounts or to provide examples they may be prompted with questions like:

- Can you give me an example of that?
- Can you tell me a bit more about that?
- How did you decide on [XX]
- What made you XX [exploring motivations underpinning everyday practices]
- Who did you, Who is [exploring relationships]
- Descriptive content probes e.g. "At what time do you wake up?" for more depth
- How did that affect your [recovery] or [day – activities, relationships etc]

e.g.

- "Can you talk me through a day where you felt good; (*felt good*, in terms of eating-related difficulties specifically)"

- "Are there any specific people, places, things, situations, practices or activities that surround the feeling of a good day?

- "Can you talk me through a day where you didn't feel so good; a day where eating distress may have impacted you more than usual for example"
    - Are there any specific people, places, things, situations, practices or activities that surround the feeling of a not so good day?

3. For those who have accessed services/formal intervention or treatment

Please note, not all individuals will have had access or experience with intervention or treatment, however, among those that have, it would be interesting to contrast such experiences.

e.g.,

- "You mentioned that you have accessed treatment before, what impact do you think treatment had on your eating-related distress and how do you think this impacted the position you're in today?
- What services and/or support might people need to help them through eating distress?
    - What might those services look like?

4. Example questions to prioritise wellbeing during the interview

E.g.,

- "I'm sorry you went through that. Thank you for sharing that with me"
- Managing distress during interview:
    - "Would you like to take a break? You can stop or pause the interview at any time and we can move on from that topic if you like?
    - Are you okay, would you like me to make you a cup of tea or coffee?
    - Who can we call for support?
    - Is there anything I can do to support you here and now?

Appendix E. Research Case Study

RESEARCH CASE STUDY

A Personal Recovery Focus: How my Doctoral Research Contributed to my Clinical Practice at Nurture Psychology

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Student ID: [redacted]
Setting: Intern Psychologist at Nurture Psychology

This case was completed during internship at Nurture Psychology in 2022 and represents the work of the candidate

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Date: 28/10/22

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_____
Date: 28/10/22

Abstract

This case study outlines the contribution and learnings of my doctoral research as applied to my clinical practice as an Intern Psychologist at Nurture Psychology. The case study opens with a reflection on my own standpoint within the field, acknowledging my own identity, privilege, and positioning. I provide a summary of my doctoral research as relevant to this case study, outlining background information, research aims, and methodology. Reflections then follow on how my research experience contributed to my development as a practitioner working within an eating-disorder specialist private service, specifically, the areas of my practice that are informed by a personal-recovery model and the findings of my research. These reflections overview both adaptations made to my practice as I applied a personal-recovery model within a clinical space and the tensions that arise. Adaptations in my practice informed by my research include person-centered language, utilising a daily life approach within assessment and treatment, and celebrating personal recovery milestones beyond psychometric indicators alone.

Reflexivity

To begin this case study without a reflection of my own standpoint would be contradictory to my stance. I position myself in this writing from a place of privilege as a thin, young, female academic and early practitioner. Presently, as a young woman living and working as an ethnic minority within a dominant western society, I am at ease with myself and my body – comfortable and confident with who I am.

Although I do not draw from a place of lived experience of eating-related distress, I draw from lived experiences surrounding the complexities of embodiment and weight stigma. As a female acculturated to a western world, I grew up at odds between two identities: ticking the "other" box when identifying as Sri Lankan limited strictly to paperwork. Eventually, I realised that the western world does not cater for the health complexities and intricacies of those who fit into an unspecified categorisation; a minority amongst a dominant culture, an outlier on a graph. Throughout adolescence, I experienced frequent weight stigma. Assumptions were made about my eating based upon my physiologically smaller body shape and weight, deemed "severely underweight" by body mass index parameters. Embarrassment, shame, humiliation, over-explaining and justification, were some of the many feelings and reactions this provoked at the time. I reflect on how damaging such discourses are, for those in smaller bodies and larger bodies alike, when society reflects assumptions and preconceived notions around body shapes, sizes and eating practices. This experience crystallised my more recent passion for Health At Every Size, introduced to me by my former supervisor who has taught me all that I know and have yet to learn about weight-inclusive, health enhancing, respectful care. This is an area I hope to fully adopt into my clinical practice, one that is personally and professionally value aligned.

My academic experiences have also undoubtedly shaped who I am and the lens in which I view distress and recovery, recognizing that my role as an Intern Psychologist will

continue to influence my research and practice. I also reflect on my former education, where it wasn't until my third year of postgraduate study that I was introduced to the concept of consumer recovery. Before this, my clinical education was predominantly within the dominant biomedical paradigm. This realisation was a pivotal turning point for my research career, changing from a quantitative biomedical approach to a qualitative lived experience perspective. The accounts of those with lived experience have truly touched me, inspired me, and sparked in me a desire to explore recovery beyond the limiting categories in which we are taught. I am passionate about hearing stories from others within underrepresented and underserved communities who may struggle with eating-related distress, particularly stories that are often not told or narrated under popular discourses. I believe I am joining many others in clinical psychology who are beginning to critique and be critical of dominant narratives of mental health. I do not see this as a negative; in fact, I feel privileged to have a foot in the door, so to speak, into two realities. I hope my future professional career is eclectic in choosing merit from both paradigms. Reflexivity is crucial for this case study, with ongoing reflection necessary to attune to the bidirectional impact of my own beliefs, attitudes and experiences on research and practice.

Doctoral Research Overview

My doctoral research focussed on the narratives of recovery among adults with lived experiences of eating-related distress. I examined ways of understanding and constructing recovery situated within sociocultural contexts and relationships, particularly, the day-to-day practices and self-identification processes of distress and recovery. This overview includes a description of the background literature, the aim, and methodology of this project. Greater background detail is provided about the aspects of this research which I will subsequently reflect on in my role as an Intern Psychologist.

Background Literature and Aim

What constitutes eating-related distress, and similarly, what is defined as recovery from such distress, is an area of contention across the literature (Grilo et al., 2008; Wade & Lock, 2020; Whitley & Drake, 2010; Wonderlich et al., 2007). Current understandings of recovery are influenced by the lens through which recovery is understood, the perspectives that are given space, and the sociocultural and political contexts in which recovery occurs (Duff, 2016; Wade & Lock, 2020).

Clinical research explores eating-related distress through the lens and language of "eating disorders", framing experiences within a biomedical perspective with an emphasis on *psychopathology*, *illness*, and *disorder* (e.g., Bardone-Cone et al., 2010; Tomba et al., 2019). While a biomedical approach has its merit, many critical feminist scholars question its use, specifically the language around the term "eating disorder" implying pathology located within the individual (Malson & Burns, 2009). Instead, understanding eating problems as a survival strategy shifts the focus and power from gendered femininity based upon appearance to a deeper understanding of the complex intersect between trauma and eating-related distress (Brewerton, 2019; Gur & Keren, 2018). Despite this understanding, feminist theories on

eating problems have not been taken up in dominant frameworks to date (Ferreday, 2012; Holmes et al., 2017; Malson, 1998; Orbach, 1985).

Similarly, academic and clinical definitions of recovery are often rooted within the dominant biomedical model (Berkman et al., 2007; Murray et al., 2018). The definition of recovery traditionally outlines sustained remission and long-term reduction or absence of symptomology accompanied by functional improvement to pre-morbid levels of functioning (Slade et al., 2008). Within this, outcome and recovery are often conflated. In contrast, the language typically used when framing experiences within a personal recovery framework are more person-centred, defined by the *person* and their *individual experiences* (D'Abundo & Chally, 2004; LaMarre & Rice, 2016, 2021). The recovery model privileges knowledge gained through personal experience, where symptom remission is not necessary to recover/y but instead "recovery in" as opposed to "recovery from" is better aligned.

While there is a body of qualitative research on eating distress and on stories of recovery, there is limited research for people in recovery to speak candidly about their day-to-day experiences. Outside of the eating disorder field, researchers have engaged with using descriptive interviews that explore a "day in the life" approach, an activity-based methodology that develops in-depth data from day-to-day experiences (Del Rio Carral, 2014). This approach adds value through micro-contextualising day-to-day life practices and relationships, allowing for a greater exploration of a person within their social contexts.

Aim. The aim of the research was to explore the narratives of recovery in adults with lived experiences of eating-related distress, by examining the ways of understanding and constructing recovery deeply situated within sociocultural contexts and relationships, the day-to-day practices of distress and recoveries, and self-identification processes. Reconsidering what people mean by the terms they identify with broadened and deepened understandings, shifting perspectives on what constitutes recovery. With a focus on the sociocultural contexts

in which living is done and recovery is negotiated and navigated, I was most interested in the day-to-day practices, relationships, and contexts that have helped people navigate a self-defined state of personal recovery. The project was designed to contribute knowledge to the providers of care and hope for those living recovery. I hoped to integrate this knowledge within my own practice attuning to both the *person* and their daily practices of recovery.

Methodology

A qualitative approach was taken. The research was grounded in a social constructivist paradigm within a post structuralist narrative theoretical approach.

Participants. Fifteen participants were recruited between the ages of 19-47 years of age, living across Auckland, Dunedin, and Christchurch. Participants identified as Female or Non-Binary, across various ethnicities (Chinese, NZ European, East Asian, South African, Malaysian, Filipino, Australian, British/Pakistani, mixed). Participants were eligible to participate in this study if they were at least 18 years old, had experiences of eating-related distress (struggled with food, shape, weight, and/or exercise), and identified as having found a way to limit the impact of distress on daily living, particularly, identifying as doing and feeling better now than they have in the past (relative to their own experiences).

Procedure. Recruitment was predominantly conducted through wide community outreach and supervisory and researcher relationships across both the clinical and non-clinical spaces. Given the importance of including the stories of people with diverse experiences (included but not limited to those from different cultures, ethnicities, genders, and age categories), a special invitation on the advertisement and information sheet called for underrepresented and underserved groups and communities in Aotearoa, New Zealand. Following participant expression of interest and suitability, a time and place was arranged for the interview. Ten interviews were conducted through Zoom to accommodate for COVID-19

and participants living outside of Auckland. Interviews took between 1 hour and 26 minutes, to 2 hours and 22 minutes. Audio recordings were typed verbatim, and participants were given the opportunity to review their transcripts.

Data Analysis and Setting up the Narratives. The epistemological, theoretical underpinnings, and method of data collection was primarily aligned with a narrative thematic approach. Transcripts were first analysed using a holistic interpretive approach where both the content and form of the stories are considered as a whole unit as opposed to being parsed into smaller units for crosscutting themes (Murray, 2015; Riessman, 2008; Spector-Mersel & Knaifel, 2018). Each narrative began with a description of the key narrative features, honing in on daily practices and weaving together threads of participants' stories of distress alongside recovery, as participants spoke about both tandem to each other. Over-arching narrative types were devised based on broad themes across and within narratives illustrating intentional daily practices. Four narrative types were constructed: *Re-Appraising Body, Image, and Identity, Neutrality and Nourishment, Structure and Routine, and Media and #Recovery.*

Clinical Psychology Internship Reflections

My internship began in February 2022 at Nurture Psychology, a private practice specialised in eating disorders and common co-morbidities. The following reflections were made within the context of my work at this service, informed and privileged by the knowledge gained from my clients who presented with diversity across age, ethnicity, gender, and distress. The main reflections and contributions of my research within clinical practice include the power in self-identified labelling, taking a daily life approach within both assessment and treatment, celebrating personal recovery alongside quantitative clinical recovery markers, and commitment towards Health At Every Size approach.

Self-Identified Labelling of Distress

Passionate about widening the umbrella on distress beyond discrete diagnostic categories, I utilised self-identification and labelling of distress viewing those with lived experience as experts of their own experiences. Intentionality with my language use was central to this. Across my practice I opted for more general language use such as “disordered eating” rather than choosing to refer to specific diagnostic categories. My belief is that all clients who presented for treatment would benefit from psychological support in some shape or form, regardless of diagnosis. Therefore, I often kept diagnoses out of this discussion if it was deemed unhelpful for them to have made explicit to them. This is at contrast to the public system where clients are required to have a diagnosis on file, to access support. What was more important within my practice was a collaborative formulation for the client to understand their experiences within wider sociocultural, relational, and cultural contexts.

I often spent the first session of treatment taking time to illustrate a disorder-specific formulation, tailored to the client. This involved collaboratively drawing the cycle out with the client, synthesising relevant information gathered from the assessment. I would aways

begin this cycle by focussing on the core issue that brought them to therapy, binge eating, for example. Instead of assuming the clinical term was how they identified with the problem, I would take the time to ask them what/how they would like to self-define their distress. Many clients stopped to think and described never being asked this before. For some who had received multiple diagnoses across their lifetime, this was a therapeutic moment as it allowed them agency over their own presenting issue and history. Clients with diagnoses that reflected assumptions or stigmatisation within itself (for example, Atypical Anorexia), attributed wider meaning to the presenting issue and were relieved at the chance to choose how they wanted to identify. For some participants, this meant describing their problem more contextually (as I had seen several participants do within my own research). Examples include restriction as a "coping mechanism", "a survival strategy", "a form of self-harm", Binge eating labelled "over-eating" or "emotional eating". An understanding of the context in which disordered eating/distress occurred was co-constructed between the client and myself, where I endeavoured to use their chosen terminology throughout treatment. By creating space and holding a discussion on self-identification, this simple yet therapeutic stance allowed for greater therapeutic alliance and actively reduced any power imbalance in the room.

Daily Life Approach Utilised in Assessment and Treatment

It is through the utilisation of a "day-in-the-life" approach that my research adds unique value probing into the contexts and meanings ascribed to daily activities and practices in recovery. I aimed to translate this micro-contextualised daily life approach to my clinical practice across both assessment and treatment. Within assessment, I utilised a "typical day" questioning style to probe into a client's intake from the morning they woke up to the moment they went to sleep. While this illustrated not only important eating disorder information (intake, frequency, amount, variety, and food rules), this also allowed for a

deeper contextualisation of distress. Probing beyond a standard typical day questioning style, I showed naïve curiosity when exploring meaning behind practices, attuning to sociocultural contexts and relationships that helped or hindered eating practices. This included exploring morning and evening routines in detail, probing into acts of self-care, hobbies, or the lack thereof. This approach also allowed for the collection of information around living situation, employment, alongside other baseline measures such as sleep, mood, physical health. When done well, this collaborative and conversational style of assessment gathered a lot of rich information but more importantly attuned to distress and hope for recovery within contexts. One aspect of my research that I did not bring into clinical practice was the notion of a "good" and "bad" day, a binary categorisation which may possibly perpetuate black and white thinking styles (a common eating disorder cognition held by clients and targeted in treatment). While clients often compared their typical day to fluctuations in their distress, it was important I was careful with my own language recognising my own possible role in perpetuating a cognitive style and view of recovery that may not be as helpful or realistic to the various shades that exist. Instead, I was deliberate around conveying the various shades to recovery that often exist and speaking openly about the curvilinear process this often entails. If clients had a "bad" recovery day, we had open discussions around more helpful ways to view the lapse/slip, utilising a more fluid, flexible view on recovering.

Throughout treatment, clients utilized a self-monitoring tool (Recovery Record) that allowed for real-time logging of eating, activities, thoughts and feelings within context. I encouraged clients to use this tool flexibly – putting in the context in which disordered eating behaviours occurred. This allowed for a deeper awareness of practices and people that both hindered and helped recovery and allowed for greater insight into the context in which clients navigated recovery for me. This allowed me to draw on wider discussions and enabled us to work effectively at spotting common triggers across contexts.

Highlighting both Personal Recovery AND Clinical Recovery

Evidence-based practice in the scope of clinical psychology involves the careful selection and utilisation of psychometric measures with strong validity and reliability to guide treatment (Wood et al., 2012). The use of psychometrics are an important part of my practice as I gathered Pre-Assessment, Session 6, Session 10, and Discharge data points and utilised these results at review sessions throughout treatment. Notably, several clients displayed a significant reduction in scores across the Eating Disorder Examination Questionnaire (EDE-Q), Clinical Impairment Assessment (CIA), and the Depression and Stress Anxiety Scale (DASS-21), at the point where a review session was placed under Stage Two of the CBT-E treatment framework (between Session 6-8).

While psychometric scores were a crucial and helpful part of my clinical practice guiding treatment focus and length, an additional focus on qualitative recovery was brought into practice guided by my research. Personal recovery moments were celebrated weekly, the small yet monumental "wins" clients experienced within and across daily practices. For example, no longer habitually checking the calorie count on the back of a biscuit packet, feeling fully connected and engaged in a conversation when previously distracted by thoughts around food, ordering takeaways intuitively when previously plagued by food rules around "good" versus "bad" food. These moments were documented through daily self-monitoring, and highlighted in session within the initial check-in. I took the time to document these wins in clinical notes and generated a list at both the review session and end of treatment, as a point of reflection on all the small yet monumental moments of personal recovery that became additive over time. Naming the makers of personal recovery that extended beyond psychometric measures was particularly important for client's who did not feel their progress graphs were valid, or disqualified the positives with the core belief that they were never "sick

enough" to begin with. It was also particularly powerful as a strong memory into a window of time, a time that felt so different to the present which displayed to them how far they had come. I reflect on one client in particular who held a lot of mistrust towards treatment and resistance towards me initially. By the end of treatment not only were clinical recovery markets evident across psychometrics, I noticed significant improvements in the way she interacted and communicated with both me and her partner. I reflected on the quality of the therapeutic alliance and named the initial resistance and mistrust. When trust grew and the client learnt more about her defences and attachment styles she was able to shift her typical patterns of communication which led to significant changes within and beyond her recovery. These recovery wins go beyond the EDE-Q, CIA, and DASS and reflect an overall shift in identity, attachment, understanding of self and distress within and across contexts.

Health At Every Size

A final point that continues to be an area of on-going clinical development is the incorporation of a Health At Every Size (HAES (Bacon & Bacon, 2010) approach. With an interest in how people in diverse bodies navigate both distress and recovery from my research, this naturally aligned well with a HAES orientation. I worked with several clients across diverse cultural backgrounds and body shapes and sizes, soon recognising the limitations of CBT-E when applied cross culturally and for people in larger bodies. I began upskilling in this area, fuelled by my original research interest recognising the need to understand weight-stigma/fat-phobia and intersectionality more thoroughly. By acknowledging the multiple and intersecting identities clients brought into the room, I as a clinician could begin to recognise and attend to the full complexity of the clients' experiences. I began to recognise the various ways in which weight-stigma presents across both research and practice and became committed to doing better. With careful and close

supervision around this, I teased apart the importance of languaging and communication, creating a safe and comfortable physical environment, checked in with my own implicit biases as/if they came up, and considered the clinical versus individualised rationale for weighing. I was guided by the five principles of HAES; weight inclusivity, health enhancement, respectful care, eating for well-being, and life-enhancing movement. I recognised assumptions made based on body type and strived to do a more thorough assessment holding little assumption, this included, asking about food scarcity and restriction regardless of body shape/weight. I focussed on creating a safe place for all clients, naming my own thin-privilege at times when it was getting in the way of our therapeutic relationship. Overall, I am committed to learning more, striving to do better, and always respectfully doing my best.

Concluding Statement

I feel privileged to have been able to work in a clinical space that complements my doctoral research and allows me to bring in practices, informed by the lived experience perspectives gathered from my research. The merging of two worlds was foundational to my personal and professional development as an early researcher and clinician in the eating disorder field. I feel privileged to have heard various stories from my clients and research participants alike. I put all that I know to their own experiences and their willingness to share their story. These stories showed me the various shades of self-defined recovery that exist beyond clinical criteria, an important theme through all these stories was the hope and resilience. I hope to continue to integrate these learnings into my clinical practice and be informed and guided by the true experts – people with lived experiences of distress navigating the journey of recovery themselves on a daily basis. I have a lot more to learn, but I strive to take each lesson with me into future practice.

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