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Exploring Assemblages of Irritable Bowel Syndrome, Dietary Practices and Disordered  
Eating / Eating Disorders

A thesis presented in partial fulfilment of the requirements of the degree of

Doctor of Philosophy

in

Health Psychology

at Massey University, Albany, New Zealand

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2026

## **Abstract**

Diet plays an important role in the management of irritable bowel syndrome (IBS). Individuals, with and without their health care professionals, often adopt dietary interventions or undertake dietary adjustments to help self-manage their condition. Higher prevalence rates for disordered eating and an increased risk towards eating disorder development have been observed within IBS populations, however it is unclear how to interpret these patterns with the wider relational and temporal contexts of IBS related dietary practices having received little attention. Drawing on 26 semi-structured online interviews conducted with women from Aotearoa New Zealand and the digital photo diaries they created, this qualitative study explored the intersection between dietary practices prescribed and/or adopted for the management of IBS and disordered eating/eating disorders. Informed by DeleuzoGuattarian concepts of assemblage, becoming, territory, the refrain, stratification, rhizome, understandings of time as non-linear and the DeleuzoSpinozist question 'what a body can do', a post qualitative analytic process was undertaken to explore how different IBS related dietary practices were produced through various 'IBS eating assemblages'.

Findings highlight how IBS related dietary practices were shaped by various bodily, relational, temporal and socially stratifying components (such as norms, feminine appearance ideals, postfeminist healthism and healthy eating guidelines) which assembled in various configurations to produce new and different ways of engaging with (and avoiding) food. Bodily precarity experienced in relation to the sudden and unpredictable nature of severe and debilitating symptom onset, meant that restricted dietary practices were often necessarily adopted to enable bodily stability and life continuity, leading to new and different understandings of healthy/unhealthy eating.

For some, IBS related dietary practices had produced new and affirmative ways of engaging with food. These included extending the process of eating beyond the individual, engaging with the material and sensory aspects of food and deeply attuning to embodied sensations in ways which facilitated intense feelings of wellness and enhanced social

connections. However, for those with histories of food/body distress, IBS related dietary practices which had necessarily required the elimination or avoidance of certain foods or food groups, had the potential to create new hierarchies of food avoidance which made food/body management more difficult.

These findings have implications for how dietary practices considered problematic within 'normal' populations, might be understood as adaptive, functional and health enabling by those managing IBS symptoms. Findings may further enrich understandings of IBS related dietary management in ways which may assist health care practitioners, dietitians and researchers to better support women with IBS.

## **Acknowledgements**

I would like to start by acknowledging my amazing supervisory team Prof. Sarah Riley, Dr Kathryn McGuigan and Prof. Kirsty Ross. I cannot put into words how grateful I am for your time, feedback, suggestions and for helping shape this research project. Thank you for enduring my terrible Deleuzian jokes, and for reading some of my earlier drafts (sorry!) until I was able to start establishing my own lines of flight!

I would especially like to thank Sarah (and Prof. Chris Setephens) for enduring with me through a Karen Barad reading group (a theoretical framework which I didn't even end up using!) and various other post-humanist articles. It is only now, that I am able to reflect and fully appreciate the true value of these sessions, and I am deeply grateful for your time and the ongoing effort you made over the past few years to foster my academic development – I am more appreciative than I can possibly express on an acknowledgments page. Thank you.

I would also like to thank Dr Andrea LaMarre as one of my initial supervisors, who returned to Canada during the first year of my PhD. I am extremely grateful for your time, feedback and guidance throughout the planning phase of this project.

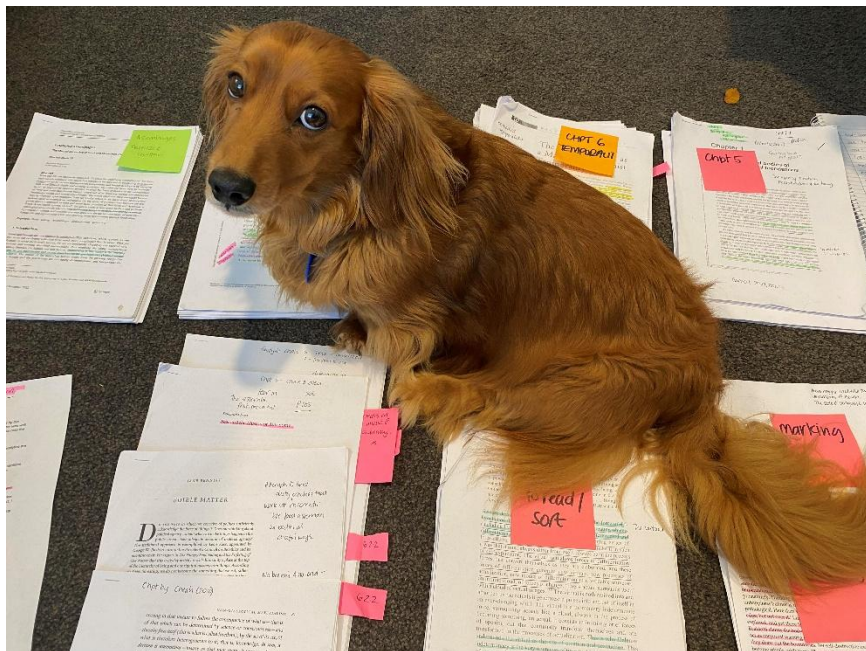
Thank you to Dr. Siobhan Healy-Cullen and Dr. Jessica Tappin, two wonderful members of the Health Psychology team, for their words of encouragement along the way.

I also extend my thanks to my thesis examiners and confirmation panel, Associate Prof. Keith Tuffin, Prof. Chris Stephens and Dr. Clifford Van Ommen – thank you all for your time, feedback and recommendations.

I would particularly like to acknowledge the 26 women who participated in this research project. Thank you to each of you for responding, agreeing to participate, taking the time to collate digital photo diaries and so generously donating your time to this research. It was an absolute pleasure to meet each of you and a privilege to have been entrusted with your stories, experiences and perspectives. Your enthusiasm towards this project and desire for better ways of understanding IBS, made the data collection and analytic process a

thoroughly enjoyable experience. Your contributions were paramount to the successful completion of this research project and I am extremely grateful to you all.

Thank you finally to my husband Jason for his tremendous support throughout this long rhizomatic process, and for his willingness to spend many hours doing other things whilst I completed this research. I also acknowledge the two furry non-human components of this research assemblage, Baxter and Cooper, who sometimes helped (but mostly hindered) this project in various ways.



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## **A Preliminary Line of Flight**

I commence this thesis with a brief introductory line of flight, to provide an overview of how this thesis works, what it functions in connection with, and to highlight how, in places, it may proceed differently to more traditional thesis formats.

This thesis is theoretically informed by the philosophy of Deleuze and Guattari (1987) and feminist new materialism frameworks. Throughout the following chapters, I draw on the DeleuzoGuattarian concepts of assemblage, becoming, territory, the refrain, rhizome, understandings of time as non-linear and 'what a body can do', to provide a dynamic, relational framework through which to think differently about IBS related dietary practices.

This DeleuzoGuattarian theoretical framework also informs the format of this thesis. Deleuze and Guattari (1987) explain that "Every rhizome contains lines of segmentarity according to which it is stratified, territorialized, organized, signified, attributed, etc., as well as lines of deterritorialization down which it constantly flees" (p. 9). Although largely following a more traditional or 'arborescent' structure, this thesis does at times jump rhizomatically between different chapters (and literature bases). Whilst this may feel a little disjointed for the reader, the lines of rhizome "always tie back to one another" (Deleuze & Guattari, 1987, p. 9).

Deleuze and Guattari's (1987) concept of the rhizome is oriented toward experimentation in connection with real experience, the creation of new concepts and the formation of new connections which enable us to think differently and become otherwise (Deleuze & Parnet 2002; de Beistegui, 2018). I invite the reader to "lodge yourself on a stratum" (Deleuze & Guattari, 1987, p. 161) and follow the process of experimentation outlined in this thesis. To trace the lines which map when different assemblages were actualised, where intensities were being produced, when stratifying lines functioned as "acts of capture" (p. 40), where new connections were being formed and when participants were successful in "freeing lines of flight" (p. 161). These are the lines through which different and

more affirmative ways of thinking about, and understanding food engagement (and avoidance) in the context of IBS symptom management emerged.

## **Mapping the Lines of This Thesis**

Although the rhizome has no beginning or end and is always in the middle, it was necessary to create both an entry and exit point for this thesis. Before creating my entry point and ‘jumping’ to my introductory chapter, I provide the following overview so that the reader may map the rhizomatic lines which connect each of the nine chapters which comprise this thesis.

## **Chapter 1: The Problem: A Biomedical Entry Point**

I commence by creating a biomedical entry point, providing an overview of IBS and outlining the importance of diet in managing gastrointestinal disorders (GIDs). I identify how the biomedical literature has consistently found an increased risk towards disordered eating and eating disorder development for people living with dietary controlled GIDs and I review this biomedical literature base. In so doing, I show how biomedical approaches are essentially incompatible with IBS, and argue that DeleuzoGuattarian concepts and feminist new materialism frameworks are better suited to understanding IBS and IBS related dietary practices more specifically.

## **Chapter 2: Theoretical Framework**

Proceeding in a non-linear rhizomatic fashion, in chapter two I provide an overview of my theoretical framework. I outline each of DeleuzoGuattarian concepts I draw upon, which together enabled me to theorise IBS related dietary practices as being relationally, contextually and temporally produced through various IBS eating assemblages. I also identify postfeminist healthism as a powerful line of stratification which flowed through IBS eating assemblages, further enabling IBS related dietary practices to be understood in relation to dynamics of gendered power, embodiment and agency.



### **Chapter 3: Assembling Different Bodies of Literature**

Further embracing the concept of the rhizome, in chapter three I assemble a range of different literature bases, which together function to produce a rhizomatic literature review. I firstly review the IBS qualitative experiential literature and identify some of the components of IBS eating assemblages which function to produce experiences of IBS related distress, often in ways which are gendered. I then provide an overview of what is currently known about IBS related dietary practices, reviewing how different ways of engaging with food have been theorised and understood within the IBS experiential literature. Lastly, as IBS has yet to be explored through an assemblage framework, I provide a brief overview of how DeleuzoGuattarian concepts, feminist new materialist frameworks and understandings of time as non-linear have been used to explore other health and illness contexts.

### **Chapter 4: Research Assemblage**

In chapter four “things pick up speed” (Deleuze & Guattari, 1987, p. 25) and I provide an overview of the various methodological components which together comprised my ‘research assemblage’ (Fox & Allred, 2015). I outline my recruitment, data collection and analytic processes, which culminated in a DeleuzoGuattarian informed analysis of digital photo diaries and interviews conducted with 26 women who self-identified as suffering from IBS. I also discuss some of the key ethical considerations associated with this project, and outline some of ways in which I engaged reflexively throughout the research process.

### **Chapter 5: Analysis – Becoming IBS**

In chapters five through eight, I present my analysis. In chapter five, I draw on DeleuzoGuattarian concepts of assemblage, becoming, de/reterritorialization and stratification to illustrate the severe and debilitating nature of IBS symptom onset. I theorise the onset of IBS symptoms as a process of bodily deterritorialization, and refer to this process as ‘becoming symptomatic’. My analysis highlights how for the women in this study,

managing periods of severe gastrointestinal distress was profoundly impactful and entwined with experiences of emotional and psychological distress.

I also unpack experiences of severe bloating and abdominal distention, which when assembled with feminine appearance ideals and postfeminist healthism, had the capacity to produce powerful intensities which limited the conditions of possibility for women with IBS to experience and understand their bloated bodies affirmatively. As the process of deterritorialization is inseparable from the process of reterritorialization (Deleuze & Guattari, 1987) I also explore some of the ways in which women with IBS attempted to reterritorialise, or restabilise their bodies through the actualisation of various IBS recovery assemblages, temporarily producing different dietary practices which were considered to be restorative and health enabling.

## **Chapter 6: Analysis – Social Eating Assemblages**

In my second analysis chapter, I draw on the concepts of assemblage, stratification, the refrain, territory, de/territorialisation and lines of flight to explore social eating assemblages. My analysis in this chapter demonstrates how eating in specific social settings and contexts, assembled a range of bodily, social, cultural and gender norms in ways which produced strong territorialising forces that had the capacity to deterritorialise usual dietary practices, and temporarily produce different ways of engaging with (and avoiding) food.

I also highlight how the incorporation of IBS related dietary practices into family eating contexts could be difficult, and had the potential to produce relational cracks and ruptures. In contrast, I also report on how other participants had managed to create new lines of dietary flight which had enabled them to re-establish, maintain and in some cases enhance, social connection. These practices related to attuning to the material and sensory aspects of food, eating in ways which were distributed and establishing controlled parameters of indulgence.

## **Chapter 7: Analysis – Temporal Multiplicities**

The potential for IBS symptoms to develop at any time, meant that there was always a temporal component to IBS dietary management. My analysis in chapter seven explores some of ways in which time was implicated within IBS eating assemblages by drawing on the DeleuzoGuattarian concepts of rhizome, territory and the refrain and Deleuzian understandings of time as non-linear. I highlight the long rhizomatic process of dietary experimentation that participants described embarking upon in order to establish individualised ways of eating that enabled body stability. However, with bodies always in a state of flux, the emergent nature of food/body relations left some feeling helpless and lacking control when symptoms developed unexpectedly, even when managing food carefully.

With all assemblages having tendencies towards both stasis and change (Deleuze & Guattari, 1987), I draw on the concepts of territory and the refrain to identify how some IBS related dietary practices gained stability overtime, by functioning as defensive territories and dietary refrains which produced feelings of containment, safety and predictability. For some, these feelings of safety had left participants stuck with restricted dietary practices, unable to return to previous ways of eating and struggling to move forward. I also identify how other dietary practices functioned as temporary processes of de/reterritorialization, facilitating moments of eating for pleasure and enjoyment, before necessarily having to reterritorialise and return to the 'rhythmic regularly' of their usual dietary practices.

## **Chapter 8: Analysis – A Different Kind of Healthy**

In my final analysis chapter, I ask the Spinozist/Deleuzian question of “what a body can do” and draw on the DeleuzoGuattarian concepts of rhizome, multiplicity, stratification and deterritorialisation to explore understandings of health and healthy eating in the context of IBS dietary management. With each participant experiencing different food intolerances and symptomatic responses, these theoretical concepts enabled me to illustrate how new and different understandings of healthy eating had necessarily emerged through various IBS

eating assemblages. For those with IBS, what was understood as healthy was unable to be reduced down to one pre-determined, or dualistic way of eating, and was instead determined by what specific food/body relations enabled an IBS body to do.

Although enabling symptom management, IBS dietary practices were not always understood as healthy by those with IBS. Territorialising lines in the form of healthy eating guidelines had the capacity to produce feelings of dietary deficiency, even when such prescribed ways of eating did not produce healthy outcomes for those with IBS. IBS related dietary practices could also limit the conditions of possibility for some participants to choicefully engage with other dietary practices they considered to be healthier or health optimising.

I also explore how for those with histories food/body distress, having to establish new and individualised ways of eating which had necessarily required the elimination or avoidance of certain foods or food groups, had the potential to create conditions of possibility which could produce harmful outcomes.

## **Chapter 9: An Exit Point: Discussion and Conclusion**

In the final chapter of this thesis, I bring together and discuss the key findings and contributions which emerged through this research assemblage. I discuss how my findings addressed each of my three research questions and develop the existing literature base. I also discuss the lines of flight my findings offer, and outline how these might be put to use by healthcare professionals, dietitians and researchers. I finish by identifying the limitations of this research assemblage and offer suggestions for new lines of future inquiry.

## **Chapter 1 – The Problem: A Biomedical Entry Point**

### **1.1 The Importance of Diet**

It is extremely difficult to separate food and health (Barnhill & Civita, 2020). Diet, as a modifiable lifestyle factor, is implicated in the development and prevention of many chronic health conditions (Simpson-Yap, 2021). Diet also plays an important role in treatment, with individuals often advised by healthcare professionals to undertake lifestyle adjustments and adhere to medically informed life-long dietary practices to self-manage their chronic health conditions and avoid further disease progression (Quick et al., 2013). Dietary interventions may also be adopted to help manage chronic health condition symptoms as part of a complimentary or alternative medicine approach, or as an adjunctive therapy where other treatment approaches, such as pharmaceutical or surgical interventions, have been unsuccessful or failed to relieve symptoms adequately. For example, the ketogenic diet has been implemented to manage refractory epilepsy (Ruberto et al., 2021), anti-inflammatory diets have been adopted to reduce endometriosis symptoms (Nirgianakis et al., 2020) and the Swank diet has been used to reduce the frequency and severity of multiple sclerosis flares (Swank & Goodwin, 2003).

Gastrointestinal disorders (GID's) are one group of chronic health conditions where diet is particularly pertinent for symptom avoidance and ongoing disease management. Irritable Bowel Syndrome (IBS) is one such GID where diet and the embodied experience of ingestion/digestion is implicated in ongoing management. IBS is a common chronic disorder of gut-brain interaction, affecting approximately 10-20% of New Zealanders (Barbezat et al. 2002; Laing et al., 2022; Spencer et al., 2014; Welch & Pomare, 1990; Wyeth, 2011). It is characterised by a collection of symptoms occurring between the oesophagus and rectum, whereby the presence of gastrointestinal symptoms occur in the absence of any structural abnormalities (Drossman, 2016; Grundman & Yoon, 2010).

Although the cause of IBS is not well understood, the symptoms associated with IBS are considered to result from complex interactions between multiple altered or dysfunctional

factors including the gut microbiome, visceral hypersensitivity, mucosal immune function, central nervous system, and motility disturbance (Drossman et al., 2016; Shaikh et al., 2023). Post infectious IBS may also develop following gastroenteritis (Spiller, 2009). Psychological and physical stressors are also understood to impact brain-gut interactions resulting in the onset of symptoms (Sapkota et al. 2014) with genetic factors and early life stressors considered to play a role (Assouline-Dayana, 2018; Mustafa, 2025).

According to epidemiological studies, in comparison to men, women in Western countries are twice as likely to meet the criteria for IBS (Drossman, 2016). Women further report more symptoms, higher symptom severity, engage in higher levels of health seeking behaviour, report higher levels of psychological distress and experience a lower quality of life (Assouline-Dayana, Y. 2018; Kim & Kim, 2018; Marano et al., 2025; Meleine & Matricon, 2014; Voci and Cramer, 2009). These differences may in part be attributable to biological factors such as sex hormones, in particular oestrogens, which are understood to interact with other risk factors and play a role in modulating IBS symptoms during menstrual cycles, pregnancy and pre/post menopause (Bárdos, 2024; Mulak & Taché, 2010). For example, women report more severe and frequent symptoms and higher levels of pain during menstrual cycles (Mulak & Taché, 2010).

IBS symptomology is chronic in nature, often following a relapse-remission cycle (Laing, 2022). Those living with IBS may experience severe symptoms such as abdominal pain, altered bowel habits such as diarrhoea, constipation or faecal incontinence, abdominal bloating/distension, belching, feelings of fullness, early satiation, nausea, vomiting, weight loss and extreme fatigue (Rome Foundation, 2016). IBS may be diagnosed against the Rome IV criteria<sup>1</sup> (Drossman & Hasler, 2016). Within this diagnostic framework, there are four main subtypes categorised by bowel habits: IBS-C constipation predominant symptoms, IBS-D diarrhoea predominant symptoms, IBS-M mixed presentation of both constipation and diarrhoea, and IBS-U, whereby symptoms do not fall within the other three categories and

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<sup>1</sup> Further information regarding the Rome IV diagnostic criteria can be accessed on the Rome Foundation website: <https://theromefoundation.org/rome-iv/rome-iv-criteria/>

are therefore unclassified. Such classifications are not always helpful as symptoms can fluctuate over time, and those with IBS may find their symptoms transitioning between different diagnostic categories. Symptoms may also overlap or extend beyond these categories and disappear for periods of time (Burgell & Ye, 2019). In many instances, IBS, may also function as 'catch all' diagnosis, or 'diagnosis of exclusion' for gastrointestinal symptoms which are unable to be attributed to another identifiable causes (Cash, 2024; Hidayat et al., 2024; Spiegel, 2007).

Currently there is no cure for IBS. Due its complexity, chronicity and heterogeneity, IBS management can be challenging due to lack of long term treatment strategies which provide effective and sustained relief (Mustafa, 2025; Vedantam et al., 2022). Treatment options currently include lifestyle advice such as increased physical activity, stress reduction, sleep hygiene, maintaining regular meal patterns and the inclusion of fibre (Mustafa, 2025). Pharmacological options such as antispasmodics to alleviate pain, anti-diarrhoeals, antidepressants and laxatives may be helpful for some, although such options only provide temporary relief (Mustafa, 2025). More recently, psychological interventions such as cognitive behavioural therapy (CBT-IBS), gut directed hypnotherapy and mindfulness-based stress reduction have become available. Although leading to improvement in symptoms and increased quality of life for some, such therapies however remain inaccessible for most due to financial barriers and a lack of appropriately trained health psychologists (Ballou & Keefer, 2017; Verma et al., 2025).

As IBS management largely focuses on controlling symptoms and improving daily life, those with IBS often make dietary changes or undertake dietary interventions such as the low-FODMAP diet (LFD)<sup>2</sup> or gluten free diet (GFD). Such dietary changes may be undertaken under the guidance of a healthcare professional (Gibson & Shepherd, 2010),

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<sup>2</sup> Further information regarding the low FODMAP diet may be found on the Monash University website: <https://www.monashfodmap.com/ibs-central/i-have-ibs/starting-the-low-fodmap-diet/> I also provide an overview of this dietary intervention in Appendix A.

however many self-initiate dietary adjustments to self-manage their symptoms (Lenhart et al., 2018).

Dietary management is often associated with a number of positive aspects for people living with IBS. Personalised dietary adjustments enable individuals to actively participate in their own symptom management, which for some, results in feelings of control over their body (Chey, 2019). Diet is also perceived as more natural, holistic treatment option than medications and considered less likely to cause side effects (Chey, 2019). Although dietary interventions may be successful in alleviating or improving gastrointestinal symptoms for some, they also have the capacity to produce a range of unintended consequences.

Dietary interventions are often reported as efficacious in clinical trials, but the translation of such approaches is not necessarily reflective of how they are implemented into clinical and self-directed practice (Simons et al., 2021). For example, the LFD is intended to be implemented by a dietitian or healthcare professional with knowledge of the patient's condition and the ability to assess their suitability as a candidate for an elimination diet (Halmos & Gibson et al., 2019; Simons et al., 2021). In practice this is not always the case, with patients often receiving inadequate education, little tailoring or personalisation and are required to interpret the limited information provided (Bellini et al., 2020; Lenhart et al., 2018; Trott et al., 2019). Undertrained healthcare professionals may also endorse over-restriction which risks resulting in nutritional deficiencies and weight loss (Trott et al., 2019).

When adopted in a self-directed capacity, dietary interventions may also be implemented in ways which are not recommended, or contradictory to their intention (Cruz et al., 2018). People with IBS commonly report that the consumption of certain foods triggers symptoms (Böhn et al., 2013; Lenhart et al., 2018) with over half of IBS patients attempting to self-manage their symptoms prior to seeing a gastroenterologist (Lenhart et al., 2018). Those with IBS often engage in unique dietary practices as they formulate personalised hypotheses regarding specific foods and food quantities which may trigger or alleviate gastrointestinal symptoms, often through a process of trial and error (O'Brien et al., 2021; Reed-Knight, 2016; van Tilburg & Flexi, 2013). Many also seek dietary advice via non-



medical pathways, such as online support groups and unqualified internet health content creators (Baker & Rojek, 2020) and as a result, self-directed dietary changes are often followed for unnecessary extended periods of time, resulting in restricted diets (Bellini et al., 2020). Perhaps not surprisingly then, one significant risk associated with dietary modifications for IBS management consistently identified within the biomedical literature, is an increased risk toward disordered eating / eating disorder development (Simons et al., 2021; Scarlata et al. 2020; Harer et al., 2019).

## **1.2 Disordered Eating / Eating Disorders and IBS**

Feeding and Eating disorders, as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), refer to a range of formally classified diagnostic categories which currently include: Anorexia nervosa (AN) restricted energy intake and weight loss associated with an intense fear of gaining weight and body image distortion; Bulimia nervosa (BN) recurrent periods of eating an unusually large amount of food associated with loss of control, alternating with compensatory behaviours to prevent weight gain; Binge eating disorder (BED) eating large quantities of food in a short period of time, associated with a loss of control and distress; Avoidant/restrictive food intake disorder (ARFID) eating disturbance which results in extreme picking eating or a failure to meet nutritional needs; Other specified feeding and eating disorders (OSFED) eating disorders or disturbances in eating which do not meet the criteria for other ED categories however result in distress; and unspecified feeding and eating disorders (UFED) eating behaviours which do not meet the AN or BN criteria but are clinically significant and cause distress (APA, 2013; Walsh, 2019).

Regardless of their specific classifications, eating disorders (EDs) are characterised by disturbed or abnormal attitudes, thoughts and behaviours associated with food and eating and often a preoccupation with body weight or shape. ED's are persistent, severe, associated with distress, disability and can result in impaired physical, psychological and social functioning (APA, 2013). The term disordered eating (DE) is used to encapsulate a spectrum of eating behaviours which are characterised as abnormal, however do not meet

the clinical threshold for an ED diagnosis (Klein & Walsh, 2004). Although disordered eating may encompass food and body practices which cause distress and impairment, they may also refer to eating practices which deviate from the cultural norm and are not associated with distress (Fjellstrom, 2004; Harer et al., 2019). Increasingly however, the line between what may be understood as disordered or healthy may be minimal and difficult to differentiate, as observed in the context of orthorexia nervosa (Lewthwaite & LaMarre, 2022) a proposed new eating disorder which is characterised by an unhealthy obsession with health eating (Bratman, 1997).

It should also be noted that the DSM-5 classification system is only one of several ways of categorising food/body distress. Whilst clinical diagnostic categories may hold pragmatic utility to facilitate access to clinical diagnosis and treatment for some, they also have the potential to create barriers to care for others who are unable to obtain a diagnosis, for whatever reason. Further, the ED categories may not necessarily be adequate for encompassing all lived experiences of food and body distress, nor are they able to capture what distress feels like or what it may lead to within specific social contexts (LaMarre et al., 2022). Nonetheless, the ED categories and the assessment tools designed to identify DE/ED risk or presence, are frequently used within the literature exploring the relationship between IBS and DE/EDs.

Research has consistently found an increased risk towards disordered eating and eating disorder development for people living with dietary controlled GIDs (Quick et. al., 2013; Satherley et al., 2015). Further, higher prevalence rates of disordered eating have been found within IBS populations (Mitchell et al., 2018; Peters et al., 2021; Satherley et al., 2015; Wardle et al., 2018) and those with dietary-controlled chronic illness are twice as likely to be diagnosed with an eating disorder than the general population (Quick et al., 2012). A number of factors have been proposed as potential mechanisms for increased disordered eating risk within GID populations: restrictive eating practices (Satherley et al., 2015); fear, anxiety and hypervigilance associated with GI symptoms (Arigo et al., 2012; Melchior et al., 2020); GI symptom severity (Sainsbury et al., 2013; Tang et al., 1997); and constantly

having to make appropriate food choices, resulting in an increased focus on eating behaviours and a pre-occupation with food (Wagner et al., 2015).

Further, the requirement to follow a restricted diet requires significant effort which can become burdensome for some, resulting in a negative relationship with food (Chey, 2019; Harer & Eswaran, 2021; McGowan et al., 2021; Murray & Staller, 2021; Scarlata et al., 2020; Simons et al. 2021). Imposed dietary restrictions, together with the challenges associated with living with a chronic condition therefore mean that factors which have the potential to increase risk towards disordered eating are embedded within dietary treatment and management plans (Criego et al., 2009). Together, such factors have the potential to create environments in which unhealthy eating habits and destructive attitudes towards food and bodyweight may develop (Quick et. al., 2013).

### **1.3 Positioning the Problem – IBS and Disordered Eating**

To date, much of the literature exploring the relationship between IBS and disordered eating / eating disorders has tended to focus on the presence of gastrointestinal symptoms in those with existing eating disorders such as AN, BN and BED (Hanel et al., 2021). Fewer studies have explored disordered eating or eating disorder development following an IBS diagnosis. Further, within this body of work, the motivations behind day-to-day dietary practices for people living with IBS have received little attention beyond seeking to establish DE and ED prevalence within, and across, various GID populations.

Disordered eating has also been treated as one large all-encompassing group (Satherley et al. 2015) rather than exploring the wide range of eating practices which may be undertaken whilst managing GIDs (Peters et al, 2021). Studies have typically reported on the presence of food restriction, skipping meals and binge eating (Satherley et al., 2015, 2016) however, it has also been difficult to ascertain which disordered eating practices are being adopted by people with GIDs, due to the range of different screening tools used to identify disordered eating presence. For example, eating disorder risk is largely assessed by self-

reported food restriction and binge/purging behaviours, with questionnaires designed to identify eating behaviours associated with specific diagnostic categories such as AN or BN.

As a result of focusing only on diagnostic specific eating beliefs and behaviours however, the presence or absence of other eating behaviours which may deviate from traditional eating patterns, and which may or may not be healthy, but are specific to people living with GIDs remain unexplored (Peters et al, 2021; Satherley et al., 2015). Further, the ED screening tools being used to assess ED risk have not been adapted or validated for use within GID populations. For example, the SCOFF assessment tool (Morgan et al., 2000) is a 4-item questionnaire designed to screen for AN/BN risk in young women, so it is possible that the SCOFF may not indicate disordered eating behaviour in IBS patients, particularly where the LFD has been adopted to manage symptoms (Chumpitazi et al., 2019; Mitchell et al., 2018).

Given the importance of diet for managing GID symptoms, restricted eating or disordered body image, may be less related to disordered eating, and more related to dietary practices associated with the LFD and symptom management (Chumpitazi et al., 2019). Scarlata et al., (2025) highlights how such tools may misconstrue adaptive eating when used within GI populations and have the potential to over-pathologise. Food avoidance is also often pathologised by peers and healthcare providers, even when perceived as normative and adaptive by those with IBS (Simons et al., 2021). For example, those with IBS may engage in disordered eating practices as a means to manage symptoms, such as self-induced vomiting to relieve nausea, or laxative 'misuse' to alleviate severe constipation (Simons et al., 2021). As such, what might be categorised as disordered eating patterns within otherwise healthy populations may not necessarily be reflective of disordered or pathological eating within the GID context, particularly where an elimination diet has been implemented.

Whilst some overlap has been noted between 'traditional' eating disorders and those observed in people living with GID's, eating behaviours in GID's are often considered to be motivated by the avoidance or mitigation of gastrointestinal symptoms rather than being

motivated by weight or shape concern (Mujagic et al., 2022; Reed-Knight et al., 2016; Satherley & Higgs 2015). However, this distinction has been difficult to ascertain. Body weight and BMI has not been associated with elevated disordered eating scores for people with IBS in a number of studies (Kayar et al., 2020; Perkins et al., 2005; Tang et al., 1998). Reed-Knight (2016) found no difference in BMI or disordered eating patterns between those with IBS and healthy controls. However, those with IBS did engage in potentially unhealthy eating practices such as avoiding specific foods (97.7%), not eating when hungry (43.2%) or vomiting after eating (13.6%) as a means to control gastrointestinal symptoms. It is also likely that the EDE-Q, used to assess eating behaviours associated with weight or shape concern in this study, was not sensitive enough to determine the motivation behind disordered eating practices, and cannot therefore differentiate between eating practices adopted to manage gastrointestinal symptoms, and those intended to influence weight or shape (Reed-Knight, 2016).

A number of IBS specific factors, such as severe bloating and abdominal distension, may also contribute to physical body changes. Whilst studies have attempted to identify correlates between weight (BMI) and DE using ED assessment scales such as the EAT-26<sup>3</sup> and the EDE-Q<sup>4</sup>, it remains unclear whether weight or shape concerns influence day-to-day dietary practices for those with IBS or whether dietary restrictions are adopted primarily to alleviate gastrointestinal symptoms. Further, such findings do not take into consideration wider socio-cultural influences and feminine appearance ideals which might also impact how those with IBS understand and experience and their bodies, and how they might try to manage them in response. For example, IBS symptoms such as bloating and diarrhoea, may conflict with feminine appearance ideals and gender norms, impacting how those with IBS experience their bodies (Ballou & Keefer, 2017; Björkman et al., 2014).

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<sup>3</sup> The EAT-26 can be viewed on the following link: <https://www.eat-26.com/eat-26/>

<sup>4</sup> The Eating Disorder Examination Questionnaire (EDE-Q) can be accessed via the following link: [EDE-Q](#)

Conversely, the items in many currently available screening tools may also miss IBS specific factors, resulting in an under identification of atypical eating behaviours and the presence of distress and disordered eating. Higher disordered eating scores in IBS populations, may also indicate that a large proportion of people with IBS do experience difficulties associated with dietary and body management, and further attention as to how IBS may be interacting with day-to-day dietary attitudes and behaviours is therefore important to further understand these relationships.

### **1.3.1 The Importance of Context**

Perhaps most importantly, the chronic illness context within which day-to-day dietary practices are enacted has received little consideration. The recommended protocols within dietary interventions such as the LFD and the implementation process itself for example, may make it difficult to differentiate between eating patterns that may be characterised as healthy/disordered or adaptive/functional.

Specific dietary practices which may be unique to the IBS context and associated with embodied experiences of day-to-day symptom management also remain poorly understood. For example, food and body practices associated with aversive gastrointestinal symptoms are also enacted in relation to contexts of multiple and sometimes competing personal goals such as the accomplishment of normative daily activities (e.g. the ability to attend employment, participate in social and leisure activities, travel, sleep and maintain intimate relationships) (Campbell, 2015; Crombez et al., 2012; Drossman et al., 2009; Farndale & Roberts, 2011; Shorey et al., 2021). Intestinal and bowel activity also holds social meaning beyond function, with gastrointestinal dysfunction and bowel contents associated with embarrassment, body shame, social stigma and self-blame (Drossman, 2016; Taft et al., 2017).

Additionally, in order to avoid aversive gastrointestinal symptoms, day-to-day dietary practices for people living with IBS may differ dramatically to those in healthy populations. Eating practices often characterised as 'disordered' for those not experiencing GIDs are

normal within the context of GID management (Quick et al., 2013) with food avoidance often considered a reasonable response to symptom management (Harer et al., 2019). As such, in order to avoid aversive gastrointestinal symptoms, day-to-day dietary practices for people living with IBS may differ dramatically to those in healthy populations.

It is therefore important to consider what might be understood as normative and healthy eating within the IBS context. Beliefs around the affective capacity of specific foods to produce symptoms, may be particularly pertinent to explore for those with IBS given the role that food intake is perceived to play in symptom onset. Aversive gastrointestinal symptoms may not only motivate particular ways of eating, they may also disrupt or limit the conditions of possibility for 'normal' healthy eating. Accordingly, it is important to explore and understand eating practices and patterns which might be understood as functional, adaptive or workable and intended to facilitate health and wellbeing.

### **1.3.2 Identifying Experiences of Distress**

Dietary practices which have the potential to become problematic or result in distress or impairment for those engaging with them are however important to identify and understand. In addition to contending with severe and debilitating nature of physical symptoms, those with IBS also experience a wide range of psycho-social experiences such as the emotional burden of living with IBS, feelings of loss of control, anticipatory concerns about eating certain foods, experiences of embarrassment or stigma, interpersonal/social distress and emotional distress such as feelings of anger, frustration, overwhelm or burnout (Woodward et al., 2016; Dibley et al., 2017). If distress is experienced by those adjusting their dietary practices to manage IBS symptoms, it therefore becomes important to explore how aspects of IBS management may assemble with food and body practices in ways which produce or alleviate such experiences.

Whilst not all restricted or disordered eating practices result in distress and impairment, the identification of disordered eating presence in those with IBS remains important due to the potential implications for symptom management and the adverse health

outcomes which may potentially result. The long-term adoption of restrictive diets for example, may result in nutritional deficiencies and cause imbalances in the gut microbiome (dysbiosis) (Molina-Infante et al., 2016) and disordered eating practices may exacerbate or lead to more severe gastrointestinal symptoms (van Tilberg et al., 2014; Reed Knight, et al., 2016).

Although any elimination diet creates concern around the potential for nutritional deficiency and weight loss resulting from insufficient calorie intake (Bellini et al., 2020; Bellini & Rossi, 2018), the introduction of a restrictive diet may precipitate or reinforce existing disordered eating behaviours (Bellini et al., 2020). Further, restricted dietary practices may also transition into clinically significant eating disorders associated with distress and impairment (Grilo, 2006).

For people with histories of eating disorders/disordered eating, the introduction of self-care dietary restrictions following an IBS diagnosis, may also have the potential to configure vulnerable contexts whereby unhealthy eating practices may re-emerge and threaten eating disorder recovery (Bellini et al., 2020; Halmos & Gibson, 2019). Due to the overlap in symptoms experienced in IBS and eating disorders, identifying increased risk toward disordered eating development is important because disordered eating may also interfere with the management of IBS (Melchior et al., 2020) with treatment for each co-existing condition becoming more complex and requiring individual tailoring (Mascolo et al., 2017). It is therefore important to identify if/where experiences of distress are being produced and whether this distress is linked to IBS related dietary practices directly or more relationally.

#### **1.4 Opening the Circle: Research Rationale, Aims and Questions**

To date, most of the research exploring IBS has been dominated by quantitative studies conducted from a biomedical perspective. The biomedical model and its empiricist epistemology prioritises objective, observable, measurable and quantifiable forms of knowledge about health and illness, conceptualising the body as a biological system in which disease can be identified, managed, and treated through scientific approaches,



(Pickren, 2019). As outlined above, quantitative studies are unable to attend to the often complex and contextual nature of IBS. Furthermore due to their multifactorial nature, functional disorders such as IBS are essentially incompatible with the biomedical model (Hausteiner-Wiehle et al., 2023).

Van Tilberg (2020) explains that because the biomedical model defines health as the absence of disease, symptoms which are unable to be biologically attributed to the body must therefore be psychological in nature. The bidirectional role of a dysfunctions brain–gut axis implicated in IBS, defies this mind/body dichotomy and as a result the biomedical model is unable to account for the severity of symptoms associated with functional GIDs. As disease and illness are not understood as the same, IBS is therefore unable to be treated from a biomedical perspective (van Tilberg 2020). Due to their complexity and variability, functional disorders therefore require a different approach (Hausteiner-Wiehle et al., 2023).

One way to expand understandings is through different research paradigms. Little et al. (2025) highlights how over the last 20 years only 0.0008% of articles published by Gastroenterology journals have been qualitative. Qualitative studies in relation to gastrointestinal disorders are therefore significantly lacking, especially given their high prevalence rates, impact on daily life and cost to the health care system. Even fewer qualitative studies which focus specifically on experiences of IBS related dietary practices and food/body distress have been undertaken. As a result, in-depth understandings of the motivations and intentionality behind day-to-day dietary practices within IBS contexts are lacking. The use of qualitative research methods which can attune to embodied experiences and enable in-depth analyses are therefore necessary to increase nuanced understandings of the complex and dynamic food practices which may emerge in relation to IBS management.

This research fills this important qualitative research gap, extending Hauteiner--Wiehle et al.'s (2023) assertion that a different approach to the study of IBS is required, together with the necessity for more GID related qualitative studies (Little et al., 2025). This research also helps answer Scarlata et al.'s (2025) call to action to further unravel the

complexity of 'grey area' dietary behaviours which whilst functional and adaptive within the context of GI symptom management, can be misconstrued and over pathologised by DE/ED screening and assessment tools.

To do so, I adopt a DeleuzoGuattarian and feminist new materialist theoretical framework to think differently about IBS related dietary practices. Across the following chapters, I draw upon DeleuzoGuattarian concepts of assemblage, rhizome/multiplicity, affects/intensities/becomings, territory, the refrain, stratification and Deleuzian understandings of time as non-linear, to provide a dynamic, relational framework through which IBS related dietary practices can be understood in new and creative ways.

Thinking with DelzuoGuattarin concepts enables me to move beyond 'old style' biomedical frameworks (de Beustegui, 2018), which function to reproduce the same kind of scientific knowledge, by classifying and reducing understandings of IBS related dietary practices down to pre-established categories which dichotomise food engagement as healthy/unhealthy. Instead, IBS related dietary practices can be understood as being relationally produced through various IBS eating assemblages, and emerging in relation to embodied illness experiences, various social contexts, gender norms, feminine appearance ideals, different temporalities and wider sociocultural and political contexts.

Different ways of engaging with food are further able to explored in relation to Deleuze and Guattari's (1987) theory of the body, which poses the ethological question: "what can a body do?". From this perspective, health is understood as processual rather than lack (Buchanan, 1997), enabling hierarchical distinctions of healthy/unhealthy to be avoided. This theoretical framework allows me to explore what different IBS related practices 'do', what they function with, and what capacities they enable or constrain for women with IBS. Adopting a feminist new materialist theoretical framework in this space therefore enables me to understand IBS related dietary practices as complex, deeply contextual and always multiple.

The overarching aim of this research project was therefore to explore IBS related dietary practices, and what different ways of engaging with (and avoiding) food 'do' for

women managing IBS symptoms. I address this aim with the following three research questions:

1. How do women who make dietary changes to manage IBS understand and feel about them - what do IBS related dietary practices actually 'do'?
2. What is understood as healthy eating within contexts of IBS management?
3. How are IBS related dietary practices assembled with experiences of distress?

## Chapter 2 – Theoretical Framework

### 2.1 Staring in The Middle

As my theoretical framework provides the scaffolding for this thesis, it felt appropriate to think with Deleuze and Guattari's (1987) concept of rhizome and start "in the middle" (p. 25). For a person trained in psychology, where the beginning point is usually the literature review, starting in the middle aligns with my DeleuzoGuattarian orientation; it allows me to introduce the concepts that I have selected to shape my thesis, and then put these theoretical tools to work throughout the following chapters.

The theoretical concepts I assembled comprised of feminist new materialist perspectives more broadly, DeleuzoGuattarian concepts of rhizome/multiplicity, assemblage, affects/intensities/becomings, territory (de/reterritorialisation), the refrain, stratification and understandings of time as non-linear. Together, these concepts enabled me to theorise IBS related dietary practices as being relationally, contextually and temporally produced through various IBS eating assemblages; and to consider these in the context of traditional feminist concerns such as gendered power, embodiment and agency.

This chapter commences with a brief outline Deleuze's ontology of immanence, before outlining each of the concepts named above, which together, formed my theoretical framework centred on assemblages. With all assemblages comprised of tendencies towards stability and change, this chapter then proceeds with two main sections. The first focuses on DeleuzoGuattarian concepts which highlight tendencies towards change ([section 2.3](#)), whilst the second ([section 2.4](#)) outlines concepts which demonstrate how assemblages acquire stability over time. The final section briefly explores Deleuze's (1994) concept of the living present and understandings of time as non-linear and their application to understanding the temporal nature of IBS related dietary practices.

It is also important to highlight that it is extremely difficult to discuss Deleuze and Guattari's (1987)'s concepts in isolation due to their interrelated nature. As Deleuze (1991) notes, "There is no one concept with one component" (p. 16). As a result, there is inevitably

some overlap throughout this chapter as each of the concepts I have drawn upon rhizomatically link back into each other in various ways. Massumi, in his introduction to *A Thousand Plateaus* observes how concepts “tend to cycle back...Some might call that repetitious. Deleuze and Guattari call it a refrain.” (1987, p. xv).

This chapter has its own refrain. After outlining the various DeleuzoGuattarian concepts I have assembled to comprise my theoretical framework, I then explain (where appropriate) how I have theorised or applied each concept throughout my analysis to IBS related dietary practices more specifically, either in relation to a specific section, chapter, or my thesis more broadly (such applications are also further detailed in relation to my analytic process outlined in chapter 3). I invite the reader to engage with the format of this chapter with its playful intention to create a little theoretical refrain, and hope that its somewhat repetitious (and rhizomatic) nature does not produce feelings of stagnation or closure!

## **2.2 Deleuze’s Ontology of Immanence and Transcendental Empiricism**

Deleuze and Guattari argue that the role of philosophy is to challenge the way in which philosophy itself has been formulated. They encourage us to create new concepts or put existing or inherited concepts to work in new and creative ways by looking for the ‘slippages’ between existing disciplinary boundaries and questioning what things do, as opposed to interpreting taken for granted assumptions (Message, 2010). The creation of new concepts should therefore not involve thinking in ways which are subordinated to, or predetermined by, factors that specify what thinking should be or look like, or pre-suppositions of universal truths (Bell, 2015; Rolli, 2016). Nor should it involve thinking with essences, hierarchies, representation or recognition which only reduces thought to the same, such that the pre-established and identical is maintained and reconstituted, and the meaning of the uncommon is reduced back to the common (Deleuze, 1994; Bell, 2015). Deleuze argues these ways of thinking, which are characteristic of much of Western philosophy, only serves to organise, quantify, order and label phenomena in relation to abstract norms and does not

enable us to explore and appreciate the richness and uniqueness of life and experience (Stagoll, 2010).

Life, according to Deleuze is not discrete but composed of multiple relations which can be messy, unstable and constantly changing. Deleuze argues that any attempt to understand life as discontinuous only results in reproducing what is sought to find and works to limit new ways of thinking which also prohibit the connection between new ideas and different disciplinary boundaries and fields of specialisation (Stagoll, 2010). Further, Deleuze (1991) argues that more traditional empirical approaches remain unable to account for the formation of subjectivity itself and fail to explain how the structures which organise subjects' capacities emerge themselves, leaving the subject outside of their own experience (Duff, 2014).

Deleuze's philosophy is one of immanence. Immanence, which is ontologically flat or monist, opposes transcendence which is dualistic. This flat ontology enables Deleuze and Guattari to reject essences and Cartesian dualistic divisions, such as those between nature/culture, subject/object and mind/body, and open up a logic of relations and multiplicities which extend beyond, and exceed the dichotomies they replace (Braidotti, 2011; Deleuze & Guattari, 1987). Deleuze's transcendental empiricism emphasises connection over separation, and the movements between bodies which are understood as increasing or decreasing capacities and powers, with the goal of producing new concepts and different ways of seeing, thinking about, and understanding "real experience" in all its contextuality and complexity (Deleuze & Parnet, 2002, p. 54).

The ontology of immanence associated with Deleuze's transcendental empiricism, enables a way "to avoid tracing the transcendental from the outlines of the empirical" (Deleuze, 1994, p. 144). As such, Deleuze's and Guattari's (1987) transcendental empiricism involves the application of concepts which are intended to encourage experimental thought by not pre-determining what something is or how should be understood, but instead focuses on what it can become in relation to the limits of creative possibility. I expand further upon various aspects of Deleuze's philosophy in the following

sections, as I outline each of the DeleuzoGuattarian concepts which comprised my theoretical framework and analytic process.

## **2.3 Mixtures and Tendencies Towards Change**

In this section, I outline the DeleuzoGuattarian concepts of rhizome / multiplicity, assemblage, desire, body without organs (BwO), affect/intensities/becomings, and 'what a body can do'. These concepts relate to the tendencies all assemblages towards change, and are discussed in relation to how they have been theorised, and applied throughout my analysis of IBS-related dietary practices.

### **2.3.1 Rhizome and Multiplicity**

The concept of rhizome is about experimentation, establishing new connections and the creation of new concepts which enable us to think and live differently, and to become something else – “to rhizome” (*‘faire rhizome’*) (de Beistegui, 2018, p. 10). A rhizome is comprised of directions in motion which are always coming and going. It has no beginning or end and “is always in the middle, between things, interbeing, *intermezzo*” (Deleuze & Guattari, 1987, p. 25). A rhizome operates “by variation, expansion, conquest, capture, offshoots. The rhizome pertains to a map that must be produced, constructed, a map that is always detachable, connectable, reversable, modifiable and has multiple entryways and exists on its own lines of flight” (Deleuze & Guattari, 1987, p. 21).

Deleuze and Guattari (1987) contrast rhizomes with trees, which are stable, logical and follow a structure of hierarchical organisation associated with Western knowledge systems of scientific thought. Trees function by means of representation, resemblance and tracing, reproducing the same. Arborescence is further critiqued as being irreducibly binary, and through its hierarchical structure perpetuates a model of authoritative and centralised power which functions to turn phenomena into fixed orders and sedentary hierarchies (de Beistegui, 2018). The nature of rhizome in contrast privileges connection and heterogeneity through its “roots and taproots” which enable a “multiple, lateral and circular system of

ramification, rather than a dichotomous one” (Deleuze & Guattari, 1987, p. 25). The rhizome is therefore open to experimentation because the manner in which it’s points can connect to one another are not predetermined or fixed, and have the potential to connect in any number of ways, producing a range of different assemblages and experiences.

Deleuze and Guattari (1987) however, avoid creating new oppositional dualisms by accounting for the dual tendencies of all assemblages towards both stability (the tree) and change (the rhizome). As Deleuze and Guattari (1987) explain “There are only multiplicities of multiplicities forming a single assemblage, operating in the same assemblage... Trees have rhizome lines, and the rhizome points of arbor-escence” (p. 34). As a result, not all points of the rhizome are equal and some connections may function to delimit, territorialise or stratify, whilst others produce deterritorialising lines of flight (de Beistegui, 2018) ([see section 2.4](#) for further discussion in relation to the concepts of stratification, territorialisation, deterritorialization and lines of flight). What is produced through rhizomatic thinking is a new model which “operates as an immanent process that overturns the model and outlines a map, even if it constitutes its own hierarchies, even if it gives rise to a despotic channel” (Deleuze & Guattari, 1987, p. 20). What is important is to find the lines of flight, establish which assemblages they may be connected to, what they function with, and what such connections produce. This requires seeing things differently and looking from the middle (Adkins, 2015).

Creating rhizomes also requires the concept of multiplicity: “a multiplicity has neither subject nor object, only determinations, magnitudes, and dimensions that cannot increase in number without the multiplicity changing in nature...” (Deleuze & Guattari, 1987, p. 8). A multiplicities dimensions describe the number of connections to other multiplicities that are made possible, by its determination and magnitude. Multiplicities are not discrete unities and are always breaking off and forming new connections with other multiplicities. This relates to the question of what a body can do ([section 2.3.4](#)) with bodies defined by their ratios of motion and rest (a multiplicity) which impacts their capacities to enter into new combinations (Adkins, 2015).



The concept of multiplicity enables Deleuze and Guattari (1987) to reject the dialectic of the one and universal essences, which signify, represent and reduce everything back to unities, and to instead think with multiplicities (Adkins, 2015). It is important to note that multiplicities differ from the many, due to the continuity thesis which enables a way of thinking with intensities rather than extensities, and not discrete and countable entities associated with the one (Adkins, 2015). Deleuze and Parnet (2002) explain how multiplicities designate a set of lines which are unable to be reduced to one another. All ‘things’ are comprised in this way, and it is what is in between these lines (the set of relations which are unable to be separated from each other) which are important. As such, ‘things’ cannot be understood as individual discrete units as there are only multiplicities, which are themselves multiplicities (Adkins, 2015). Rhizomatic thought therefore functions to connect segments of bodies with other segments through a logic of problems, rather than resemblance, division and categorical consistency (de Beistegui, 2018).

“To extract the concepts which correspond to a multiplicity is to trace the lines of which it is made up, to determine the nature of these lines, to see how they become entangled, context, bifurcate, avoid or fail to avoid the foci. These lines are true becomings, which are distinct not only from unities, but from the history in which they are developed. It is a being multiple, instead of being-one, a being” (Deleuze & Parnet, 2002, p. viii)

Thinking rhizomatically in relation to IBS related dietary practices, enabled me to move beyond dualistic understandings of healthy/unhealthy eating, and open up new and different ways of understanding health enabling dietary practices. Using this conceptual lens, healthy eating was unable to be reduced to one predetermined or fixed way of eating, and was instead understood by the capacities and connections it enabled, and what specific dietary practices enabled an IBS body to do. As my analysis in [chapter 8](#) highlights, establishing what was healthy for each participant involved embarking on an individualised process of dietary experimentation, which had required attuning to bodily intensities rather than extensities. These lines of experimentation were often characterised by blockages and dead

ends, however also moments of connection and success when new ways of eating which enabled symptom management (even if only temporarily) were discovered ([section 7.2.1](#)). New ways of eating healthfully were therefore able to be understood as emerging in various configurations through participants' IBS eating assemblages.

### 2.3.2 Assemblage

Assemblage is a key concept for Deleuze and Guattari (1987) however the word assemblage is a common translation of the French word *agencement*, which does not mean the same thing as assemblage in English. Agencement means “a construction, an arrangement, or a layout” of heterogeneous elements, whereas assemblage refers to a “bringing or coming together” which is more reflective of a unity or unified gathering (Nail, 2017). This distinction is important because Deleuze and Guattari reject unity for multiplicity, and essences for events. Assemblage as a concept, should therefore direct “attention to processes of agencement” (Anderson et al., 2012, p. 173), whereby an assemblage is both a noun (i.e. the working arrangement) as well as a verb (the process of its components functioning together) (Frazer, 2019).

Assemblages are multiplicities, diagrammatically imagined with both horizontal and vertical axes. The horizontal axis comprises of two segments: the “machinic assemblages of bodies, actions and passions, an intermingling of bodies reacting to one another” (content) and the “collective assemblage of enunciation, of acts and statements, of incorporeal transformations of bodies” (expression) (Deleuze & Guattari, 1987, p. 88). The vertical axis has both “territorial sides, or reterritorialized sides, which stabilize it, and cutting edges of deterritorialization, which carry it away” (Deleuze & Guattari, 1987, p. 88). Whilst these axes are independent of each other, they are also in presuppositional reciprocal relationship (Buchanan, 2021). It is the articulation of content and expression, which is the mechanism of the assemblage (Buchanan, 2020).

Assemblages comprise of a “diverse range of components which might include echoes of the past, awareness of the present, projections of a future, affect, feelings, emotions,

specific general cultural dimensions and other discursive effects” (Crowhurst & Emslie, 2018, p. 40). However, assemblages as multiplicities provide an alternative logic to unities and essences, such that what is important is not the terms or the elements which comprise assemblages, but the relations which are in between (Deleuze, 1994). Assemblages therefore, should not be defined by the heterogeneous components of which they are comprised, but the composition, aggregation and mixture of their external relations and what they produce (Buchanan, 2020; Nial, 2017). Accordingly, when thinking with assemblages, rather than asking the question “what is it”, we should instead be asking “what it functions with, in connection with other things it does or does not transmit intensities, in which other multiplicities its own are inserted and metamorphosed, and with what bodies without organs it makes its own converge” (Deleuze & Guattari, 1987, p. 4).

### **2.3.2.1 Desire**

The concept of desire is essential to understanding assemblages, with desire considered the basis for all behaviour (Buchanan, 2020). For Deleuze and Guattari, desire is not understood as lack or deficiency, but as primary and productive (Ross, 2010).

Assemblages are compositions of desire “there is no desire, but assembling, assembled desire” (Deleuze & Guattari, 1987, p. 399) and operate through desire as abstract machines in ways which are functional and productive (Livesey, 2010). Abstract machines place “variables of content and expression in continuity” and consist of “unformed matters and nonformal functions”, operating within assemblages as the cutting edges of decoding and deterritorialization, constituting becomings and opening up territorial assemblages onto something else (Deleuze & Guattari, 1987, p. 511). Abstract machines therefore extract particular arrangements, and it on the BwO that assemblages are formed.

Assemblages are solutions to a specific problem, whereas abstract machines are the cause, or the problem itself (Adkins, 2015). As such, specific assemblages are actualised in response to particular problems which necessitate their emergence. An assemblage therefore, is purposeful “It always benefits someone or something outside of the assemblage

itself (the body without organs)... it is not simply a happenstance collocation of people, materials and actions, but the deliberate realisation of a distinctive plan (abstract machine)” (Buchanan, 2015, p. 385). Assemblages are a “concrete expression of an abstract process” (Buchanan, 2015, p. 61).

Deleuze and Guattari (1987) conceptualise bodies, objects and institutions as ‘desiring machines’ that are constantly generating new relations and connections, emphasising the ways in which “desire moves through and between (human and non-human) machines, assemblages, and bodies in complex patterns” (Ringrose, 2011, p. 599). The concept of desire therefore, further highlights how assemblages are not just collections of materialities or things. Rather, desire is an organising force, selecting the components of an assemblage, giving them their properties and producing reality (Buchanan, 2020). As the organisation of desire is different within each assemblage, it is therefore it is important to focus on what assemblages do, why they are required and what they produce (Buchanan, 2020).

Desire is therefore conceptualised as positive and life affirming, enabling new connections and increasing a bodies capacities to act in the form of material flows, through the process of experimentation on the plane of immanence (Ross, 2010). However, desire in its pure state is also powerful and has the potential to be destructive, terrifying and can drop us into a black hole (Buchanan, 2020). It must therefore also be interrupted and constrained through processes of stratification that territorialise or code it and render it stable (Deleuze & Guattari, 1987). (See [section 2.4.1](#) in relation to chaos/black holes, and [section 2.4.3](#) in relation to stratification).

### **2.3.2.2 The Body Without Organs**

A closely related concept to desire is the Body without Organs (BwO). The BwO does not refer to the human biological body, as such a body with its discrete organs and distinct functions would be ‘organised’, fixed and incapable of change as its relations are already pre-ordained (Adkins, 2015). Instead, the BwO allows us to conceptualise of a body which is capable of change and experimentation, and one which is able to enter into new relations

and compounds. The BwO is in effect the plane of consistency and on this plane anything and everything combines and interacts because it is all affect (Buchanan, 2020). It is a plane of pure possibility and abstraction, and it is on the BwO that becoming is possible (Fraser, 2019). The BwO therefore closely relates to the concept of becoming ([section 2.3.3](#)), addressing how one creates space for change and transformation in order to open up new connections and increase capacities to affect and be affected (Adkins, 2015).

The BwO is populated by multiplicities and is a limit of intensities (Adkins, 2015). To construct a BwO is to embark on a process of experimentation which tends towards change however you can “never reach the Body without Organs, you can't reach it, you are forever attaining it, it is a limit” (Deleuze & Guattari, 1987, p. 150). The BwO therefore functions as ‘powers of selection’, determining when, how, and under what conditions desire is able to flow (Buchanan, 2020). The limit enables some affects to circulate, whilst blocking others, such that the BwO functions as a form of defence, protecting the subject by ‘walling them in’ and preventing them from going too far (Buchanan, 2020).

By doing so however, the BwO also works to limit or prevent the forming of new connections, containing capacities to affect and be affected. Processes of subjectification, signification and codification inhibit and constrain the disorganised body, by organising or stratifying it into something more stable and recognisable, interrupting and blocking the intensive flows of the BWO and reducing its capacities to become otherwise (Fraser, 2019). The concept of the rhizome provides a means of connecting our way out, escaping from walled in organised spaces so that we can create the new and experience different ways of becoming (Buchanan, 2020; Message, 2010). The BWO however, can never fully escape from the stratifying layers that constrain it and therefore one must always maintain some connection to the strata. For this reason the BWO, can never be reached or attained, it always remains a limit one approaches.

Deleuze and Guattari (1987) also caution that composing a BwO is not necessarily easy. There are dangers associated with creating the new, it can be terrifying and a BwO can be “botched” (p. 149). Due to the nature of experimentation, we cannot know in advance

what a body can do (Deleuze, 1992) so, the invitation is to experiment, but experiment carefully so as not to risk complete destratification, or the production of a harmful or empty BwO which is not open to new connections and combinations. A full BwO in contrast, is one which promotes the attainment of the maximum number of combinations and becomings, without collapse (Adkins, 2015). Deleuze and Guattari (1987) outline how the process of experimentation (creating a BwO) should proceed:

Lodge yourself on a stratum, experiment with the opportunities it offers, find an advantageous place on it, find potential movements of deterritorialization, possible lines of flight, experience them, produce flow conjunctions here and there, try out continuums of intensities segment by segment, have a small plot of new land at all times. It is through a meticulous relation with the strata that one succeeds in freeing lines of flight, causing conjugated flows to pass and escape and bringing forth continuous intensities for a BwO (p. 161).

In the context of IBS related dietary management, establishing new and individualised ways of eating following an IBS diagnosis, could therefore be understood as embarking on a process of dietary experimentation in an attempt to ‘liberate’ the body from adverse physical outcomes, and enable body stability and life continuity. The process of creating a BwO as explained by Buchanan (2020), might be usefully applied to the context of IBS, when those with IBS were required to “confront food differently.... since we cannot change what food does to us, we must change ourselves. This demands that we find a new way of being, which effectively means a new way of becoming. This is really what the BwO really is, a new way of becoming” (p. 79).

Importantly, the concept of the BwO allows us to map what a body is trying to do, what kind of experiment is being undertaken and why. When applied to understanding IBS related dietary practices for example, the BwO invites us to think about how new ways of eating which emerged throughout the process of dietary experimentation participants described embarking upon in [section 7.2.1](#), did not pre-exist the experiment, but were generated in relation to the experiment, with every becoming producing its own limit (Adkins, 2015). The

limit in this context being that as food cannot be avoided all together, specific individualised (and often restricted) dietary practices were adopted in ways which enabled symptom management (the blocking of some affects associated with the consumption of symptom producing foods) whilst simultaneously enabling the flow of other affects (eating/not eating in ways which enable body stability) so that overall, capacities to maintain and form new relations are not diminished by the onset of IBS symptoms.

Thinking with assemblages, and associated concepts of BwO and desire, therefore enabled me to explore when various IBS eating assemblages were being actualised across different contexts and temporalities, what kinds of dietary practices were being produced, what functions they performed for women with IBS. This further allowed me to identify when specific ways of eating were considered helpful, and where experiences of food/body distress were being produced. Thinking with assemblages more simply, enabled me to explore what women with IBS were trying to do when engaging with (and avoiding) food in different ways, creating new ways of thinking about how we might understand IBS related food/body relations.

### **2.3.3 Affects, Intensities, Becomings**

Whilst there are various different conceptualisations of affect (Ott, 2017), Deleuze and Guattari draw on Spinoza's (1992) distinction between affect as emotion ('affectio') and 'affectus'. Drawing primarily on 'affectus', Deleuze and Guattari (1987) conceptualise affects as intensive forces, with affect described by Massumi as a "prepersonal intensity corresponding to the passage from one experiential state of the body to another and implying an augmentation or diminution in that body's capacity to act" (p. xvi). Affect therefore entails "the change, or variation, that occurs when bodies collide, or come into contact" (Colman, 2010, p. 11) and are the capacity that a body has to form new relations, in relation to qualities and quantities of force (Buchanan, 2020). (I expand on this further in [section 2.3.4](#)).

Affects are also referred to as Deleuze and Guattari (1987) as intensities and becomings, “Affects are becomings” (p. 256). This is because they are transitional in nature and lack extension, such that they move through events and precede the perception or consciousness of such encounters, “that indescribable moment before the registration of the audible, visual, and tactile transformations produced in reaction to a certain situation, event, or thing” (Colman, 2010, p. 11). Massumi (2002) explains how affects exceed conscious understanding, language, and personal agency because they operate autonomously, lack specific qualities and are not possessed by the individual. As such, there is always an excess which escapes discursive production, and is unable to be captured by signification or representation (Grossberg, 2010). Thus whilst affects are felt and experienced through differences in intensity, these ineffable intensities exceed our current parameters of recognition (Fullagar & Bozalek, 2021, O’Sullivan, 2006).

Affects however, can also produce sensations which resonate with identifiable, or recognisable coded emotions and feelings such as shame (Taylor & Fullagar, 2021). It is also important to highlight that affectio, or emotions “follow different logics and pertain to different orders” (Massumi, 2002, p. 27). A distinction is therefore made between the two different registers of bodies (content), and attributes (expression) which can attach themselves to bodies as emotions/feelings but which are not bodily themselves (Buchanan, 2020). Whilst emotions/feelings have the capacity to transform us, this transformation is incorporeal and internal to enunciation, and differs to the process of becoming (Deleuze & Guattari, 1987). “Affectio are traces of interactions; residues of experience that live on and through and in the body” (Hicky-Moody, 2013, p. 81). In in this sense, emotions can be understood as personal and subjective captures of affects (Gibbs, 2010; Scrimshaw, 2013).

Becomings do not occur via evolution, correspondence or resemblance, but through alliance and contagion, with such unions referred to by Deleuze and Guattari (1987) as asymmetrical blocks of becoming or coexistence, which constitute a zone of proximity producing a shared deterritorialisation. Becoming always involves a multiplicity, because “becoming and multiplicity are the same thing” (Deleuze & Guattari 1987, p. 249) and occur



at the limits of what a body is capable of, the point where an increase in intensity transforms the multiplicity into something else (Adkins, 2015). As such, becomings occur at the borders, or threshold of transformation and are what escapes:

A line of becoming is not defined by points that it connects, or by points that compose it; on the contrary, it passes between points, it comes up through the middle... A line of becoming only has a middle... A becoming is neither one nor two, not the relation of the two; it is the in-between.... Becoming is the movement by which the lines frees itself from the point, and renders the point indiscernible (Deleuze & Guattari, 1987, pp. 293-294).

As becomings are not binary and occur on a continuum, there is no logical or predicable order through which transformation occurs (Adkins, 2015). Thinking with becomings, therefore challenges linear understandings of cause and effect whereby causality is typically understood as a specific relation between distinct, isolatable and autonomous events/entities, such that one causes an effect on another (Murriss & Bozalek, 2021). Deleuze and Guattari (1987) are clear that assemblages do not contain causal infrastructure and consider linear causality so generalised and extrinsic (e.g. psychological or sociological) that it ends up explaining nothing.

Assemblages, however do have “an abstract line of creative or specific causality, its line of flight or of deterritorialization; this line can be effectuated only in connection with general causalities of another nature, but is in no way explained by them” (Deleuze & Guattari, 1987, p. 283). Becomings therefore produce an aggregative and emergent form of causality, whereby constantly unfolding relations self-organise in ways which are not predetermined and produce new and sometimes unexpected and unpredictable outcomes (Connolly, 2010). This is why Deleuze and Guattari (1987) advise exercising caution with becomings, as there is no guarantee that an alliance will be beneficial, or will not end with becoming “bogging down and veering into the void” (p. 251). No one knows in advance what a body can do, so one must make a rhizome and experiment carefully (Adkins, 2015).

In contrast to being (the reproduction of the same), Deleuze and Guattari (1987) consider becoming (the creation of the new) to be virtuous, as becomings increase a body's capacities (Adkins, 2015). Although some becomings may be blocked or recaptured by processes of stratification or signifying systems (see [section 2.4.3](#)) or end in destruction, these becomings are still considered valuable by increasing the possibility of future becomings. The more combinations a body enters into, the more likely it will be able to increase its powers by increasing its capacity to affect and be affected in ways which are advantageous and affirmative (Deleuze & Guattari, 1987).

The concept of affects/intensities/becomings, provided a useful and powerful analytic for exploring how, when and where affective flows are produced, intensify and how certain blocks of becomings have the capacity to produce different embodiments which shape different ways of thinking and feeling, and experiences of human life. For example, In [chapter 5](#), I theorise the onset of severe and debilitating physical symptoms resulting from specific food/body relations (or contagions) as a process of becoming, which I refer to as 'becoming IBS'. The concept of becoming enabled me to illustrate how experiences of IBS related distress (both physical, psychological and emotional) could be understood as being relationally produced, as opposed to isolatable, discrete states of being, devoid of context. I was further able to explore how certain affects could gather and accumulate over time in ways which produced certain subjectivities (Ahmed, 2006, 2010), such that participants who endured long periods of severe bowel dysfunction had come to understand themselves as non-viable, broken subjects and unworthy of love (see [section 5.2.1](#)).

### **2.3.4 What a Body Can Do – Ethology**

Deleuze and Guattari (1987) argue that bodies should not be defined by their organs or organic functions, but rather as aggregates “whose elements vary according to its connections, its relations of movement and rest, the different individuated assemblages it enters” (Deleuze & Guattari, 1987, p. 157). Relations therefore constitute a body.

Drawing on Spinoza, Deleuze and Guattari's (1987) theory of the body poses the question: what can a body do?

We know nothing about a body until we know what it can do, in other words, what its affects are, how they can or cannot enter into composition with other affects, with the affects of another body, either to destroy that body or to be destroyed by it, either to exchange actions and passion with it or join with in a composing a more powerful body (Deleuze & Guattari, 1987, p. 257).

From this perspective, there is no separation between subject and object, and bodies (human and non-human) are constantly being made/unmade as they collide and diverge with one another (Ott, 2017). Is it though "given relations of movement and rest, speed and slowness...the sum total of the affects it is capable of at a given power or degree of potential" (Deleuze & Guattari, 1987, p. 287). Spinoza was interested in the distinctiveness of individuals bodies and how different combinations of affects and relations comprise and define such bodies (Deleuze, 1992).

As highlighted in [section 2.3.4](#), affects are not considered to be inherent in bodies, but are instead the capacity of bodies to form new relations, with the body understood as a multiplicity of affects. Relations are virtual links between bodies of which a specific body is capable of forming, however these relations only become actualised in connection with other bodies (Buchanan, 1997). Accordingly, a body's structure corresponds to its practical abilities and as such "what a body can do corresponds to the nature and limits of its capacity to be affected" (Deleuze & Guattari, 1992, p. 218). A body is therefore understood as a composition of forces, which are constantly in a state of flux, and as such "a body can be affected in many ways by which it's power of activity is increased or decreased" (Spinoza, 1992, p. 103).

Deleuze (1992) distinguishes between two kinds of encounters between bodies. The first enables bodies to be preserved and prosper, and these are considered to be "good" or "useful" encounters, which produce an "affection that is itself good, which itself agrees with my nature" (pp. 240-241). These kinds of encounters are considered joyful and increase or

aid our power of action and our capacity to be affected increases. The second kind are those which are not agreeable with, or are contrary to body's nature. Such encounters are considered to be "harmful", "bad" and produce feelings of "sadness" and result in a reduction of powers and capacities to be affected are diminished. Within all encounters, the outcome depends upon the respective powers of the bodies encountering each other, such that if one body is more powerful than other, it will "destroy the others, decompose its relation" (Deleuze, 1992, p. 241). These different types of encounters are in constant interaction, with our capacities always in a state of flux.

It is also important to highlight that good and bad encounters are not inherently so, they are only determined through composition "There is no good or evil in nature in general, but there is goodness and badness, useful and harmful for each existing mode" (Deleuze, 1992, p. 247). Whether an encounter is good or bad, can only be determined from a particular perspective. By nature we seek to organise our encounters, striving for those which are the most useful and agreeable to our nature, those which enable us to become reasonable, strong and free, given the contexts and circumstances within which such encounters take place (Deleuze, 1992). For those with IBS, certain foods could be therefore understood as harmful "in relation to the circumstances in which I encounter it, it doesn't agree with my nature" (p. 248), and therefore avoided. As Spinoza explains "we avoid eating food that our nature finds disgusting" (cited in Deleuze, 1992, p. 248).

Deleuze (1992) highlights how "a body less strong than my own may be stronger than one of my components, and may therefore be enough to destroy me, should the composition in question be a vital one" (p. 242). When applied to the context of IBS related dietary management, certain trigger foods can therefore be understood as vital or affective, in that specific food/body relations had the potential to produce harmful encounters which were not agreeable with the body's nature and instead favour destruction. Such encounters produce severe and debilitating physical symptoms which significantly diminished a body's powers and capacities, tending them their "lowest degree" (Deleuze, 1992, p. 243). I explore some of these 'harmful' encounters in [Chapter 5](#) and highlight how restoring a body's capacities

back to state of health following an IBS flare, also required significant effort, or “concentration” of the body’s power of action, in ways which further reduced participants capacities during the process of ‘becoming well’ (Duff, 2014).

Asking the question “what a body can do”, therefore seeks to understand which specific relations a body is capable of composing with other human and non-human bodies and which particular affects determine a body’s capacity to affect and be affected (Deleuze, 1992; Duff, 2014). Approaching the body this way enables a cause and effect (etiology) approach be reconfigured with an ethological account, which focuses the sum of its affects/capacities (Buchanan, 1997). “The distinction between good things and bad provides the basis for real ethical difference, which we must substitute for a false moral opposition” (Deleuze, 1992, p. 254). Deleuze argues that an ethical view of the world must always be a matter of capacity and power, nothing else. Life cannot be measured, or defined in relation to norms and moral laws which order and prohibit, reward and punish (Deleuze, 1997). An ethological approach to life therefore seeks to extend the body’s powers and increase its capacities to affect and be affected, as far as it can. Deleuze’s ethics are therefore understood as a philosophy of pure affirmation and joyful affections (Deleuze, 1992).

#### **2.3.4.1 Healthy Bodies / Encounters**

When applying these philosophical concepts more specifically to understandings of health and healthy eating, health can be defined as “the actual measurable capacity to form new relations, which can always be increased, and the concomitant determination of whether or not the newly formed relations between bodies lead to the formation of new compounds, or the decomposition of already existing compounds” (Buchanan, 1997, p. 82). Those relations which promote the formation of new connections (physical, psychological and emotional) are considered health enabling, whilst those which lead to the decomposition of existing compounds and prevent the formation of new ones, unhealthy (Buchanan, 1997). Healthy bodies would therefore have numerous affects and relations, which further increase capacities for the forming of new compounds. Such capacities however are also determined

by the unique affects and relations a body's individual set of circumstances (i.e. include a body's biological functioning (or dysfunction), past experiences, social/cultural factors, treatment options, social support, the emotional meaning of illness etc.), and its responses to a particular ill-health assemblage (Fox, 2011).

Health from this perspective, is not definable by lack, and can never be achieved as an end point or absolute, it will always be processual (Buchanan, 1997; Duff, 2014). Duff (2014) describes health as a process of becoming, a becoming-other that fluctuates along with the body's capacities (p. 625). Bodies are therefore always engaging with an active process of 'becoming-healthy' and health/ill-health assemblages can be explored by examining the affects and relations that compose a specific body (Fox, 2011).

When applied more specifically to IBS related dietary practices, an ethological approach enables hierarchical distinctions of healthy/unhealthy eating to be avoided, whilst simultaneously recognising that certain ways of engaging with (and avoiding) food are also contextually and temporally produced. As such, asking the question 'what a body can do' enabled me to consider what women with IBS were actually trying to do when engaging with (and avoiding) food in specific ways.

Adopting an ethological approach further enabled me to avoid essentialism by affirmatively highlighting that all bodies are different and constantly becoming different through an ongoing process of change (Feely, 2016). Whilst acknowledging there are physical limitations of IBS bodies (limits to the conditions of possibility), an ethological approach also opens up the potential for affirmative futures. This enabled new and different ways of engaging with food to be understood in relation to their affects and capacities (what they enable an IBS body to do), rather than viewing certain dietary practices from a moralistic or deficiency perspective (see [chapter 8](#) for discussion of how new understandings of 'healthy' eating emerged through IBS eating assemblages).

## 2.4 How Assemblages Gain Consistency

In this section, I outline the DeleuzoGuattarian concepts of chaos / black hole, the refrain and territory, strata and stratification, which relate to how assemblages come to gain consistency over time. Where appropriate, I outline how each concept has been theorised or put to work in relation to understanding IBS-related dietary practices.

### 2.4.1 Chaos / Black Hole

Key to understanding the concept of territory ([section 2.4.2](#)) is chaos (Buchanan, 2020). Chaos is an existential condition (although it can also be a physical state) which Deleuze and Guattari consider to be the basis of our existence, the foundation of all thinking, life and death (Buchanan, 2021). Chaos is described as a “non-dimensional state of pure formless undifferentiation, a non-space or non-time with no points of reference and no localisations” (Somers-Hall et al., 2018, p. 193). As an ever present potentiality, chaos remains a constant threat to both our physical worlds and mental lives, however even the most stratified aspects of our lives are only able to provide a temporary victory over the forces of chaos which are never far away (Buchanan, 2021).

Whilst Deleuze and Guattari often refer to chaos as something to be feared and avoided, the goal is not to completely avoid chaos, as this would shut down all creative potential and result in stasis. Instead, chaos must be managed through the art of dosages “one needs chaos, but only so much and not too much – just enough to disrupt ‘normal service’ so to speak and allow creativity to flow” (Buchanan, 2020, p. 66). One still needs to retain enough consistency (territory, or a minimum of strata) to rebuild a life (Buchanan, 2020; Deleuze & Guattari, 1987). I further address this ethics of prudence, or the art of dosages in [section 2.4.2](#).

Chaos can also be appealing in specific circumstances and therefore has its own directional components, however if we let too much in we may never escape it, and this is why chaos is also referred to as a black hole, because it can capture you and not let you out (Buchanan, 2020; Deleuze & Guattari, 1987). Drawing on F. Scott Fitzgerald, Deleuze and

Guattari (1987) describe how the black hole can make itself felt in our lives in three ways; big blows that hit you from the outside, micro-cracks, and clean breaks which destroy all connections to the past. The three ways in which the black hole can be felt are not often observable to others, as they occur in our most fundamental territory, namely ourselves but they can produce raptures which result in the obliteration of the subject as they become multiple (Buchanan, 2020). As a result of this de-constitution, a new kind of assemblage is formed on the plane of consistency, a space of pure desire and creativity (Buchanan, 2020). However, the plane of consistency can also be a place of death and destruction, so one must exercise caution when attempting lines of flight. The black hole is a possible outcome of an ill-conceived, or too fast a deterritorialisation as a result of a threshold being crossed too quickly, or when an intensity becomes too dangerous and no longer bearable (Deleuze & Guattari, 1987). Too much chaos can temporarily, or permanently incapacitate us (Buchanan, 2020).

#### **2.4.2 The Refrain and Territory**

The refrain, or *ritornello*, is often an overlooked and under recognised Deleuze/Guattari concept, however it is important for understanding how living beings create space and construct a home for themselves in order to maintain their existence (Kleinherenbrink, 2015). Within Deleuze and Guattari's philosophy of immanence, the refrain is essentially related to the concept of territory, in that the refrain, "is territorial, it is a territorial assemblage" and its main function is to create and demarcate a territory (Deleuze & Guattari, 1987, p. 312). As such, one cannot be thought of without the other, and territory can be understood as a liveable order which is produced and sustained by a refrain (Buchanan, 2020). Refrains are therefore constitutive, and structure affects/intensities into "existential territories" (Deleuze & Guattari, 1995, p. 15) or territorial assemblages, which are found simultaneously between chaotic, territorial and affective forces (Adkins, 2015).

The refrain consists of three interdependent movements, or components which occur simultaneously: the determining of a centre, the drawing of a circle around this centre, and



the opening of the circle towards novelty and the unfamiliar (Ingala, 2018). Firstly, through their repetitions and repeated patterns, refrains function to hold the world safe by keeping the chaos at bay and providing a sense of comfort (Davies, 2021). Grosz (2008) describes the repetition of the refrain as “a kind of rhythmic regularity that brings a minimum of liveable order to a situation in which chaos beckons. It is the tapping of a kind of order of safety that protects the body through the rhythms of the earth itself” (p. 52). Rhythm however, is not understood as cadence or a stable unit of measure (as that would relegate it to resemblance and repetition of the same) but of difference (Somers-Hall et al., 2018). Through this territorialising function, the refrain establishes a fragile “calm and stable, centre in the heart of chaos” (Deleuze & Guattari, 1987, p. 311) which provides the beginnings of order in chaos, from which one can orient themselves (Ingala, 2018). This component of the refrain is referred to as an infra-assemblage and is found below the assemblage (Solar Santibanez, 2023).

Secondly, the refrain provides a circle of control which establishes a home, a safe plot of land, or territory (Davies, 2021). This component is referred to as an intra-assemblage, and is often associated with a feeling of safe containment, or having a territory around us (Solar Santibanez, 2022). Grosz (2008) describes how territories are constructed through “rhythmic, melodious patterns, small chants, ditties, that shape the vibrations of milieus into the harmonics of territories, the organization of a wall or barrier” (p. 54). This wall or barrier is constructed through a process of “selection, elimination and extraction” (Deleuze & Guattari, 1987, p. 311) and functions as a bounded territory to keep the forces of chaos outside of the interior circle as much as possible.

A territory has two effects, which Deleuze and Guattari (1987) refer to as “a *reorganization of functions and a regrouping of forces*” (p. 320 original emphasis). In this sense, the concept of territory can be understood as defensive in that its components function in a specific way, enabling us to maintain critical distance from others, and to avoid or escape the forces of chaos or/and black hole (Buchanan, 2020). The functions of a territory however, do not pre-exist and their reorganisation arises only because they have

been territorialised, not the other way around. The functions and components of different territorial assemblages may therefore differ significantly depending upon our capacities, circumstances and the territory we assemble (Kleinherenbrink, 2015).

Even after constructing a territory, the drawing of this circle only ever enables a temporary victory over the forces of chaos, with Deleuze and Guattari (1987) noting that any “mistake in speed, rhythm, or harmony would be catastrophic because it would bring back the forces of chaos” (Deleuze & Guattari, 1987, p. 311). Any component of a territory may rot or collapse, which may also lead to its dissolution, or something from outside of the circle may disrupt or destroy the inner space. Additionally, given the components of any given territory are brought together through a process of “selection, elimination and extraction” and do not naturally belong together, there always remains an amount of surplus value, or “autonomy” which can escape or be captured (Kleinherenbrink, 2015; Deleuze & Guattari 1987, p. 312).

Finally, the third aspect of the refrain involves opening up the circle a crack and launching oneself forth towards the unknown on “a line of flight to the outside, a movement of migration, transformation or deformation” (Grosz, 2008, p. 52). This final component is referred to as the inter-assemblage and enables movement between assemblages and beyond current territories, to explore, change, create the new and become-otherwise (Edgardo & Santibanez, 2023). This involves the deterritorialisation from a familiar territory into a new territory, via a line “line of flight” which is the pathway, or operation of a specific deterritorialisation (Deleuze & Guattari, 1987, p. 9).

The concepts of deterritorialisation and reterritorialisation are used to convey the dynamic, transformative processes of assemblages (Fullagar & Malone, 2022). Deterritorialising forces or intensities, are those which break away or escape as lines of flight from the cutting edges of assemblages, in order to produce something different. This process can be understood as “the movement of affects as they unite and disunite with bodies” (Buchanan, 2021, p. 34). In effect, the process of deterritorialisation, or the movement of leaving the safety of one’s territory, means temporarily functioning without a

territory and as this process is highly dangerous we immediately find ways to reterritorialise, leaving one territory so that we can immediately enter another. The process of deterritorialisation is therefore inseparable from the process of reterritorialisation (Adkins, 2015). To deterritorialise is therefore to free up fixed relations (the selection or extraction of intensities) in order to place them in different relations elsewhere (Buchanan, 2020).

A territory is always subject to change and territories are always regenerating themselves with new components from outside of the territory, and are therefore always entangled with other territories and multiple refrains. As such, territories always in a process of becoming something new and different and always in the process of deterritorialization, even when they may appear stable due to the slowness of change (Kleinherenbrink, 2015). Deterritorialisation is never regressive, but a movement beyond the current territory into the cosmos to join with future forces (Kleinherenbrink, 2015). Davies (2018) explains how sometimes these deterritorialising movements might be so small they are barely noticeable, however on other occasions they may afford joyful releases from the constraints and repetition of day-to-day life which can feel suffocating (Davies, 2018). Whilst the first two components of the refrain function to protect against chaos, this third component therefore ensures that a territory does not become stifling and result in stagnation by ensuring that the circle is able to be opened up and new territories created (Kleinherenbrink, 2015).

With any lines that escape, there is always the potential for danger and destruction. As a result, Deleuze and Guattari (1987) emphasise the 'art of caution' (art de la prudence) (Deleuze & Guattari, 1987, p. vi), or an ethics of quantities, passages and dosages. Dosages however, cannot be determined once and for all and it is the refrain which regulates this calculation. A consistent assemblage necessitates enough differentiation to preserve the heterogeneity of its components, however not too much that it collapses or regresses into a homogeneous state of chaos (Somers-Hall et al., 2018). Further, dosages must always be determined in relation to a specific problem and particular set of circumstances. How much critical distance is required between chaos and other territories, and how much difference is required to think and act in order to regulate passages and enable just enough movement to

avoid imbalance and risk tipping the assemblage, can only be determined in situ (Ingala, 2018).

There is also no guarantee that a deterritorialisation will create the new, and it is always possible that “instead of opening up the deterritorialised assemblage into something else, it may produce an effect of closure” (Deleuze & Guattari, 1987, p. 333). It is also important to note that even when rhythm operates through difference, the refrain may still end up degenerating and establishing a kind of regularity which ends up reproducing the same. When this occurs, and the refrain loses its differentiating power, this would be considered a “bad or mediocre refrain” or a “bad usage of the refrain” (Deleuze & Guattari, 1987, p. 349; Ingala, 2018). A healthy territory, in contrast, is one which is not closed off, and has the capacity to interact with its environment and embrace contingency and openness (Adkins, 2015).

The refrain therefore addresses the problem of consistency and enables Deleuze and Guattari (1987) to demonstrate how things come to hold together, and how assemblages gain consistency (Adkins, 2015). However, consistency in relation to the concept of the refrain and territory offers a different, rhizomatic view of consistency which is the result of territorialisation and the self-organization of assemblages, “the becoming expressive of rhythm” (Deleuze & Guattari, 1987, p. 316), not reproduction of the same.

When applied to IBS related dietary practices, the refrain and territory were useful concepts to explore how certain ways of engaging with (and avoiding) food gained consistency over time. In [chapters 6](#) and [7](#), I theorised the rhythmic and temporal nature of participants day-to-day dietary practices as territorial components of IBS eating assemblages. I further theorised the repetitious adherence to restricted dietary practices as dietary refrains, which functioned to create feelings of safety by enabling participants to hold their bodies stable and keep the ever present danger of chaos at bay. The concepts of territory and the refrain were also useful to demonstrate how in certain contexts, some participants would choose to open “the circle a crack... and launch forth” (Deleuze & Guattari, 1987, p. 311) from the safety of restricted dietary practices and knowingly eat

problematic foods for pleasure and enjoyment knowing it would likely result in symptom onset (sections [6.4.3](#) and [7.3.3](#)).

### **2.4.3 Strata / Stratification**

Strata are layers and the concept of strata provides a way of problematising the appearances of things which are often assumed to be naturally occurring, by instead enabling them to be understood as multiple processes and forces which assemble over time (Buchanan, 2020). Life is therefore able to be understood as multilayered, however these layers are not necessarily organised and interconnected, and we often experience life in-between layers we are not always aware of, or can articulate. Further, not everything happens simultaneously. There are variations between layers which do not always follow a pattern or linear pathway and whilst things may have a start and finish or continue on from each other, this does not necessarily mean that one is a precursor or progenitor to another (Buchanan, 2020). The concept of strata enables a way to conceptualise, and identify how variations between and within different layers come to gain consistency and hold together over time, such that they are able to resist disruption and destabilisation (Buchanan, 2020). Strata can be understood as a ‘thickening’ of the flow of matter, which results in stable, unified assemblages (Adkins, 2015).

The concept of strata also enables Deleuze and Guattari (1987) to demonstrate how subjects are produced through assemblages. Strata “consist of giving form to matters, of imprisoning intensities or locking singularities into systems of resonance and redundancy...Strata are acts of capture; they are like "black holes" or occlusions striving to seize whatever comes within their reach.” (Deleuze & Guattari, 1987, p. 40). The process of stratification operates through coding and territorialisation, highlighting how strata can ‘bind’ us, “the organism, significance, and subjectification. The surface of the organism, the angle of significance and interpretation, and the point of subjectification or subjection” (Deleuze & Guattari, 1987, p. 53). Subjects and social contexts are therefore not ‘given’, or derived from ‘essences’ (DeLanda, 2006) but rather assembled together in specific arrangements and

produced through various relations, processes, affects and events which come into being (Duff, 2016). The assemblage as the unit of analysis (Fox & Alldred, 2022), is therefore able to account for how certain subjectivities and contexts hold together in experience (Duff, 2014).

The concept of stratification also enables a means of identifying and mapping relations, or orders of dependency; those which increase capacities for expression, and therefore deterritorialisation, and those which become more rigid and reduce or block such capacities. Deleuze and Guattari (1987) describe the socially binding processes of stratification as an inevitable phenomenon, beneficial and fortunate in some respects, however also unfortunate and undesirable in others, depending upon one's context and perspective. As a society we would be unable to function without language, culture and many traditions for example, however not all forms of stratification are mutually beneficial for everyone (Buchanan, 2020). However, whilst Deleuze and Guattari (1987) often describe stratification as undesirable or unfortunate, they also warn of the dangers of escaping certain strata, if "you blow apart the strata without taking precautions then instead of drawing a plane of immanence you will be killed, plunged into a black hole, or even dragged towards catastrophe" (p. 50). Neither state (chaos/disorganisation or organisation) is therefore fully desirable and there is a constant movement between the two.

When applied to IBS related dietary practices, the concept of strata/stratification enabled me to identify how various socially binding forces, such as the pressure to conform to social eating norms and feminine appearance ideals, flowed through participants IBS eating assemblages. These territorial codes functioned to limit how participants could understand and feel about themselves, their bodies and their dietary practices. As Colebrook (2002) notes, "The very forces that allow any form of life to become what it is (territorialise) can also allow it to become what it is not (deterritorialise)" (p. xxii) and for those with IBS, becoming symptomatic and suddenly finding themselves outside of feminine appearance ideals could lead to a feeling of having "coming undone" (Deleuze & Guattari, 1983, p. 322) (see [chapter 5](#)). The concept of stratification also enabled me to explore how participants felt

about their own dietary practices, with understandings of normative healthy eating having been territorialised by population level healthy eating guidelines (see [chapter 8](#)).

#### **2.4.3.1 Healthism and Postfeminist Healthism as Lines of Stratification**

The concept of ‘healthism’ refers to contemporary understandings of health, whereby health is understood as stable, individualised and something which is primarily attainable through ongoing lifestyle modifications and consumer practices (Crawford, 1980, 2006). Within the context of neoliberalism, the predominant economic and political ideology which prioritises individual choice and economic freedom, health has become a highly valued multifaceted endeavour expanding into multiple domains, and as a result has come to represent the “possibility for the good life, or even the good life itself” (Crawford, 2006, p. 404).

Personal responsibility for engaging in health and wellness practices are further moralised and connected to identity, such that those make the ‘right’ lifestyle choices are understood as self-disciplined, virtuous and positioned as living a good life (Crawford, 2006; Reiley et al., 2018). As a consequence, those who fail to attain health or become ill despite the inevitability of ill health, are held personally accountable and become open to blame, judgement and criticism (Riley et al., 2022, 2025). Such failure may further be internalised, and in the case of IBS, produce anxiety, shame, disgust, and feelings of “brokenness”, even when ill health is beyond individual control.

Healthism therefore, creates an illusion of control by positioning health as expected, but also always at risk, such that the more health conscious we become, the less secure we feel (Crawford, 2006). As a result, healthism is highly affective subjective force, with Crawford (2006) arguing that “in a health-valuing culture, people come to define themselves in part by how well they succeed or fail in adopting healthy practices and by the qualities of character or personality believed to support healthy behaviours” (p. 402).

Healthism however, is also gendered (Riley et al., 2025). The concept of postfeminist healthism (Riley et al., 2018; Evans et al., 2020) provides a framework through which

healthism, femininity and health assemble, enabling a gendered analysis of healthism. Postfeminism as a 'sensibility' (Gill, 2007, 2017) is understood as a distinctive 'structure of feeling' (Williams, 2001). The term 'structure of feeling' is used to describe the sensations and feelings associated with a cultural sensibility which emerges through recognisable patterns of femininity which shape subjectively in ways which are deeply affective (Evans & Riley, 2023). Such patterns are not fixed, but constantly shifting in response to cultural change and often comprise contradictory elements which unfold through dynamic relations in ways which foreground multiplicity and complexity (Riley et al., 2025). For example, "good health" which now extends into multiple domains of life (i.e. relationships, social lives, bodies, minds and attitudes), is positioned as a normalised desire and something which all women should want, as an optimal idealised state of happy healthy feminine perfection, however what is considered to be healthy is also dynamic and constantly changing, whilst also being exceptional and unattainable (Evans et al., 2020).

Postfeminist healthism further entails a cultural imperative for women to constantly work on, and transform themselves in order to pursue narrow ideals of healthy embodied femininity and health perfection which encompass both body and mind (Evans et al., 2020; Riley et al., 2017, 2025). Transformation efforts are further depicted as fun and valued, with notions of agency, empowerment, individual freedom and pleasure surrounding such work (Riley & Evans, 2018). Restricting food intake for weight loss purposes for example, is framed as empowering and pleasurable (Cairns & Johnston, 2015) and something one can be good at (Rich & Evans, 2008). Yet the same time, one does not want to appear too obsessed or overly restrictive, and one must still love their body but also want to transform it (Riley et al., 2018). Femininity is therefore constructed as "always-already flawed" (p. 6) yet rectifiable through ongoing work, and undertaken within a complex, yet also contradictory landscape where one must care about their health but not too much (Riley et al., 2025).

Transformation however is also tied to morality and value, such that any failure to attain health ideals resides within the individual (Riley et al., 2018, 2025). In neoliberal healthist culture, health, weight and morality are entangled, with health and weight having



become interchangeable, and weight considered to be a measure of a woman's health and attractiveness (Riley et al., 2018). With female bodies contrasted against the aesthetically valued 'thin ideal', weight becomes is a powerful affective lens through which women come to understand themselves (Riley et al., 2018). For example, with thinness placed at the top of a moral hierarchy of bodies (Jaeger & Jovanovski, 2024), being able to meet healthy feminine appearance ideals enables women to feel good about themselves, whereas falling outside of such ideals can instead produce feelings of self-disgust, shame and unattractiveness.

Postfeminist healthism therefore functions through norms (such as feminine appearance ideals) and socially valued identities (a healthy good person) in ways which render people knowable in relation to how much they align or deviate from such standards (Riley et al., 2025). Such forces of normalisation work on, and through us, such that we desire and seek to maintain them in ways which intensify anxiety and fear in relation to both our own, and others difference (Davies, 2013). Within this thesis, I conceptualise postfeminist healthism as a powerful affective line of stratification which flowed through IBS eating assemblages, shaping how women with IBS think and feel about themselves, their bodies, and their health and dietary practices, in ways which could be both helpful and harmful.

## **2.5 Understandings of Time as Non-Linear**

The final concept that I outline in this chapter is Deleuze's first synthesis of time, the living present (Deleuze, 1994). Deleuze and Guattari (1987) critique the concept of linear time, which is typically understood as a continuous line of sequential motion which moves from past to future and represents the notion of directionality (Arienzo, 2016). Drawing on Henry Bergson, they instead propose different conceptualisation which involves cartographies of time which are comprised of spatial lines, curves and constant processes of territorialisation and deterritorialisation, which are not linear but multiplicities (Arienzo, 2016).

Deleuze's philosophy of time is one of difference and becoming, whereby time itself is understood as a process, but more specifically the processes involved in making multiple times, or temporal multiplicities (Williams, 2011). According to Deleuze (1994) processes make time, however each process is determined by singularities as opposed to general laws, which determine their own time. As a result, there are many presents which incorporate aspects of pasts and futures in their dimensions, drawn together by events which produce time, however none of these things exist in the same present or time, they are processes which fold into one another (Williams, 2011). The past, present and future therefore, are not separate or independent of one another, but interacting dimensions of each other.

In Deleuze's first synthesis of time, the past and future are dimensions of the present which contract into one another, such that past experiences and events are retained in the present, with the future considered to be constituted through anticipation, or awaited in the living present (Deleuze, 1994; Williams, 2011). When applied to the context of IBS related dietary practices, past events (such as the onset of severe physical symptoms) are retained, and future possibilities (for example, fears of experiencing bowel dysfunction in a social context) become actualised, and are synthesised into the living present in ways which transform it and produce subjectivities. These may be passive, or associated with distress (e.g. food related anxiety) depending upon the active components which are drawn together in the living present.

Conceptualising time in this way enabled me to explore another layer of IBS related food complexity, and illustrate how multiple processes of time were always interacting and determining the ways in which participants managed their bodies and engaged with (or avoided) food, as they attempted to avoid symptom onset, particularly in contexts where this would be embarrassing, stigmatising and difficult to manage (see [chapter 7](#)). Deleuzian understandings of time as non-linear and multiple, therefore enabled me to highlight how participants day-to-day dietary practices were produced through the coexistence of the past, present and future in the 'living present' (Deleuze, 1994).

## 2.6 Chapter Summary

In this chapter I have outlined the theoretical concepts of rhizome/multiplicity, assemblage, desire, BwO, affects/intensities/becomings, what a body can do, territory and the refrain, stratification and understandings of time as non-linear, which together comprise my theoretical framework. I have highlighted how thinking with assemblages enables IBS related dietary practices to be understood as being relationally produced, and contextually, temporally and dynamically situated, and outlined some of the ways in which I have theorised and applied these concepts in relation to IBS related dietary management more specifically.

In this chapter I 'started in the middle' by outlining my theoretical framework. In next chapter I move out from the centre of this thesis and undertake a 'rhizomatic' literature review. To do so, I jump between three different bodies of literature. As I review these different literature bases, I further engage with the DeleuzoGuattarin concepts I have outlined in this chapter. I also highlight how DeleuzoGuattarian concepts have been applied to other health and illness contexts, and provide a generative framework through which to think differently about the gendered nature of women's health.

## **Chapter 3 – Assembling Different Bodies of Literature**

### **3.1 A Rhizomatic Literature Review**

In chapter 1, I commenced my thesis by creating a biomedical entry point. As IBS related dietary practices are yet to be explored from a DeleuzoGuattarian assemblage perspective, exploring this literature base served as the starting point during the early stages of the research, helping me to identify the gaps in the literature and to establish the problem position for this research. My exploration of the biomedical literature also emphasised to me how few studies have focused on women's embodiment in relation to IBS related food/body distress, whilst my knowledge of DeleuzoGuattarian concepts and assemblages led me to believe that they had the potential to open up new and different ways of thinking about IBS related dietary practices. Given the role that food and dietary practices play in symptom onset and management, it was further surprising that even fewer qualitative studies have explored IBS related dietary practices, and experiences of food/body distress for those with IBS more specifically. I wanted to address this, and believed a DelzuoGuattarin framework provided a means through which I could not only address this important research gap, but also had the potential to open up new and different ways of thinking about IBS related dietary practices.

Embracing the concept of the rhizome, this chapter assembles together a "patchwork" (Deleuze & Guattari, 1987, p. 476) of different literature which functions together to produce a rhizomatic literature review. Deleuze and Guattari describe how the rhizome is "without symmetry, the stems of the rhizome are always taking leave of the trees, the masses and flows are constantly escaping, inventing connections that jump from tree to tree and uproot them" (p. 506). As highlighted in the previous chapter, all 'things' are multiplicities, and as such a rhizomatic approach enables me to connect different bodies of literature through a logic of problems, rather than division of categorical consistency (Adkins, 2015; de Beistegui, 2018). As such, this creative approach to a literature review "jumps from one point to another" (Deleuze & Guattari, 1987, p.120) enabling me to not only identify a

range of components which comprise IBS eating assemblages, but also illustrate how they become entangled, connect and bifurcate (Deleuze & Parnet, 2002).

This literature review comprises three subsections, each mapping different lines of literature. In [section 3.2](#), I firstly review the IBS experiential literature and provide an overview of some of the components of IBS eating assemblages which function to produce experiences of IBS related distress, often in ways which were gendered. These components include the severe and unpredictable nature of IBS symptoms, experiences of dismissive and gendered healthcare encounters, societal perceptions of IBS and gender norms in relation to caring for others and feminine appearance ideals.

[Section 3.3](#) then provides an overview of what is currently known about IBS related dietary practices. I outline how dietary practices have been theorised and explored to date within the IBS experiential literature, and outline why an assemblage approach is better suited to understanding the complex nature of food/body relations within the context of IBS symptom management.

As assemblage thinking is yet to be applied to IBS, in the final [section 3.4](#), I provide a brief overview of how assemblages, DeleuzoGuattarian concepts, understandings of time as non-linear and feminist new materialist frameworks, have been used to explore other health and illness contexts and the gendered nature of women's health.

### **3.2 Assembling Component of IBS Related Distress**

Reviewing the existing IBS experiential literature provides an important entry point to understanding IBS related distress. This qualitative literature base which foregrounds lived experience, has been instrumental in highlighting some of the difficulties associated with managing severe and unpredictable IBS symptoms. I therefore commence by identifying some of the components of IBS related distress (the unpredictable nature of severe IBS symptoms, dismissive healthcare encounters, perceptions of IBS and the gendered nature of IBS), so that throughout my analysis I can draw attention to how understandings of IBS related distress can be further expanded upon, when understood as complex multiplicities.

This further enables me to identify how, when and where experiences of distress emerge through various configurations across different contexts and temporalities within IBS eating assemblages, in ways which produce different IBS related dietary practices.

Together, these components refer to what Deleuze and Guattari (1987) might call the “cutting edges” (p. 88) of IBS eating assemblages, enabling me to identify “the specific characteristics and features of a concept” (Buchanan, 2015, p. 383). It further allows me to establish some of the boundaries or limits of an assemblage of health (Duff, 2023; Storpor & Scott, 2016) and identify some of the ways in which different arrangements may endure or change over time, in ways which might oppress, promote or enable health, depending upon “what is brought into play in each multiplicity” (Ruddick, 2012, p. 4).

### **3.2.1 The Unpredictable Nature of Severe IBS Symptoms**

Although IBS symptom severity is often reduced to descriptors such as troublesome, bothersome, or a nuisance within the IBS biomedical literature, experiential qualitative studies have outlined how those with IBS describe experiencing severe and debilitating physical symptoms (Hakanson, et al., 2014; Harvey et al., 2018; Schneider & Fletcher, 2008; Mohebbi et al., 2019). IBS however, is not just a physical illness. Whilst symptom severity might often be considered in relation to physical symptoms such as severe pain, constipation, diarrhoea and extreme fatigue, qualitative studies have highlighted how those with IBS understood severity as also relating to many additional experiences which permeated throughout all aspects of life (Drossman et al., 2009a; Håkanson, 2014).

Women in Farndale and Robert’s (2011) qualitative study for example, reported pain as their most impactful symptom, with the pain they described enduring as worse than labour. This pain was further accompanied by fainting and vomiting, which made it difficult to move, sleep or concentrate, and therefore impacted upon employment and various other social aspects of their lives, which for some had resulted in depression.

Similarly highlighting the severity of symptoms, Assmann et al. (2024) illustrated how faecal incontinence was a debilitating experience which extended beyond bowel dysfunction,

also impacting upon emotional and psychological wellbeing. For their participants, unpredictable and uncontrollable bowels placed severe limitations on wider lives, relationships and employment, with participants having become fearful of leaving their homes. The fear associated with the unpredictable nature of urgency, diarrhoea and faecal incontinence was highly distressing (Assmann et al., 2024).

The distress associated with feelings of uncertainty and unpredictability in relation to bowel dysfunction highlighted within these studies, can further be understood in relation to social norms. In their focus groups exploring patient perspectives on IBS illness severity, Drossman et al.'s, (2009) participants described experiencing feelings of shame, embarrassment and disgust when unable to control their bowels. Although social norms were not touched upon in their study, in contemporary Western cultural contexts (where these and the present study were undertaken), defecation is considered a private concern, and something which should be taken care of privately, with the sights, smells, sounds and associated disgust, minimised (Weinberg & Williams, 2005; Chelvanayagam, 2014). As a result, those with IBS risk being stigmatised, with a loss of bodily control violating such socially prescribed norms (Chelvanayagam, 2014).

Feelings of shame in relation to bowel dysfunction are also gendered. Bowel dysfunction further violates normative understandings of femininity, whereby women are expected to be clean, modest and compliant (Bjorkman et al., 2013). More so than for men, women are taught that bodily functions are something which should remain private or kept secret, and as a result, being unable to control one's bowels is something which is experienced as more shameful for women (Houghton, 2016).

Having to use toilets at work or in public places for example, was therefore experienced as highly embarrassing for women with IBS, and could provoke feelings of shame when the sounds and smells of bodily functions were unable to be concealed or controlled, and where the frequency of bathroom visits became observable to others (Farndale & Roberts, 2011; McCormick et al., 2012; Nevots et al., 2023; Rønnevig et al., 2009; Scheider & Fletcher, 2008). Participants in Skrastins and Fletcher's (2018) study for

example, described having to use a public bathroom as devastating due to the nature of their symptoms. Fear of losing bowel control, together with highly distressing and devastating social consequences, have similarly been noted across other qualitative studies (Drossman, 2009; Goodoory et al., 2022; Rønnevig et al., 2009).

Due to the unpredictable and fluctuating nature of symptom onset, living with IBS could feel like living in an unpredictable, unreliable, untrustworthy and uncontrollable body (Håkanson et al., 2009; Håkanson, 2014; Rønnevig et al., 2009; Schenider & Fletcher, 2008). This led to feelings of helpless and frustration (Houghton et al., 2016; Rønnevig et al., 2009) with the potential for disruption and anticipation of symptoms often experienced as even more frustrating than physical symptoms themselves (Kamp et al., 2022).

Living with severe and unpredictable symptoms could therefore be extremely life limiting and intrude upon all domains of life including diet, leisure activities, employment, education, capacity to travel, sleep, intimate and social relationships, self-image, physical appearance and psychological wellbeing (Ballou et al., 2017; Crocker et al., 2013; Goodoory et al., 2022; Håkanson et al., 2014; Kamp et al., 2022; Rønnevig et al., 2009). In addition, because of gender norms and expectations, women may experience more social restrictions as a result of fear associated with losing control over their bowels, in order to avoid the potential of this occurring (Drossman et al., 2009).

### **3.2.2 Dismissive Healthcare Encounters**

Across the experiential IBS literature, healthcare encounters were highlighted as a significant cause of emotional distress for those with IBS. Despite the fact that IBS symptoms can be severe, debilitating and impact multiple domains of life, IBS is often trivialised and dismissed by medical professionals (Björkman et al., 2013; Bjorkman et al., 2016; Håkanson et al., 2014; Nevots et al., 2023; Miller et al., 2004; Skrastins & Fletcher, 2018). This may be because IBS lacks visible pathophysiology, is often associated with stress and psychological states such as anxiety, does not lead to other serious disease and



is not considered to be life threatening (Crocker et al., 2013; Miller et al., 2004, Mira et al., 2015, Mustafa, 2025).

As a result, IBS symptoms were not always taken seriously by healthcare professionals, and were often attributed to other health, or mental health conditions (Kamp et al., 2022). In their qualitative study exploring experiences of symptom management, Kamp et al. (2022) found that subjective descriptions of symptoms were dismissed and subordinated to objective medical findings by healthcare professionals, leaving those with IBS feeling dismissed and invalidated (Kamp et al., 2022).

Women's experiences of IBS are also more likely to be trivialised and overlooked as a 'female health concern', with gendered stereotyping during healthcare encounters further perpetuating distress (Björkman et al., 2013). Marano et al. (2025) observe there is a tendency towards underdiagnosis or misdiagnosis for IBS with women, with women's symptoms sometimes dismissed or attributed solely to psychological causes or emotional issues leading to feelings of invalidation and frustration (Marano et al., 2025). Lu et al.'s (2009) participants similarly described how doctors attributed their symptoms to psychosomatic origins, stress and nervousness, prescribing relaxation or a holiday to help alleviate their symptoms.

This is not surprising according to Vidali (2013), who details how problematic medical discourses have historically associated IBS with an anxious personality, such that those with IBS were understood as hysterical, hypochondrial and unreliable. Such discourses functioned to produce a typical 'gastrointestinal women', who was characterised as unjustly anxious and to blame for her symptoms. Although contemporary studies acknowledge IBS as a medical condition and the role of the gut-brain axis, the enduring notion of the 'gastrointestinal women' may however have ongoing consequences for women with IBS who are viewed through this lens during healthcare interactions. The modern 'gastrointestinal women' is still characterised as overly anxious, individually responsible for her own care (and blamed for overburdening the healthcare system) and largely excluded from healthcare interactions (Vidali, 2013). These findings fit more broadly within patterns of epistemic

injustice in relation to “women’s issues” and are discussed in relation to IBS further by Dryden (2022).

The IBS experiential literature has also outlined how emotional distress is tied to a perceived lack of empathy and understanding from healthcare professionals. For example, Hearn et al. (2020) found that almost all the nurses in their study felt that IBS patients wasted doctors’ time, were lazy, attention seeking and that IBS was all in their minds. Other qualitative studies have reported similar experiences, with those with IBS made to feel like their subjective experiences were not acknowledged or taken seriously, their symptoms did not matter, they were exaggerating, their illness was being imagined or all in their heads, or that they were drug seeking (Björkman, 2013; Dent et al., 2025; Håkanson et al., 2014; McKerchar et al., 2023).

Due to the unpredictable nature of symptom onset, symptoms could also appear and disappear, leaving those with IBS feelings foolish and embarrassed when their bodies failed to present with symptoms during healthcare encounters (Håkanson et al., 2010). As a result of such dismissive attitudes, many healthcare professionals lacked understanding of the impact of IBS on daily life (Sibelli et al., 2018), with the effects on the lives of those living with IBS minimised, leaving them feeling misunderstood (Björkman, 2013) and like their symptoms had not been investigated sufficiently (McKerchar et al., 2023).

Dismissive healthcare encounters may also have further implications for Māori. In their research exploring Māori experiences of navigating the Aotearoa New Zealand health system in relation to gut (puku) symptoms, Hapuku et al. (2025) found that Māori also experienced difficult gut related healthcare interactions. These Kaupapa Māori experienced researchers highlighted how it was awkward to talk about the gut when the body was seen as sacred. The hierarchical positioning of biomedical approaches further made it difficult to talk about gut issues when many felt too whakamā (shy) to speak up, after being previously brushed off or having experienced racism and suboptimal treatment, and thus already held mistrust in the system.

Embarrassment and shame in relation to talking about bowel dysfunction in healthcare settings has also been highlighted in other literature. Dent et al. (2025) found that perceived stigma associated with GI conditions made it a taboo subject and therefore difficult and embarrassing to talk about. As a result, few had disclosed or discussed the extent and impact of their symptoms with their healthcare provider (Casiday et al., 2009) and unless specifically asked, those experiencing IBS-related faecal incontinence for example, may not disclose this symptom (Atarodi et al., 2014). Symptoms could also be difficult to articulate when those experiencing 'gut issues' felt that something was 'not right' (McKerchar et al., 2023). The high level of stigmatisation associated with IBS, therefore had the potential to result in misconceptions by healthcare professionals and distress for patients, leading to worsening in symptoms (Kuliaviene et al., 2023).

Not surprisingly, those with IBS describe feeling alienated from the biomedical model with Western medical approaches unable to provide a cure (Harvey et al., 2018). Healthcare interactions were further considered frustrating due to the lack of satisfactory long-term management options available, and the long trial and error process often required to identify something which enabled symptoms to be managed (Sibelli et al., 2018). Harvey et al.'s (2018) participants described an 'unending quest for a cure' which left them feeling trapped in a vicious cycle which alternated between the hope of new treatments, and despair when finding them to be ineffective. As a result, many had sought information through alternative sources and had taken symptom management into their own hands, with many instead choosing natural approaches such as dietary changes (Houghton et al., 2016; Kim & Park, 2011, Lu et al., 2009).

### **3.2.3 Perceptions of IBS - An Invisible, Unspeakable and Gendered Syndrome**

Qualitative literature has also identified a significant disjuncture between the severity of symptoms and societal perceptions of IBS, often leading to a lack of understanding and empathy from others (Dent et al., 2025; Nevots et al., 2023). In their focus group discussions, Drossman et al., (2009a) found that a lack of understanding from family and

friends led to feelings of stigma which created barriers to social relationships. A lack of empathy and understanding in relation to the struggles experienced by those with IBS, was also highlighted by Skrastins and Fletcher (2018). The women in their study described how friends were unsympathetic to the impact of IBS on their lives, which negatively impacted upon their social lives and relationships.

Those with IBS also expressed frustration with the lack of pathophysiological explanation for their symptoms, which also resulted in the lack of understandings from others (Lu et al., 2009). As a result, IBS was not considered a 'valid' illness and had been the cause of conflicts with partners, family members and friends, who had been annoyed and inconvenienced about their bowel problems.

The uncertainty surrounding bodily control and bowel patterns could also intensify feelings of stigma, particularly when family and friends struggled to understand or take symptoms seriously. This perceived doubt or judgment from others contributes to the fear, shame, and embarrassment frequently experienced by people living with IBS (Drossman et al., 2009; Houghton et al., 2016).

This lack of understanding and empathy may in part be due to the hidden nature of IBS, which is often managed discretely and the severity of symptoms not talked about (Dent et al., 2025; Drossman, 2009; Schneider and Fletcher, 2008). As previously touched upon in [section 3.2.2](#), the shame and stigma associated with bowel dysfunction and the embarrassment associated with explaining the nature of symptoms, meant that the women in Schneider and Fletcher's (2008) study were forced keep the severity of their symptoms secret, due to concerns surrounding the nature of others' reactions. Other studies have similarly highlighted how women with IBS tried to conceal symptoms and did not seek help from others (Kim & Park, 2011). Societal misperceptions and gendered stigma in relation to IBS symptoms could therefore make it difficult for women with IBS to experience and talk about their symptoms, without experiencing feelings of shame or fear of judgement.

### **3.2.4 Gendered Components of IBS Eating Assemblages**

As highlighted in my introductory chapter, women are twice as likely as men to develop IBS (Drossman, 2016). Although much of the biomedical research has focused on the role of female sex hormones and their relationship with IBS symptoms, such biological factors comprise only one component of this assemblage and do not alone account for why women with IBS experience higher levels of distress than men. So far, I have touched upon some of the gendered aspects of IBS management which have been identified across the IBS experiential literature in relation to the unpredictable nature of severe symptom onset, dismissive healthcare encounters and societal perceptions of IBS which contribute to IBS related distress for women. In this subsection, I focus on gender more specifically and outline how gender norms and roles in relation to caring for others and feminine appearance ideals, also had the capacity to produce additional layers of distress for women with IBS.

#### **3.2.4.1 Gender Roles, Care and IBS**

Of the IBS experiential studies which have explored gender, experiences of IBS have been found to differ for men and women in relation to differing societal expectations, life contexts and gender norms (Björkman et al., 2013). Societal expectations of women and gender-specific stressors, may therefore contribute to higher IBS prevalence rates, with women more likely to have care giving responsibilities, societal expectations and gender inequalities (Marano et al., 2025).

Women with IBS experience shame when unable to meet gendered notions of care in relationships and friendships. Women for example, are socialised to put others first, even when doing so may be detrimental to themselves (Ali et al., 2000; Björkman et al., 2014). Kim and Park's (2011) participants for example, hid symptoms from friends as an act of caring for others so as to maintain friendships, even when this involved self-sacrifice. Others reported feeling guilty when impacting others by having to delay or cancel plans due to symptom onset (Dancey & Backhouse, 1993), putting others out such as requiring different

or specially prepared food (Lu et al., 2009) and by being a burden, all of which weighted heavily (Schneider & Fletcher, 2008).

Women also felt their IBS symptoms had a negative impact on their relationships, home and family life. For example, women with IBS described experiencing distress when feeling like they were unable to fulfil their role as mothers, attend to partners and care for others when experiencing symptoms (Björkman et al., 2013; Farndale & Roberts, 2011; Håkanson et al., 2009; Nguyen et al., 2018). Murphy et al. (2020) found that mothers who had young children (5-10 years) also expressed guilt about how their IBS impacted their children. Experiencing IBS symptoms made it difficult for mothers to care for themselves and their children at the same time, making it difficult to be a good mother. They described being unable to play with their children, missing important family moments due to being ill, having to cancel plans which impacted their families, and worrying that their children would also develop IBS.

In one of the few qualitative studies on IBS which mentions food, the mothers in their study further described safeguarding their children's health by seeking to optimise their children's diet in ways which were IBS friendly and promoted a healthy gut microbiome. Some mothers described eliminating certain foods from their children's diets, or placing their children on a 'special diet' as a means to prevent their children developing IBS, based upon beliefs that certain foods had precipitated their own IBS (Murphy et al., 2020).

Experiencing IBS symptoms also made commencing and maintaining intimate relationships difficult. Women's in Håkanson et al. (2009)'s study described not feeling attractive or fresh, with bloating and gas making them feel unattractive and embarrassed. Fear associated with urgency or having to pass wind during sex, had further led some women to feel shame in relation to their lack of desire to be intimate (Bjorkman et al., 2014). Concerns in relation to flatulence and having to conceal multiple trips to the bathrooms, in addition to hiding the sounds and smells associated with such visits, further impacted upon intimate relationships (White, 2016). This had led some women to express concerns around the potential of future relationships (Håkanson et al., 2014). For those without partners,

women described feeling reluctant to disclose flatulence and diarrhoea to potential new partners, and did not how explain their symptoms and commence new relationships (Nevots et al., 2023). IBS could therefore impact negatively on intimate relationships, making dating and having a fulfilling sex life difficult (Nevots et al., 2023).

In one of the few studies to draw on critical feminist theory, Nguyen et al.'s (2018) narrative study used interviews and creative methods to explore three women's experiences of intimate relationships in the context of IBS. Findings highlighted how IBS impacted upon women's emotional well-being, body image and agency within intimate relationships. Their participants described feelings of vulnerability, undesirability and insecurity, which left one participant feeling like they had the lower hand in the relationships. Findings also highlighted the extensive gendered emotional labour required to maintain intimate relationships whilst living with IBS. Supportive partner responses such as acceptance, empathy and the provision of practical support facilitated emotional connections, however a lack of understanding resulted in concealment, feelings of isolation and strained relationships.

Women with IBS may therefore face a unique array of additional gender related stressors, which have the capacity to produce additional layers of distress and make IBS management more difficult. Societal expectations and gendered norms in relation to the provision of care, and putting the needs of others first, further make it more difficult for women with IBS to prioritise their own health needs, which can exasperate stress and produce feelings of frustration (Marano et al., 2025).

#### **3.2.4.2 Feminine Appearance Ideals and IBS**

Feminine appearance ideals also impact how women experience IBS. Those with IBS for example, experience less favourable body image, frequently experience negative bodily sensations, and often perceive their body as a trigger for negative emotions (Bielecka et al., 2021; Jones et al., 2006; Kopczyńska et al., 2018). Such emotions have been tied to the appearance of bodily symptoms associated with bloating and femininity (Håkanson et al., 2009; Kim & Park, 2001; Lu et al., 2009; McCormick et al., 2012).

Women with IBS experience more bloating and abdominal distention than men (Houghton, 2016) and specifically express concern over bloating and changes in physical appearance (Björkman, 2013; Farndale & Roberts, 2011; Toner & Akman, 2000). Björkman et al. (2014) for example, found that women experienced shame when unable to meet feminine appearance ideals (being attractive and thin) and suffered due to negative impact of physical changes associated with bloating (Björkman et al., 2014). Bloating further made women with IBS feel self-conscious about their physical appearances, leaving them feeling unattractive and dissatisfied with their bodies, with one of Nguyen et al.'s (2018) participants describing herself as looking like a "whale" and feeling like she had an "alien baby" inside her (Nguyen et al., 2018). Feelings of distress associated with embodied change have similarly been noted in other critical feminist research. Ussher and Perz (2020), found that experiences of premenstrual bloating were shaped by cultural norms of idealised femininity, body control and fat phobia, resulting in premenstrual body hatred, self-objectification, dehumanisation and distress.

Similar experiences of body distress have been noted by Lu et al. (2009) in their ethnographic study of Taiwanese women with IBS, who described how diarrhoea was considered a more preferable symptom to constipation, as it was associated with weight loss and more favourably linked to gender norms of female slenderness and a correctly proportioned body. Constipation in contrast was experienced as more distressing, due to their participants feeling heavier due to full bowels and like they had retained weight.

Taken together, these findings highlight how feminine appearance ideals play a central role in shaping women's experiences of IBS, by highlighting how symptoms such as bloating and abdominal distention carry meaning beyond physical discomfort in ways which can intensify feelings of IBS related distress. Whilst experiential approaches are able to capture the emotional distress associated with bloating, they also overlook how such feelings are produced through broader structural forces.

For example, experiential studies rarely critique how feminine appearance ideals, assumptions of body stability, disciplined body work and self-surveillance, shape women's



embodiment, or how post-feminist healthism (Riley et al., 2019, 2025) discourses moralise the inability to attain health and maintain feminine appearance ideals as a personal failure, in ways which could intensify women's distress in the context of IBS management. Theorising postfeminist healthism as affective line of stratification which flowed through IBS eating assemblages, therefore provides a useful theoretical framework through which the gendered nature of IBS related distress can be further be explored. Given the high prevalence rates of disordered eating and eating disorders reported within IBS populations, it is surprising that feminine appearance ideals have not been explored in relation to IBS related dietary practices more specifically, and this an important research gap this thesis addresses.

### **3.2.5 Summary**

In this section I have reviewed the existing IBS experiential literature base and identified some of the components, or “cutting edges” (Deleuze & Guattari, 1987, p. 88) of IBS related distress. These included the severe and unpredictable nature of IBS symptoms, experiences of dismissive and gendered healthcare encounters, societal perceptions of IBS, and gender norms in relation to the provision of care and feminine appearance ideals. Whilst this literature offers valuable insights into how women with IBS interpret and make sense of their symptoms in ways which are experienced as difficult and distressing, such findings have primarily privileged individualised accounts which locate IBS distress as residing within the individual, limiting their analytical capacity.

Thinking with assemblages therefore extends the current literature base, by moving beyond individualised accounts and enabling IBS related distress to be understood as relationally produced and dynamically emerging through multiple relational forces within various assemblages. Assemblage thinking further enables experiences of IBS distress to be mapped, so as to identify where distress is being produced and sustained, and where it dissipates across multiple contexts, temporalities and bodily states, rather than being understood as static. This makes it possible to understand how distress arises through

different configurations and temporalities within IBS eating assemblages, in ways which shape the dietary practices that emerge.

In the following section, I make a rhizomatic “jump” and connect with the IBS experiential literature which has focused on IBS related food and dietary practices, something which is “always in the middle” of, and deeply related to experiences of IBS related distress (Deleuze & Guattari, 1987, p. 25). I discuss how these practices have been theorised and examined within the IBS experiential literature to date, and explain why an assemblage approach is particularly useful for understanding the complex dynamics of food/body relations in the context of IBS symptom management.

### **3.3. Experiences of IBS Related Dietary Management**

Despite the significant role that food and dietary practices play in relation to both IBS symptom onset and management, few experiential studies have focused specifically on experiences of IBS related dietary practices and the different ways in which women with IBS engage with food. Interestingly, perspectives of those undertaking IBS related dietary treatments are infrequently included in published qualitative studies (Weznauer et al., 2023). Of the qualitative studies where food or dietary practices have been identified within thematic findings, food has most typically been explored in relation to IBS coping or symptom management strategies. Findings have further been limited to those obtained through positivist and phenomenological theoretical frameworks.

In this section, I review the IBS experiential literature and outline how dietary practices have been explored in relation to coping strategies and as means of taking control of symptoms. I then provide an overview of some of the challenges and difficulties associated with dietary change that they identify, but note that beyond symptoms improvement, affirmative experiences of IBS related dietary practices are lacking within the IBS literature. In the final section, I then provide an overview of what is currently known about healthy and problematic eating in the context of IBS symptom management. Throughout I summarise the

knowledge produced from this literature base, whilst evaluating it through the theoretical framework described in [chapter 2](#).

### **3.3.1 Food Related Coping Strategies**

Not surprisingly, food consumption and the controlling of food intake has been highlighted as the most significant means of coping with GI conditions (Fletcher & Schneider, 2006). Food as an essential coping strategy to manage IBS symptoms, has most typically involved identifying and avoiding or omitting of trigger foods and beverages, watching what was eaten and establishing rules as to how food could be eaten (Andy et al., 2022; Cassidy et al., 2009; Fletcher & Schneider, 2006; Jarrett et al., 2001; Kamp et al., 2022; McCormick et al., 2012). Food restriction, limiting what was eaten, not eating or eating beforehand, were further considered necessary coping strategies when eating away from home (such as when travelling, attending social events, eating out of when eating in the homes of friends and family), particularly when access/proximity to toilet facilities was uncertain (Kamp et al., 2022; Rønneniveg et al., 2009).

IBS related dietary practices have also been identified as a means through which those with IBS engaged in regular disciplined self-care, in order to master their IBS symptoms and take control of everyday life (Ung et al., 2013). Whilst diet was not the focus of their study, one theme which emerged through Ung et al.'s (2013) IPA analysis, was diet as a means of exercising control over their lives. Disciplined self-care involved eating healthy food, exercising and ensuring good quality sleep. Andy et al., (2020) similarly found that to preserve dignity, participants described taking control of their lives in ways which included strategies for food intake, such as food abstinence to reduce the chance of having to rush to the bathroom. Other strategies involved avoiding certain foods or reducing the volumes if unable to be avoided, cooking in specific ways, and avoiding eating out or food cooked by others when unable to control the ingredients and cooking method (Andy et al. 2022).

Although such studies are useful to identify the role of food and dietary practices in relation to IBS related coping strategies, such framings function to position IBS symptom

control as residing within the individual. Through such frameworks, bodily control is also positioned as something which can be achieved through ongoing self-discipline (such adherence to dietary practices) and then ongoingly sustained. A linear cause and effect pathway is therefore assumed, whereby the identification and removal of problematic foods are assumed to result in symptom alleviation. As a result, causative pathways were often sought by people through a process of trial and error (Casiday et al., 2009; Jarrett, et al., 2001) in an attempt to make sense of food/body relations and establish some form of control.

Contrary to such expectations, IBS symptom onset was not always linear. Symptoms could be unpredictable, food inconsistently triggered symptoms, and dietary practices were not always successful in managing symptoms (Jarrett et al., 2001; McCormick et al., 2012; Ung et al., 2013). As a consequence of this framing and something which is not touched upon within these studies, is how those who fail to manage their symptoms adequately via dietary practices, may experience feelings personal responsibility and self-blame and distress, even when such outcomes were beyond individual control.

Taking control of food and dietary practices also included eating foods which were known to be problematic. Ung et al. (2013) described how participants in their study 'took control' and made an active choice to consume foods which were known to be problematic when socialising. Interestingly, by positioning their participants as agentic decision makers, their findings failed to consider the wider social contexts within which such dietary deviations were undertaken, and how aspects such as social norms in relation to food sharing and conviviality (Higgs, 2015) may also assemble together and contribute to such 'individual' decisions.

Dietary indiscretions undertaken to experience feeling of 'normalcy', were similarly described by Schneider et al. (2009). Wider relational aspects such as social norms which contributed to participants feeling "compelled to give into dietary temptations" (p. 83) were analysed, with dietary behaviours also framed as individualistic decisions. Such dietary indiscretions however had involved undertaking a cost/benefit analysis, with consideration

provided to when and where trigger foods were being consumed (e.g. the comfort of one's own home versus unfamiliar/uncontrollable surroundings, not before social engagements etc.) and the availability of medications to treat symptoms (Schneider et al., 2009). Thus, whilst touching upon the fact that there were multiple factors contributing to dietary decisions, agency largely remained positioned within the individual.

Dietary indiscretions in the context of women's experiences of IBD/IBS management, were also categorised into binaries in different ways. Dietary practices which involved eating problematic foods alongside the use of 'aids' to help prevent symptoms such as taking Imodium (an antidiarrheal) or Pepto-Bismo (an over the counter medication used to treat heartburn, acid reflux, indigestion, diarrhoea and nausea) to mitigate the impact of such foods, were considered a proactive and adaptive behaviour by Scheider and Fetcher (2009).

In contrast, similar symptom alleviating dietary practices were positioned as maladaptive by Skrastins and Fletcher (2016). Consuming coffee to induce bowel motions to alleviate constipation, after previously haven taken Imodium in order to be able to attend a social event, was considered a negative dietary behaviour even when enabling a beneficial outcome by facilitating social lives through the prevention of symptoms. These findings appear somewhat paradoxical, given Skrastins and Fletcher's (2016) study focused on coping strategies. Ironically, categorising participants dietary practices as maladaptive, failed to highlight how those with IBS were actually trying to "cope" by engaging in specific food/body management practices.

Arguably many of the dietary practices their participants described were adaptive and functional, given the lack of alternative treatment options when considering the relational, material, affective, and discursive contexts within which their participants were operating. For example, avoiding food was also negatively framed as a maladaptive, even when enabling participants to avoid the embarrassment of experiencing symptoms in public. Such distinctions however are important, when dietary practices may not necessarily be understood as maladaptive by those engaging in them. It should however be noted that as Skrastins and Fletcher (2016) and Scheider and Fetcher (2009) explored experiences of

women with IBD and IBS which may have impacted their findings across the data set, with the health ramifications associated with IBD potentially more significant and problematic, than for those with IBS.

Posing the question “what can a body do?” (Deleuze & Guattari, 1987) therefore affords a more affirmative framework through which IBS food/body relations may be understood, by allowing different dietary practices to be considered in relation to the capacities they enable, many of which extend well beyond initial symptom management. In order to further understand the complex nature of dietary indiscretions, I argue that thinking with assemblages provides an emergent and relational framework, through which the affective flows of social norms for example, can be understood as lines of stratification within IBS eating assemblages, enabling dietary indiscretions to be understood as complex multiplicities, and more than individually produced.

### **3.3.2 Challenges Associated with Dietary Practices**

The challenges associated with IBS related dietary management are well noted across the IBS qualitative literature, with food identified as one of the most difficult and frustrating aspects of IBS symptom management (Schneider & Fletcher, 2008). One of the most notable challenges was a lack of support and guidance from healthcare professionals in relation to the LFD more specifically. Many had been given a list of FODMAPs but did not understand what they were supposed to do, or how to undertake the LFD. Others had been provided with generalised advice which had not been helpful (for e.g. to eat more fibre, but how much fibre had not been qualified) (Kamp et al., 2022). Dietitians to help oversee the process were further difficult to access, and the LFD was considered complex and burdensome, making long term adherence challenging and left some constantly thinking about food which felt overwhelming and distressing (Kamp et al., 2022).

Further, although the LFD was considered effective by some in terms of identifying trigger foods, it was not an effective strategy for all, with others reporting it had made their symptoms worse (Kamp et al., 2022). Uncertainty surrounding symptom onset further meant

that those with IBS found it difficult to know what, or how much to eat (Drossman, 2009) and as a result diets could become restrictive when unable to discern which foods were problematic (Schneider & Fletcher, 2008).

The challenges of maintaining restricted dietary practices have also been highlighted across various social contexts such as travelling and eating outside of home. Strategies to navigate these contexts involved eating beforehand, planning in advance what to eat, and being more careful about what and how much was eaten (Fletcher & Schneider, 2006). Food restriction was also considered to have a negative impact of lifestyle, with food choices required to be made in relation to potential repercussions (Schneider & Fletcher, 2008).

As previously highlighted in [section 3.2.1](#) fear of stigmatisation, and the shame associated with experiencing symptoms in public often resulted in food avoidance in public settings (Mohebbi et al., 2017). Food avoidance however, could also be challenging when women with IBS often avoid telling others about their symptoms, and therefore felt fearful of both eating and refusing food in public (Mohebbi et al., 2017). Others avoided eating publicly to side-step having to explain why they were eating differently to others (McGrath, 2018), or to avoid having to make dietary compromises in social contexts (Weznauer et al., 2023).

Dietary changes could further be burdensome, requiring considerable thinking and planning (Harvey et al., 2018; McCormick et al., 2012). This was particularly in the case in the context of full time employment and when experiencing fatigue due to IBS symptoms (Weznauer et al., 2024). Dietary interventions such as the LFD could also be difficult to integrate into family contexts where preparing separate meals created additional work. Having an unsupportive partner further made domestic meal preparation more difficult, which could lead to frustration and arguments (Weznauer et al., 2024).

An overlooked aspect of dietary management in the biomedical literature, is dietary preferences and food related pleasure and enjoyment. Having to forgo enjoyable foods has been identified as a challenging aspect of IBS related dietary changes (Schneider & Fletcher, 2008), with many now experiencing displeasure from eating (Shorey et al., 2021). Decreased food enjoyment had similarly been associated with having to repeatedly eat the

same foods which was considered boring, being unable to prepare and eat foods which were previously enjoyed, and an inability to eat spontaneously (Harvey et al., 2018).

Preestablished dietary habits could further be difficult to change, especially when dietary change conflicted with food preferences (Weznaver et al., 2024).

Despite the multiple challenges associated with IBS related dietary management, beyond symptom improvement, few experiential studies have explored affirmative experiences of IBS related dietary changes. Dietary change is generally perceived positively and considered helpful and empowering when effective in alleviating symptoms (Teasdale et al., 2020; Weznaver et al., 2024). Other notable advantages reported from patients undertaking a four week IBS related dietary intervention study, were having learnt new ways to cook, saving money, eating a more varied diet and eating more healthfully (Weznaver, 2024).

Given the reliance on diet to manage IBS symptoms, increasing understandings of the ways in which IBS related dietary practices might be understood affirmatively is therefore important. Thinking differently with the DeleuzoGuattarian concepts of assemblages, intensities and lines of flight, affords a means through which alternative ways of thinking about IBS related dietary practices may be further explored. By facilitating new ways of thinking about food/body relations which extend beyond the constraints of restrictive dietary practices, such an approach has the capacity to open up new possibilities for understanding food/body connections, in ways which may foster 'joyful' (Deleuze, 1992) encounters for women with IBS.

### **3.3.3 Dietary Practices, Healthy Eating and Weight/Shape Concern**

Despite the role that dietary practices play in symptom management, few experiential studies have explicitly explored understandings of healthy eating in the context of IBS related dietary management. In one of the first studies exploring the relationship between diet, eating behaviours and IBS symptoms, the women in Jarrett's (2001) study described a healthy diet as one which provided a "range of comfort" (p. 248) such that symptoms were



tolerable or manageable. Once having established dietary triggers, the underlying goal of their participants had been to avoid or experience only minimal symptoms, whilst also maintaining a “healthy diet”.

The relationship between food and IBS/IBD has also been explored by Fletcher and Schneider (2006) within the lived experience context of both GI conditions more generally. Healthy eating entailed omitting specific foods and beverages, in addition to consuming more foods considered to be healthier options for IBS/IBD, such as the inclusion of flaxseed, digestive enzymes, eating more fruit and vegetables such as increased fibre, vitamins/supplements and acidophilus. Such findings however were only explored in relation to coping strategies and did not extend to how their participants felt about the healthfulness of their diets, and whether the inclusion of healthier options had been successful in enabling healthier outcomes. Despite highlighting the significant impact of food for those with GI conditions, their study was not designed to explore experiences of diet and IBS and/or IBD specifically. As a result, findings may have differed had their data collection methods been tailored to diet alone, instead of individual coping strategies more generally.

More recently, healthy eating in the context of IBS has been touched upon with a desire to eat more healthfully outlined as an overall goal of those with IBS (Weznaver et al., 2024). It is important to note that Weznaver et al.’s (2024) participants were recruited from a randomised control trial intended to evaluate two different dietary interventions (a low carbohydrate diet (LCD) and LFD), and undertook a four week structured and well supported dietary intervention. Healthy eating was understood to be in line with general nutritional recommendations, and whilst participants were within the normal BMI range, several had been fearful of gaining weight and expressed a general desire to lose weight.

Although participants had understood their dietary practices to have become healthier following the dietary interventions, healthier was understood as a more varied diet, but also extended to foods which saved time. Interestingly, as some participants had gained weight following the LCD intervention which was high in fat, maintaining such a diet, although resulting in a reduction of symptoms, was not considered viable (Weznaver et al., 2024).

Despite offering some valuable insights into patient experiences of implementing the LFD and LCD, their positivist approach primarily focused on the implementation process and individual adherence, rather than focusing on embodied experiences and situating these within the wider relational contexts within which IBS related dietary practices are undertaken.

Despite the high prevalence rates of DE/EDs reported in the biomedical literature, only one identifiable experiential study has included participants with current and historical experiences of food/body distress. Although focusing on symptom management in relation to concurrent IBS and anxiety and/or depression, Kamp et al.'s (2022) findings highlighted that for those with histories of DE/ED, restricted dietary practices and food tracking, when undertaken without the supervision of a dietitian, had exacerbated food/body distress. Navigating restricted diets such as the LFD, created a “slippery slope” (p. 783) which could lead to further dietary restrictions and the return of disordered eating behaviours.

This was especially the case, when those undertaking the LFD may not have been aware of the temporary nature of the elimination phase, which could lead to a hyper-restricted version of the LFD being undertaken beyond the intended time frame, when not paired with dietetic support. The complex relationship between depression/anxiety, IBS and disordered eating was further highlighted, with bodily changes associated with bloating considered frustrating and impacting upon body image (Kamp et al., 2022). The importance of assessing suitability when recommending the LFD to those with IBS, was therefore highlighted as integral for those with histories of food/body distress.

Further qualitative studies which include the perspectives of those with lived experience of disordered eating / eating disorders within the IBS context are therefore important, so that the ‘cutting edges’ (Deleuze & Guattari, 1987) of IBS eating assemblages to be identified, to establish how certain arrangements produce harmful outcomes, and how food/body distress might be avoided.

### **3.3.4 Summary**

In this section, I have provided an overview of how IBS related dietary practices have been studied within the IBS experiential literature. I have outlined how dietary practices in the context of IBS symptom management, have primarily been conceptualised as a means of coping with, and taking control of IBS symptoms, in ways which position IBS symptom control as residing within the individual. Dietary indiscretions were further morally binarised into categories of adaptive/maladaptive food/body practices, sometimes in ways which failed to consider what those with IBS were trying to 'do' when engaging with, or avoiding food.

I have also identified some of the challenges and difficulties associated with IBS related dietary management, and observed how beyond symptom management, few IBS experiential studies have explored affirmative experiences of IBS related dietary practices. I have also provided an overview of what is currently known about healthy and problematic eating in the context of IBS symptom management and highlighted the need more qualitative studies which are able to attune to the dynamic nature of IBS food/body relations in all their relational complexity.

In the final section of this chapter, I make another rhizomatic "jump" and provide a brief overview of how assemblage thinking, DeleuzoGuattarian concepts, feminist new materialist approaches and Deleuzian understandings of time as non-linear, have been applied to the study of various health and illness contexts. I also outline how feminist researchers have drawn on DeleuzoGuattarian concepts to highlight the deeply gendered nature of health and wellness.

## **3.4 Thinking Differently About Health and Illness**

Although assemblage thinking and DeleuzoGuattarian concepts have yet to be applied to the study of IBS or IBS related dietary practices, such theoretical approaches have been applied by qualitative researchers to explore health and illness in a variety of different ways. As previously highlighted in [Chapter 2](#), assemblage thinking provides a different epistemological, ontological and methodological approach to the study of health and illness,

with the unit of analysis moving from the 'closed' individual to an 'open' assemblage. This affords a different framework through which bodies, agency, causality and subjectivity can be understood, with health and illness emerging through relational material assemblages (Duff, 2014, 2018). Health and illness are therefore no longer individual properties of bodies, but emergent relations between bodies and multiple components. As such health is not a fixed state, but a processes of becoming, with 'health' increasing capacities and 'illness' diminishing such capacities (Buchanan, 1997; Duff, 2010; Fox, 2002). Healthy bodies would therefore have numerous affects and relations, which further increase capacities for the formation of new compounds (Buchanan, 1997).

In this section, I firstly provide a brief overview of how assemblage thinking and DeleuzoGuattarian concepts have been used to explore various health and illness contexts ([section 3.4.1](#)). I then illustrate how feminist researchers have drawn a range of DeleuzoGuattarian concepts to explore the gendered nature of women's health more specifically ([section 3.4.2](#)). In the final subsection, I provide an overview of how Deleuzian understandings of time as non-linear and multiple have been applied to the study of health/illness in ways which emphasised the inadequacies of normative understandings of linear time, and the temporal complexity of health practices ([section 3.4.3](#)).

### **3.4.1 Assemblages of Health and Illness**

In recent years, assemblage approaches have been increasingly taken up across a wide range of health related contexts, enabling researchers to think differently about health and illness. The concept of assemblage for example, has been used to explore assemblages of health (Duff, 2014) and ill-health (Fox, 2011; Fox & Allred, 2016), diagnostic assemblages (Locock et al., 2016), therapeutic assemblages (Foley, 2011, 2014; Trnka, 2021), care assemblages (Buse et al., 2018; Duff & Hill, 2022; Price-Robertson & Duff, 2019) and assemblages of recovery and 'becoming-well' (Duff, 2014; Larsen et al., 2022). More specifically, assemblage thinking has also been used to explore assemblages of health/illness within the context of breast cancer (Greco, 2025), wellbeing (Atkinson, 2013;

Coffey, 2020; Duff & Hill, 2022), mental health (Duff, 2016; McLeod, 2017), maternal health (Neely, 2023), aging (Andrews & Duff, 2019; Cluley et al. 2021; Fox, 2005) and hystero-epilepsy (Diedrich, 2015).

This growing body of literature, which has largely been conducted from a sociological perspective, highlights health and illness as more than individual, and emerging through wider relational assemblages. Duff (2014) for example, applies a Deleuzian framework to open up biomedical understandings of health related behaviours, arguing that “biological, material, affective, social, semiotic, political and economic forces necessarily cohere in the articulation of an assemblage of health” (p. 4). Together, the components of each assemblage, function in ways which have the capacity to enable or constrain health and wellbeing, by determining what a body can do.

Importantly, although the capacities which emerge as a result of the affects circulating within assemblages of health/illness reflect the physical and biological aspects of illness, they also extend beyond these (Fox & Alldred, 2016). Ill health assemblages for example, comprise of physical and biological components, but also psychological, emotional, social norms and socio-cultural relations (Fox, 2011; Fox & Alldred, 2016). Attending to such multiplicities and their complexity is therefore important, because as I have foregrounded in [section 3.2](#) of this chapter, the physical and biological aspects of ill-health are not always the most impactful. Thus, across this literature base, assemblage approaches have been adopted as means of addressing many of the short comings of biomedical and humanistic qualitative approaches, allowing health to be explored beyond body/mind, biological/social, structure/agency dualisms and ‘re-materialised’ (Fox, 2012; Fox & Allred, 2016) providing a more in-depth account of how health/illness is constituted and experienced.

#### **3.4.1.1 Different Ways of Conceptualising Agency / Emergent Causality**

Thinking with assemblages also provides a different way of thinking about agency in relation to health and illness. Deleuze and Guattari (1987) argue that a body’s relations do not directly determine what a body can do, rather it is dynamic assembling of such relations,

which can develop in unpredictable ways. What emerges from assemblages will further differ between individuals, and is dependent upon the specific relations explaining why embodiment and health and illness differs between people, together with individual responses to health care (Fox, 2012; Fox & Ward, 2008). Agency is therefore understood as being as distributed across a range of components (both human and non-human), rather than residing within the individual (Fox & Alldred, 2018; McLeod, 2017) which Bennett (2010) refers to as the 'agency of assemblages'.

As a means of exploring some of the affective, or lively non-human components of health/illness assemblages, studies have also focused on digital technologies such as human-app health assemblages (Lupton, 2018, 2019; Maslen & Lupton, 2020, Riley et al., 2025), haemodialysis treatment (Cluley, 2023), type 1 diabetes (Northcott, 2025), medications (Brown & Tucker, 2010; Potts, 2004), drug-body assemblages (Gagnon & Holmes, 2016) and alcohol assemblages (Bøhling, 2015). The importance of health geographies and affective 'atmospheres', and interactions between places/spaces have also been highlighted across the sociological health literature (Duff, 2014; Fox & Powell, 2023). Together these studies highlight how non-human components have agency, or productive power within wider health and illness assemblages, in ways which have the capacity to produce affective relations. For example, menstrual tracking apps have the capacity to elicit positive feelings, when cycles are categorised normal or healthy, or produce feelings of anxiety and distress when characterised as irregular, and therefore problematic (Riley & Paskova, 2022).

Food has also been explored as affective, or lively, with the agentic potential to provoke specific bodily responses (Bennett, 2007, 2010). In her book *Vibrant Matter: A Political Ecology of Things*, Bennett (2010) argues that material objects possess 'thing-power'. Challenging understandings of matter as passive, food may therefore be understood as an affective non-human component of wider health/illness assemblages, in ways which may usefully be applied to the understanding the nature of food/body relations in the context of IBS related dietary management.

Understanding agency as distributed, also has implications for understandings of causality. As assemblages do not contain causal infrastructure, there is no logical or predicable order through which becomings unfold (Adkins, 2015). Instead, causality is conceptualised as aggregative and emergent, unfolding through dynamic relations which self-organise without prior determination, generating new, and sometimes unpredictable outcomes (Bennett, 2010; Connolly, 2010). From a Deleuzian perspective, causality is thus emergent and unpredictable.

Bennett (2007, 2010) illustrates the distributed nature of agency by demonstrating how omega-3 fatty acids may be taken up in different ways by different bodies across various populations. Van Daele (2022) similarly shows how 'plugging in' food to different assemblages, can enact different roles and facilitate different *becomings*, depending upon the novel interactions it encounters and resulting expressions which emerges through each assemblage. Food may therefore acquire additional intensities when assembled with the human body, as it transitions through the digestive tract and interacts with the microbiota, such that food and bodies act upon, and transform each other through the process of mutual becoming, emerging as relational affects (Van Daele, 2022).

Understanding agency as distributed and emergent can also be usefully applied to understanding the affective capacity of trigger foods within IBS eating assemblages, with agency understood as being distributed across a range of components in ways which may (or may not) produce symptomatic responses in bodies across depending upon each unique configuration. Thinking differently about causality in the context of chronic illness management is therefore important, because as Mol (2008) argues, the ways in which bodies respond to food (such as the metabolic process of eating), often remain outside of the eaters control and as a result remain ungovernable. Understanding agency as distributed, therefore also has implications for public health, with Bennett (2010) questioning how food and dietary practices might be understood differently, if eating was understood as an assemblage comprised of affective forces, human and nonhuman components, many of which are beyond individual control.

The concept of distributed agency also enables new and different ways of thinking about food/body relations and embodied food encounters (Abbots, 2017). Mol (2008) argues that eating tends to focus on aspects such as ingredients, flavours, and/or nutritional composition of food, rather than the “materiality of engagement” (p. 40), which is not undertaken in isolation. From a relational perspective, food and eating encounters can be understood as being shaped and mediated through multiple dynamic relations between various human and non-human bodies, discourses and materialities (Abbots, 2016).

Whilst understandings of embodied food encounters as dynamic, relational and distributed have been used to explore food/body relations associated with eating, this framework has also been applied to (not) eating practices. Lavis (2016) in her anthropological research essay, drew on data obtained from two qualitative studies undertaken in the UK with people being treated for eating disorders, participant observation and interviews in relation to pro-ana websites, and academic and media discussions on eating disorders, to explore how those with anorexia nervosa hold onto their illness through “food related (not) eating practices” (p. 456).

Eating in the context of anorexia nervosa for example, involved a dynamic process of eating and avoiding food, such that contingent forms of eating which may not look like eating, emerged in ways which were distributed across multiple bodies through a process of shared and delegated eating. This could involve reading menus, online food shopping without purchasing, looking at food porn and cooking for others and watching them eat, as modalities of not eating which were understood as alternative forms of eating. Eating may therefore not always include an individual enactment of ingestion and digestion, but distributed across multiple people, spaces and temporalities, and undertaken through smell, imagined taste and sight (Lavis, 2016). As Lavis (2018) argues “not eating can be as much about engaging with food as avoiding it” (p. 456).

Within the context of eating disorders, a small body of anthropological research has also engaged in this shift away from what specific dietary practices do to a body, to instead focus on what they ‘do’ for a body, and the purposes they serve (Eli, 2018; Lavis, 2018;



Clancy, 2022). Eating in the context of anorexia nervosa for example, can encompass many different practices and multiple relations which facilitate a multiplicity of embodied responses, such as the provision of comfort, and a safe temporal protective 'bubble' in which to retreat (Eli, 2018; Lavis, 2018). Together these studies reframe what it means to eat and how different ways of engaging with food may be better understood in relation to what they do.

Thinking with assemblages, therefore enables health and illness to be understood as more than individual, and relationally produced through multiple components which together function to determine what a body to do. As Buchanan, (1997) argues, rather than reducing the body to its functions, Deleuze and Guattari make the question of what a body can do constitutive, by reconfiguring the body as "the sum of its capacities" (p. 75). Such an approach challenges reductionist biomedical approaches, enabling health and illness to be understood as contingent, relational and distributed across a range of components, enabling an analytic shift away from pathology as residing within the individual, and towards an assemblage of components enable or constrain embodied capacities.

#### **3.4.1.2 A Line of Becoming Well – Recovery Assemblages**

Assemblage approaches also offer clinical utility, by providing a different theoretical framework through which understandings of health and illness can be applied to the practice and delivery of health care. As Duff (2023) explains "The proper therapeutic goal is to identify those assemblages that affirm life, and then to analyse how the forces immanent to these arrangements achieve this affirmation" (p. 2). It is therefore important to consider how 'assemblages of health' form, which relations, affects and materialities comprise such assemblages, and how different assemblages function to mediate experiences of health (Duff, 2014, 2023) so as to identify how health and wellbeing may be cultivated and sustained in ways which promote and increase health (Duff, 2014, 2016; Fox, 2012).

Another advantage of assemblage approaches is that within the chronic illness context, full recoveries and return to previous states of health are often not possible, and

therefore different ways of thinking about “health in illness” are necessarily required (Duff, 2016, p. 58). Duff (2016) frames mental health recovery as an emergent capacity which is relationally produced through affects, spaces and events, which together increase a body’s overall capacity to affect and be affected, enabling a body’s “becoming well” (Duff, 2014, p. 58). Recovery, however is never a final achievable end point, and can only be understood as an “always unfinished” process of becoming well (Duff, 2016, p. 59). Such an approach therefore enables the “the real experience that propels a body along a line of becoming well” (Duff, 2016, p. 59) to be accounted for, in ways which are able to accommodate the fact that the process of recovery is not linear and may be different for each recovery event.

Whilst Duff’s (2016) assemblage approach to recovery has been put to work in mental health recovery research, this framework has not been extended to physical health and chronic illness to the same extent. Thinking with assemblages in relation to IBS, therefore enables the often severe, chronic and unpredictable nature of IBS symptoms, and wider assemblages within which symptoms are experienced and managed, to be understood as ongoing process of symptom management, through which those with IBS attempt to ‘become well’ through the adoption of various different dietary practices.

### **3.4.2 Assemblages, Gender and Women’s Health**

Assemblage thinking, DeleuzoGuattarian concepts and feminist new materialist frameworks have also been put to work in ways which have enabled different ways of thinking about the gendered nature women’s health and wellbeing. Whilst gender is not always recognised, or considered by all health/illness assemblage research (such as many of the studies outlined in [section 3.4](#)), feminist researchers have highlighted the profoundly gendered nature of health and wellness through their theoretical engagement with assemblages and DeleuzoGuattarian concepts.

Conceptualising gender as assembled for example, has enabled gender to be understood as constitutive of, rather than pre-existing within, individual bodies and “one of the ways in which the affective capacities of bodies become organised and produced”

(Coleman, 2009, p. 142). Bodies may therefore be understood as being formed through the complex relations they encounter, with DeleuzoGuattarian concepts affording a means through which bodies, health and gender, can be understood in relation to wider sociocultural contexts, in ways which are able to attend to “complex and messy dimensions of ‘health’” (Coffey, 2016, p. 200).

Thinking with DeleuzoGuattarian concepts in relation to women’s health and wellbeing, has also enabled an exploration of how gender intersects with health as a wider assemblage, in ways which can attend to how such relations affect a body’s capacities to act (Coffey, 2017). Deleuze and Guattari’s conceptualisation of the body as processual for example, has been used to theorise how gender as a social process of stratification, materialises through various assemblages (Coffey, 2017; Coleman, 2009; Renold & Ringrose, 2008; Ringrose & Coleman, 2013a). Feminist sociological analyses have similarly drawn on the DeleuzoGuattarian concept of territorialisation to highlight the ways in which a body’s capacities may be produced, but also constrained and limited through gendered affects and embodiments (Coffey & Ringrose, 2017; Jackson, 2010; Renold & Ringrose, 2011).

Deleuzian concepts have also been used by feminist researchers to explore how bodies, health, appearance and body image assembled in ways which are gendered. The concept of affect has been used to explore ‘body work practices’ (e.g. diet and exercise) and everyday experiences of ‘health’ with young people in Australia (Coffey, 2015), with body work providing a means through which bodies may be understood as lived and produced in produced through gender, health and appearance relations (Coffey, 2016).

Drawing on Deleuzian theory and feminist and sociological perspectives, the concept of affect enabled an exploration of the social conditions of possibility through which complex understandings of the health and embodiment emerged. For example, body work practices which enabled appearance ideals to be met could be liberating, but also constraining in that feeling good about one’s self and body, was also contingent upon such practices. Embodied and affective experiences of health were therefore determined through relations which

included appearance ideals, sensations of health and discourses, in ways which were complex and multiple (Coffey, 2015).

DeleuzoGuattarian concepts have also been used in conjunction with postfeminist sensibility to explore young women's experiences of body concern. Drawing on Ngai's (2004) concept of 'ugly feelings', Coffey (2020) explored how the affective dynamics of gendered appearance ideals in relation to body concern, could mobilise distinct enduring embodied feelings. These 'ugly feelings' held socio-cultural significance within the context of gendered neoliberalism, where feminine appearance ideals are valued, creating an imperative for women to work on, transform and upgrade themselves (Elias, et al., 2017; Banet-Weiser et al., 2019; Riley & Evans 2018).

For the women in Coffey's study (2020) body concern could take the form of worry, which incorporated heightened attentiveness to physical characteristics of bodies such as appearance and attractiveness. Whilst positioned as a normative, mundane concern for women, body concern also had the capacity to intensity into 'ugly feelings' associated with negative self-appraisal, imagined judgement and feelings of disgust which were affectively felt. Intolerable affects of disgust, or feelings of 'becoming intolerable' (Northrop, 2012) further had the capacity to intensity around dietary and exercise practices in ways which could become rigid and destructive.

These intensifications functioned to limit what a body could do by making it difficult to form new connections which were not weight/appearance oriented (Coffey, 2016, 2019, 2020). Gendered neoliberal embodiments could therefore assemble in ways which could make it difficult to be healthy but not obsessive about body concern, when body concern remained ever-present and could intensity at different times and across various contexts of everyday life to produce ugly feelings (Coffey, 2020).

Whilst assemblage thinking and DeleuzoGuattarian concepts offer a way to identify and analyse the oppressive effects of gendered lines of stratification, they also provide an affirmative framework for imagining change and transformation. For example, in Aotearoa New Zealand, Deleuzian concepts were used to explore women's wellbeing during the

Covid-19 pandemic, in ways which had opened up new lines of flight (Thorpe et al., 2023, 2023a). Drawing on object interviews and the DeleuzoGuattarian concepts of assemblage, becoming and bodily capacities, women's physical activity practices were able to be explored in relation to more-than-human components of fitness assemblages (Thorpe et al., 2023a).

The temporary actualisation of lockdown fitness assemblages had generated unexpected lines of flight away from more dominant gendered neoliberal fitness assemblages, within which aesthetics, discipline and control had previously functioned as strata. Through a range of affective relations and movement encounters, the women in Thorpe et al.'s (2023) study had been able to escape from the confines of homes and gendered roles and responsibilities, expand connections and increase bodily capacities by opening up new ways of engaging with physical activity practices for pleasure, enjoyment, connection, and freedom. For example, one woman caring for young children had been able to escape the constraints and confines of her home environment, by going for a morning run. During her run, she had been able to appreciate the rising sun, the ocean, and to enjoy a brief moment of solitude, which had enabled her to feel centred and rejuvenated. Being able to engage with physical activity during the lockdown period, had therefore opened up temporal lines of flight away from the gendered roles and responsibilities, which for many women had intensified during the lockdown period.

Together these studies highlight how thinking with assemblages, DeleuzoGuattarian concepts and feminist new materialist frameworks, enable the gendered nature of women's health and wellbeing to be foregrounded. By drawing on theoretical concepts such as becoming, stratification, affects, sensations and capacities, these studies have drawn attention to some of the ways in which gendered norms and feminine appearance shape 'what a body can do', in ways which could feel both liberating and constraining. As Deleuze's philosophy is one of affirmation and joyful affections (Deleuze, 1992), seeking to identify the ways in which a body's power and its capacities to affect and be affected may be extended is therefore important. DeleuzoGuattarian concepts and feminist new materialist approaches

offer a means of identifying some of the conditions of possibility through which bodies may become otherwise, and more affirmative futures might be opened up.

### **3.4.3 Time as Non-Linear and Multiple**

The chronic nature of IBS makes temporality an important component of IBS eating assemblages. Time, however remains a largely overlooked and under-utilised analytical concept through which IBS related dietary practices have been explored. As outlined in chapter 2, Deleuze's philosophy of time is one of difference and becoming, whereby time is understood as non-linear and multiple, with the past, present and future coexisting and constantly folding into one another producing temporal multiplicities (Williams, 2011). As all 'things' are understood as multiplicities (Deleuze & Guattari, 1987), we would therefore expect to encounter many different temporalities, durations and patterns within different assemblages (Hamilakis, 2017) enabling the complexity of IBS related dietary practices to be explored in ways which are missed, or incompatible with normative understandings of time as linear.

Although Deleuzian understandings of time and the living present have yet to be explored in relation to IBS related dietary practices, time in relation to IBS more generally has been explored from a medical sociological and critical disability perspective. White (2023) used participant diaries and interviews to explore the mundane, yet significant aspects of everyday routines and social experience of those with IBS in the United Kingdom. Drawing on the concept of 'crip time' (Kafer, 2013), White (2023) highlighted how structural and disabling rhythms (such as full time employment) were entangled with embodied temporalities of bowels and bodily necessities. Participants' accounts of everyday life brought attention to moments where time was anticipated, slowed down and stretched out, in ways which highlighted the relevance of everyday rhythms and the (re)organisation of routines which were often required for those with IBS, both inside and outside of expected time.

Temporal disconnects between patients and healthcare professionals in relation to chronic illness management have also been explored by Lewis et al. (2022). They argue that

chronic illnesses self-management is both temporally and socially situated, incorporating aspects of past, present and anticipated future outcomes. However, healthcare professionals operate along different linear timelines which lead towards optimistic future orientated outcomes. They described how self-management goals were understood as discrete, time bound activities which could be sequentially undertaken, and successfully achieved within specific timeframes. Such temporal logic however, does not take into consideration the complexities of life and can create disjunctures between actual experiences of self-management, whereby self-management is often difficult and challenging to implement into complicated lives and complex social milieus.

Lewis et al., (2022) further illustrate how as those with chronic conditions also value the past, present and future differently. Healthcare professionals often emphasise a need to let go of the past and move towards a positive future, a better life which was within the patients control, however a positive future was not always possible or likely for those managing chronic conditions. Linear approaches to understanding chronic illness management, can therefore be deficient, requiring a different way of thinking about chronic illness management.

Deleuzian conceptualisations of time, and time as non-linear and multidimensional, have however been used to explore other aspects of health and illness, such dietary temporalities (Coleman, 2008, 2010), healthy lifestyle advice (Robson & Riley, 2019, 2025), obesity interventions (Warin et al., 2015), healthcare encounters (Lewis et al., 2022), mental health (Tucker, 2024) and chronic illness more generally (Jowsey, 2016).

In her study of dieting temporalities, Coleman, (2010) describes how although dieting is often understood as a linear and progressive pathway resulting in gradual weight loss, dieting websites function to produce new and multiple diet related temporalities. For example, notions of future progress (the desired future self) were drawn closely into the present, whilst also recognising that dieters will likely engage in multiple dieting attempts.

The complexity of dieting was further highlighted through a range of different dieting temporalities, which were non-linear, distributed and multiple, and yet also constituted and normalised.

Drawing on Deleuze's philosophy of time (1988, 1994) to explore the adoption of healthy lifestyle advice by people in long-term relationships self-managing coronary heart disease, Robson and Riley (2025) problematise linear understandings of time, which are often implicit within socio-cognitive models of behaviour change. Although such models position lifestyle change as progressing sequentially through to a future, stable health outcome, experiences of chronic illness and their day-to-day management are often non-linear and can be challenging and difficult to maintain. Rather than a smooth progression towards 'healthy' futures achieved through the 'rational' individual choices of those managing coronary heart disease, their analysis highlighted how engagement with healthy lifestyle advice instead unfolded across multiple temporal selves situated within relationally enacted, plural timeframes.

Robson and Riley (2019; 2025) argue that the absence of such temporal complexity from health promotional messaging can function oppressively and produce a logic of blame through which spoiled health identities and abject bodies could emerge. Importantly however, conceptualising time as multiple also opened up affirmative lines of flight in the form of illness and ageing acceptance, and understanding death as a natural progressive part of time, which could reduce feelings of fear, uncertainty and self-blame (Robson & Riley, 2025).

Deleuze's philosophy and approach to time, therefore enabled lifestyle advice and healthy living to be understood differently, when considered as multiple, affective and embodied. Attending to the temporal complexity of healthy lifestyle changes further afforded insights into factors that may enable or challenge people's ability to achieve and sustain healthy lifestyle changes. Temporality however, remains an important and under-theorised component of healthy lifestyle advice and dietary change which is often overlooked and



absent from understandings and critiques of lifestyle change, and is one which is important to understanding IBS related dietary practices.

Deleuze's living present has also been used by Tucker (2024) to explore online mental health peer support. They found that the temporalities of mental health support provided through digital platforms, challenged traditional, chronological models of time in ways which rendered linear understandings of time as inadequate and problematic. Conceptualising time as linear, had been unable to account for ever-present past lived realities, having the ongoing potential to be actualised as lived experience in the present. For example, peer support is often sought when past experiences produce feelings of overwhelm in the present, and/or in relation to negative anticipations of what the future may hold (Read et al., 2005). Mental distress therefore, was always 'carried' into the present, and melding with future fears and anticipations. Deleuze's conceptualisation of time, therefore provided a temporal framework for lived experience, whereby time was something which did not exist outside of experience, but created within and through embodied practices and materialities, making it an important consideration for health and illness research.

Together, these studies highlight the limitations and inadequacy of normative understandings of linear, singular time for making sense of lived experiences of dieting and chronic illness management and mental health. With all assemblages contingent, temporary and producing specific temporal affordances, it is therefore important to understand which temporalities become dominant and affective, and under which circumstances specific times are actualised (Hamilakis, 2017). The components of a particular assemblage, will therefore produce specific temporal affordances, enabling some futures to emerge and others to disappear, with the more temporal possibilities available opening up more opportunities for new possibilities and generative connections (Hamilakis, 2017). Deleuzian understandings of time as non-linear and multidimensional, therefore offers an important analytic through which to understand experiences health and illness, and one which is currently under explored and well suited to the explorations of IBS related dietary practices.

### **3.4.3 Summary**

In this section, I have provided an overview of how assemblage thinking, DeleuzoGuattarian concepts and feminist new materialist frameworks have been used to think differently and explore various health and illness contexts. This literature has highlighted how health from a Deleuzian perspective, can be understood as processual, emergent and shaped by a range of different human and non-human components. Thinking with DelzuoGuattarian concepts, further enabled agency and causality to be understood as contingent and distributed, and emerging through various assemblages. I have also identified how feminist research has engaged with a range of DeleuzoGuattarian concepts in ways which have drawn attention to the highly gendered nature of women's health and wellbeing. Lastly, I have outlined how Deleuzian understandings of time as multiple and non-linear, have been used to explore a range of health and illness contexts, in ways which have highlighted the limitations of linear, sequential time for understanding health practices.

### **3.5 Chapter Summary**

In this chapter, I conducted a 'rhizomatic' literature, which 'jumped' between three different bodies of literature. I firstly reviewed the IBS experiential literature, identifying some of the components of IBS eating assemblages which functioned to produce experiences of IBS related distress, often in ways which were gendered. These included the severe and unpredictable nature of IBS symptoms, experiences of dismissive and gendered healthcare encounters, societal perceptions of IBS and gender norms in relation to caring for others and feminine appearance ideals.

I also outlined what was currently known about IBS-related dietary practices, highlighting some of the limitations of this existing literature base and arguing that an assemblage approach was better suited for attending to the dynamic and complex nature of food/body relations in the context of IBS symptom management. I then concluded by outlining how assemblage thinking, DeleuzoGuattarian concepts, feminist approaches and Deleuzian understandings of time as non-linear and multiple, have been applied to other

health and illness contexts, and demonstrated their value for attending to the affective, temporal and gendered nature of health/illness. In following chapter, I provide an overview the various components which comprised my 'research assemblage' (Fox & Allred, 2015).

## Chapter 4 – Research Assemblage

### 4.1 Chapter Introduction

Deleuze and Guattari (1987) encourage us to think rhizomatically, to experiment and create the new. To facilitate different ways of thinking and producing knowledge, some researchers argue for engaging with new and innovative data collection methods when using new materialist approaches (Jackson & Mazzei, 2011; Lather, 2016; St. Pierre et al., 2016). Interviewing for example, has been rejected by some on the basis of being humanist and representational (St. Pierre, 2014; MacLure, 2013). Traditional coding has also been described as “unthinkable” (St. Pierre, 2016, p. 26) and criticised for attempting to organise data into neat categories of representation which neglects the texture of data and its affective complexities (MacLure, 2013). In fact Deleuze and Parnet (2002) argue that it is difficult to explain oneself in an interview, when the questions imposed work to limit what one has to say, leaving one unable to invent their own questions.

St. Pierre (2015) notes that it is not easy to work with DeleuzoGuattarian concepts, because they “offer a constellation of imbricated concepts” (p. 78) (e.g. assemblage, affect rhizome, territory) which are not commensurable with traditional humanist methodologies because they are deliberately ontologically different. However, it is also not feasible or pragmatically possible to create the new each time, as this would leave the researcher “own her own, inventing inquiry in the doing” (St. Pierre, 2015, p. 81). Others, therefore suggest the potential for re-engagement with more traditional qualitative methods such as interviewing, by focusing more not on “what the method is, but what it can do” (Fox & Alldred, 2018, p. 191).

Fox and Alldred (2015) for example, continue to use in-depth interviewing as a means to provide insights into various material health assemblages, affects and the capacities of bodies, where the data produced through online interviews is not treated as a subjective representation of experience, but as “evidence of how respondents are situated within assemblages” (Fox & Alldred, 2017, p. 172). Mazzei and Jackson (2019) similarly

‘(re)configure voice’ within interviewing, placing “voice within the material and discursive knots and intensities of the assemblage” (p. 67). Whilst acknowledging these ontological tensions and having established my own position within these broader debates on interviews and research design in new materialist work, I decided to incorporate aspects from both perspectives, using more conventional data collection methods of semi structured interviews and digital photo diaries, and adopting a post qualitative analytic process to “think with theory” (Jackson & Mazzei, 2018, p. 717).

In this chapter, I provide an overview of the various methodological components which together formed my ‘research assemblage’ (Fox & Allred, 2015). A research assemblage comprises “the bodies, things, and abstractions that get caught up in social inquiry, including the events that are studied, the tools, models, and precepts of research, and the researchers” (Fox & Alldred, 2015, p. 400), which link together to produce research. In the following sections I outline the components which comprised my research assemblage, highlight some of the key ethical considerations associated with this project, and outline some of the reflexive practices I engaged with throughout the research process.

## **4.2 Ethical Approval and Cultural Considerations**

Ethical approval was granted by the Massey University Human Ethics Committee, Southern A in March 2023 (SOA 22/58) (Appendix B). Ethical and cultural considerations were initially identified and outlined as guided by the MUHEC Code, Te Tiriti principles and Te Ara Tika. A peer review was then conducted with Prof. Sarah Riley and Dr. Andrea LaMarre (a previous Supervisor for this project). Ethical considerations were discussed and guidance was received from The Centre for Psychology and Professor Kirsty Ross in relation to the avoidance of harm and support for participants should they experience distress as a result of participation. Further peer review was subsequently provided by the panel members at my confirmation of candidature event (Assoc Prof. Keith Tuffin, Prof. Chris Stephens, Dr. Clifford Van Ommen).

When adopting feminist new materialist relational ontologies it is also important to highlight ethical relations as emergent, generative and performative (Thorpe et al., 2020). Ethical considerations therefore, also extend beyond the ethical review process and are entangled throughout all aspects of the research process. Further, ethical obligations also surpass considerations provided to 'human subjects' and include non-humans and the material world (Thorpe et al., 2020). As such, I highlight many of the ethical considerations which emerged throughout the research process under the relevant subsection headings below.

#### **4.2.1 Cultural Considerations**

Participation in this study was open to people of all ethnicities (who meet the inclusion criteria). Care was taken to ensure cultural safety and sensitivity was prioritised throughout each stage of the research process, and it was important to me that participation be safe and appealing to people of all cultural backgrounds. Adherence to tikanga Māori and Treaty of Waitangi principles of partnership, participation and protection were woven throughout the research assemblage. For example, Māori respondents and their whanau were welcome to schedule a kanohi-te-kanohi (face-to-face) meeting via Zoom so that we could meet and get to know each other prior to deciding whether they would like to participate. The digital photo diary exercise (outlined in [section 4.4.2](#)) was also intended to afford autonomy and self-determination (tino rangatiranga) by enabling free expression whereby cultural practices could be depicted and represented in ways determined by participants themselves. Digital photos could be generated in culturally safe locations, with the written descriptions accompanying photos enabling cultural understandings to be expressed and shared ways which were meaningful to participants. The results of this study will also be disseminated back to participants, to ensure that knowledge is shared with them and their respective communities.

I discussed undertaking a cultural consultation with my supervisors, however as I have previously undertaken a cultural consultation with Dr. Pikihiua Pomare for a similar project

(NOR 20/09 - exploring motivations of day-to-day dietary practices, which whilst considered 'healthful', may become highly significant and instead become problematic or result in dysfunction) in the interests of protecting the time of Māori colleagues, a consultation was not sought. An additional reason for not seeking consultation, was that whilst this research topic is relevant to Māori communities in that Māori may develop gastrointestinal disorders and seek to manage them via dietary changes, the GID literature conducted within Aotearoa New Zealand over the past 50 years indicated that Māori are underrepresented in GID prevalence statistics due to lower genetic predisposition risk proposed in Māori (low Polymorphisms in CARD15) (see Qui et al., 2022 and Gearry et al., 2006, 2007).

With IBS prevalence rates for Māori currently unknown, it was therefore possible that participation in this research may not have resonated with Māori. It was also important to acknowledge my own positionality (further discussed in section [4.6.1](#)) and recognise that being an Australian/New Zealander white cisgender woman, I may not necessarily be the person that Māori (or indeed individuals from other ethnicities) may necessarily choose to share their experiences with, especially given the private / tapu nature of the gastrointestinal symptoms and bowel dysfunction often experienced by those living with IBS which may inform dietary practices.

I was however very fortunate to have recruited one participant who identified as Māori (Miriam) and two who identified as Māori / New Zealand European (Sophie and Reese). I would like to acknowledge that my analysis within this thesis does not speak for all Māori, but was attuned to the experiences and details shared by individual participants in relation to the parameters and theoretical framework of this research project only. All three participants spoke of their dietary practices in relation to Western mainstream understandings of health, healthy eating and feminine appearance ideals, and did not make reference to Māori concepts, values, norms and practices, with the exception of Miriam who highlighted the cultural importance of food and eating together, and how eating on the Marae could create difficulties for maintaining IBS related preferred ways of eating.

It is possible that this may in part be due to my own positionality or the fact that I did not probe further in relation to cultural food considerations. In [Chapter 9](#), I discuss how future research could benefit from the inclusion of more Māori participants and how understanding of IBS management could be further explored in relation to Māori worldviews and understanding of health and healthy eating.

### **4.3 Recruitment Process and Participant Characteristics**

To date, most studies exploring the dietary practices of those with IBS have included patients from specialist gastroenterology clinics and hospitals only. As a result, such findings may be reflective of only those who have been able to access high levels of care and specialist services. I therefore sought to recruit from a wider, more community based level, rather than prioritising private gastroenterology clinics to capture and explore a wider range of experiences. This influenced my recruitment strategy and inclusion criteria.

#### **4.3.1 Participant Recruitment**

After having received ethical approval, participant recruitment took place in March 2023 via various social media platforms (Facebook, Twitter, Instagram and LinkedIn). An invitation to participate in the form of a digital poster graphic (Appendix C) was posted on my personal social media pages and was subsequently shared by friends and other interested parties to their own personal and professional pages, increasing distribution. Recruitment materials were also posted in Aotearoa New Zealand IBS and low FODMAP related Facebook groups, as well as Massey University Facebook groups. Permission to post in all Facebook groups was obtained from page administrators prior to posting recruitment materials (Appendix D). I had initially intended to distribute hard copy flyers in addition to recruiting via social media, however my initial recruitment posts on Facebook generated so much interest that I was successfully able to recruit all participants via Facebook within a number of days and no further recruitment was required.



Facebook has been widely and successfully used for participant recruitment for health research, particularly since the Covid-19 pandemic (Kamp et al., 2019; Benedict et al., 2019; Reagan et al., 2019). For this study, the posting of recruitment graphics in IBS and dietary related Facebook groups was extremely effective and efficient. Within minutes of posting, I received multiple responses from potential participants expressing their interest in participation. This process was further expedited with the information sheet (Appendix E) able to be shared immediately with potential participants via Facebook messenger. Facebook messenger also provided an efficient and convenient way for participants to ask any questions and seek further clarification around various aspects of participation, prior to agreeing to participate. For those who confirmed their interest to proceed, I was then able to obtain a preferred email address to email through online consent forms (Appendix F and G) via a Qualtrics survey link. Once written consent to participate had been granted, I scheduled interview sessions at the participants convenience and provided them with individualised Zoom login details. All further participant correspondence was then conducted via email.

Participant recruitment via Facebook additionally proved beneficial for this project by enabling me to access participants I otherwise would not have been able to reach. I was able to access participants across a diverse range of cities and geographical locations in Aotearoa New Zealand and target specific Facebook groups comprised of members who met my inclusion criteria ([section 4.3.2](#)). Recruiting via Facebook also meant I could access a pool of participants who were already actively sharing their experiences in public forums, and who were enthusiastically open to providing further accounts of their experiences in an interview / digital photo diary format.

Recruiting via social media, was further cost effective in terms of negating printing costs associated with hard copy printing and distribution costs, and time efficient removing the need to distribution/remove posters across multiple locations (Whitaker et al., 2017). More importantly, participant convenience was able to be maximised. Interviews were able to be scheduled for times and locations which enabled both convenience, privacy and

removed the need to travel to/from a specific interview locations. It also ensured participants could situate themselves within safe environments, so that should symptoms occur during the interview itself, they were close to a bathroom and somewhere where they felt comfortable.

Facebook recruitment did, however, raise a number of ethical issues in relation to privacy and confidentiality. Although many participants private messaged or emailed me to receive more information about participation, the majority of potential participants commented publicly on my recruitment posts, indicating their interest in participation. This resulted in participant names becoming publicly available underneath my recruitment posts. Not having anticipated such a public response to my posts, this was an ethical issue I had not considered in terms of ensuring confidentiality and privacy. Although only some people who participated in the study commented on the post, in order to protect confidentiality and privacy for participants going forward, once participant numbers had been reached and recruitment had closed, I subsequently deleted my recruitment posts. This ensured that all posts, participant details and comments, could not be retrospectively searched for within the Facebook groups.

Facebook recruitment also made me more 'available' to participants at times, than perhaps I would have liked. I experienced pressure to be accessible and respond immediately to participant messages, although doing so also worked to my advantage as I was able to schedule in interviews 'on the spot' whilst participants were interested and enthusiastic, which was extremely efficient from a time perspective. On reflection, I might have created a dedicated Facebook study page from which all recruitment materials could be posted, and from which all communications could take place, as opposed to using my own personal Facebook account. Alternatively, potential participants could be more specifically instructed to make contact via email or direct messenger rather than commenting publicly on recruitment posts or where possible, the commenting feature could be turned off on posts. At the same time, I also believe that there were some advantages posting recruitment materials from my own Facebook account, rather than a more formalised and

less personalised dedicated study page, such as enabling potential participants to feel safe in participating as they could 'see' who they would be sharing their experiences and stories with, rather than not knowing who they would be speaking with.

Other notable limitations of using Facebook messenger to provide information to participants, was that participants were required to accept a message request from me as per Facebook protocols. Approximately half of those who had expressed their interest, elected not to accept this request, and I was therefore unable to provide information and progress their interest. Interestingly, due to the large number of responses I received, and the subsequent number of direct messages sent to respondents, one unexpected outcome was the suspension of my Facebook account. A Facebook logarithm identified my account as a 'spam account' and I received a 24-hour ban, requiring me to challenge this suspension in order to have my account reactivated within in a number of hours.

Finally, Facebook recruitment may also have influenced the demographic makeup of the participant group as a whole in relation to gender diversity and symptom severity. These methodological limitations are further discussed in sections, [4.3.3](#) and [4.3.4](#) below. It should also be noted that the majority of participants in this study were recruited from IBS and dietary related (low FODMAP) Facebook groups. As a result, most participants dietary practices had been informed to some degree by the low FODMAP diet, even if they were not following the low FODMAP diet at the time of participation. The experiences, perspectives and understandings shared in this project, may therefore differ from those who have not engaged with, or are not familiar with the low FODMAP diet.

#### **4.3.2 Inclusion Criteria**

Participants were individuals who responded to online recruitment materials and self-identified as having been diagnosed with IBS, and having changed their diet to manage their IBS symptoms. Participants may have been prescribed / advised by a healthcare professional to make dietary changes or they may have chosen to make self-directed dietary changes to manage their symptoms. The minimum age for participation was 18 years age,

with no further participant demographics specified for inclusion. Participants required internet access and a suitable device to participate in Zoom online interviews. Those wishing to participate in the secondary data collection method (digital photo diaries) additionally required access to a phone/camera to enable the collection of digital photo images.

#### **4.3.3 Participant Demographics**

Demographic information was collected during the online consent process via a Qualtrics form prior to the commencement of the first interview (Appendix H). Participants were asked to provide their age, gender identity, ethnicity and profession. A participant demographic summary is provided in Table 1. The participant group consisted of 26 people who self-identified as female/women. Unfortunately, no respondents who identified as male or non-binary / gender diverse chose to participate in this study which was somewhat disappointing as recruitment had not intended to attract only female/women participants. The lack of gender diversity in the participant group could potentially be attributable to a number of factors. Firstly, IBS is sometimes referred to as a 'women's disease', with women overrepresented in IBS prevalence rates in general and more likely to experience severe and impactful symptoms (Bureychack et al., 2025; Sperber et al., 2021), which may have contributed to the overrepresentation of women in the participant group.

Secondly, Facebook as means of recruitment itself may also have contributed to the gender disparity. For example, in a systematic review of 110 health, medical or psychosocial research studies using Facebook recruitment, when not recruiting for a specific gender, higher representations of women in Facebook recruitment studies have been observed (Thornton et al., 2016). Thirdly, the use of my personal Facebook profile for the recruitment process, may also have meant that men, non-binary or gender diverse people did not feel comfortable having conversations about IBS symptoms, bowel function/dysfunction and dietary practices with me, or that I was not the right person for them to choose to share their experiences with. Men for example, may have preferred, or have felt more comfortable sharing their experiences with another man. Finally, it is also possible that the digital diary

**Table 1***Participant Demographic Summary*

| Pseudonym | Age | Gender | Ethnicity            | Occupation             | Predominant Symptoms                                                                                                          |
|-----------|-----|--------|----------------------|------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| Roza      | 46  | Female | European             | Therapist / Coach      | Urgency, diarrhoea, nausea, severe pain, flatulence, difficulty digesting certain foods, fatigue                              |
| Emily     | 35  | Female | Middle Eastern       | Private Tutor          | Constipation                                                                                                                  |
| Jessica   | 23  | Female | European             | Student                | Diarrhoea, constipation, vomiting after lactose and dairy, dry vomiting, feeling sluggish, pain, stomach cramps, fatigue      |
| Kate      | 33  | Female | NZ European          | Student                | Constipation, bloating, severe pain, trapped gas, flatulence                                                                  |
| Amy       | 26  | Female | Pakeha               | Student                | Diarrhoea, pain, stomach cramps, nausea, flatulence                                                                           |
| Jennifer  | 25  | Female | NZ European / Pakeha | Engineer               | Constipation, bloating, pain, flatulence                                                                                      |
| Daisy     | 32  | Female | NZ European          | Occupational Therapist | Constipation, bloating, frequent bowel motions, pain, fatigue, nausea                                                         |
| Scarlett  | 38  | Female | NZ Pakeha            | Mother / Home Educator | Diarrhoea, nausea, pain, fatigue                                                                                              |
| Alicia    | 25  | Female | NZ European          | Research Assistant     | Urgency, diarrhoea, pain, constipation                                                                                        |
| Carey     | 45  | Female | NZ European          | Nurse                  | Constipation, bloating, severe pain, uncontrolled bowels (urgency), nausea                                                    |
| Sophie    | 21  | Woman  | Māori / NZ European  | Connector              | Urgency, diarrhoea, pain, bloating, lethargy, body aches                                                                      |
| Michelle  | 41  | Female | NZ European          | Occupational Therapist | Diarrhoea, vomiting, severe stomach cramps, pain, dizziness, dehydration, fatigue, sleep interruption, haemorrhoids, fissures |

| Pseudonym | Age | Gender | Ethnicity           | Occupation               | Predominant Symptoms                                                                                                 |
|-----------|-----|--------|---------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------|
| Lily      | 21  | Female | NZ European         | Student                  | Severe constipation, bloating, pain                                                                                  |
| Mariama   | 54  | Female | Māori               | Senior Advisor           | Severe bloating, gas, stomach cramps, reflux, loose stools, urgency, headaches, fatigue                              |
| Gillian   | 52  | Female | NZ European         | Nurse Grower / Worker    | Diarrhoea, bloating, wind, gas                                                                                       |
| Elle      | 55  | Female | NZ European         | Pest Control             | Diarrhoea, urgency, loose bowel motions, bloating, constipation, pain                                                |
| Julianne  | 31  | Female | Pakeha              | Audiologist              | Diarrhoea, pain, bloating, gas, lethargy                                                                             |
| Julia     | 28  | Female | Pakeha              | Emergency Management     | Diarrhoea, pain, cramping, bloating, gas, nausea, exhaustion                                                         |
| Reese     | 23  | Female | Māori / NZ European | Activities Co-Ordinator  | Diarrhoea, constipation, vomiting, pain, burping, sleep disruption                                                   |
| Taylor    | 44  | Female | Australian          | Relationship Manager     | Constipation, nausea, pain, stomach cramps, lethargy                                                                 |
| Cara      | 43  | Female | Taiwanese           | Manager / Student        | Severe diarrhoea, urgency, acid reflux, dehydration                                                                  |
| Bella     | 28  | Female | NZ European         | Early Childhood Educator | Severe constipation, bloating and pain, stomach migraines, trapped gas, gas, fatigue, difficulty digesting, fullness |
| Natalie   | 42  | Female | NZ European         | Planner                  | Severe bloating, constant pain                                                                                       |
| Nicole    | 42  | Female | Pakeha              | Veterinary Nurse         | Diarrhoea, bloating, pain                                                                                            |
| Blake     | 46  | Female | Australian          | Relationship Manager     | Severe constipation and bloating, fissures, lethargy, digestive difficulties                                         |
| Emma      | 28  | Female | NZ European         | Product Designer         | Severe constipation and bloating, feeling sluggish                                                                   |

component of this study may not have appealed to everyone, and may have worked as a deterrent towards participation for some groups.

There was however, an unplanned advantage associated with having unintentionally recruited a participant group comprised of women, in that I was able to explore some of the gendered aspects of participants IBS eating assemblages in more depth. For example, I was able to map how Western feminine appearance ideals formed lines of stratification which flowed through various IBS eating assemblages, impacting how participants understood and felt about their bodies, particularly when bloated.

Nine participants spoke of periods in their life where they had experienced food/body distress. Participants described these experiences in various ways. Some provided diagnostic labels such as anorexia nervosa (Jessica and Bella) or binge eating (Emily). Others described these experiences more broadly, using the terms disordered eating (Cara), restricted eating (Taylor) or an eating disorder (Sophie and Lily). Disordered eating / eating disorder histories were not highlighted as ongoing concerns for all. Bella for example, downplayed such experiences and described experiencing “a little bit of anorexia” in high school “nothing dramatic”. Three participants (Emily, Natalie and Emma) explicitly spoke of current food/body practices which continued to be problematic for them in ways which were related to weight/shape concern. For these reasons, I therefore decided not to extend my recruitment process further and actively attempt to obtain a more gender diverse sample.

The average age of participants was 33 years, with ages spanning from 21 to 55 years. Participants represented a range of ethnicities; New Zealand European/Pakeha (19), Māori / NZ European (2), Australian European (2), Māori (1), Middle Eastern (1) and Taiwanese (1). Participant occupations varied widely across the group (e.g. occupational therapist, student, research assistant, engineer). All participants resided in Aotearoa New Zealand, with participants geographically spread across both the North and South Islands. Whilst geographical information was not specifically collected with other participant demographics, many discussed their location in interviews whilst situating their experiences with various healthcare services. This geographic spread is noted here for the purposes of

situating participants experiences as occurring across Aotearoa New Zealand, as opposed to taking place in one specific city or location.

#### **4.3.4 IBS Diagnosis**

The ways in which participants had come to understand they were living with IBS varied across the participant group. For most, this had involved a long diagnostic process which had included consultations with general practitioners, gastroenterologists, specialists, nutritionists, dietitians and naturopaths. In order to rule out structural abnormalities associated with other diagnoses such as inflammatory bowel disease, Crohn's disease or coeliac disease, some participants reported having undertaken medical procedures such as colonoscopies (15), endoscopies (3), blood tests (5) and stool tests (1). Other participants had simply been told they had IBS, or likely had IBS by a healthcare professional / dietitian and had not undergone any further testing. As a result, many expressed that their IBS diagnosis had felt like one of exclusion and that the severity of their symptoms had not been understood or were dismissed.

The symptoms described by participants varied across the data set. Some described their symptoms using the ROME diagnostic categories such as IBS-D, C or M (Drossman & Hasler, 2016). Others did not mention these criteria and instead described the range of physical symptoms they experienced (Table 1). It is also important to note that whilst symptom severity was not formally assessed as part of this study, nine participants explicitly stated experiencing severe and debilitating symptoms during the course of their interviews (Rosa, Scarlett, Alicia, Michelle, Julia, Cara, Bella, Blake, Emma). Although the majority of participants did not specifically mention the severity of their symptoms, they spoke of embodied symptomatic experiences which were profoundly impactful on their daily lives and significantly impacted how they understood and felt about their bodies. Only one participant described their IBS symptoms as on "the milder side" (Taylor).

When discussing the severe and debilitating nature of participants symptoms and experiences throughout my analysis, rather than organise participants experiences into pre-



determined hierarchical categories of severity, I instead took an ethological approach to highlight ‘what an IBS body can’, or in this case could not, ‘do’. This enabled me to demonstrate how participants’ capacities to affect, and be affected could become severely diminished when experiencing IBS symptoms, and how embodied experiences of distress were produced relationally through IBS eating assemblages.

As previously mentioned in [section 4.3.1](#), Benedict et al., (2019) notes that social media recruitment may capture those who experience more severe symptoms, higher levels of distress and lower quality of life, when compared to participants recruited from hospitals and illness registers. It is therefore possible that the experience of IBS related distress produced through IBS eating assemblages in this study, may differ to those experiencing less severe IBS symptoms

#### **4.4 Data Collection**

Data collection took place between March and April 2023 and involved three different data collection points. All participants were required to participate in an initial online semi-structured interview. Participants were then invited to further their participation by taking part in an optional digital photo diary exercise and follow-up interview, to discuss the diary entries they had created. Due to the strong interest in participation and enthusiasm from respondents, the majority of interviews took place within a short period of time. This meant that on some days I conducted four interviews, producing an intensive interviewing schedule. As each data collection point is discussed sequentially below, I also note ethical considerations which arose throughout this process and highlight some of the ways in which I engaged reflexively throughout the data collection process.

##### **4.4.1 Semi-Structured Interviews**

Primary data collection involved online semi-structured interviews conducted between myself and 26 participants. Participants provided written consent online via a Qualtrics survey link (Appendix F). Prior to the commencement of each interview, participants were

again taken through the information sheet, consent processes, told they had the right to withdraw at any time, and asked if they had any questions. After interview commencement, ongoing consent was further obtained throughout the interview process at three different check-in points as highlighted in the interview schedule (Appendix I).

Honan (2014) argues that interview schedules can work to create categories, hierarchies and ordered steps, however although following a semi-structured interview format, the interview process was far from linear. Many participants talked freely and at length about their experiences, with conversations flowing with ease, often accompanied with laughter, empathy and shared understandings of familiar experiences. Questions were sometimes answered before they arose in my schedule, with some participants providing insights beyond the questions/topics I had planned to cover. In contrast, other participants required more prompting and appeared to prefer a more sequential, question and answer format. Some participants did not offer in-depth responses, with questions seemingly producing blockages and falling flat. By engaging reflexively throughout the interview process, I was able to appreciate that everyone shares their stories in their own way, and I did my best to create a space for everyone to do so. What one is willing or able to share on any given day, or in any given moment, may also vary.

In order to capture more of the material and embodied aspects of IBS related dietary practices, the interview schedule contained a number of questions which focused on sensory embodied experiences of food/body relations associated with IBS symptom management. Whilst senses were not the focus of this study, the inclusion of 'sensory awareness' in interview research has the potential to open up in-depth discussions (Harris & Guillemin, 2012) and I had hoped to create additional opportunities to explore how embodied sensations associated with IBS symptoms contributed to the production of food beliefs, day-to-day dietary practices and experiences of food/body distress. Understanding participants attunement to embodied sensations and feelings as potentially affective (Hickey-Moody & Malins, 2007) was therefore considered important, and was intended to open up new understandings food/body relations in the context of IBS management.

These questions however, were not overly successful in opening up conversations about bodily sensations, and did not resonate in the way I had envisaged with many participants. Chadwick (2017) notes how even when conducting ‘sensory interviews’, participants many struggle to answer ‘fleshy’ questions, perhaps because ‘there is no fully-formed language or vocabulary with which to speak about the fleshy, emotional intensely embodies experiences” (p. 56). In Chapter 4, my analysis highlight some of the ways in which language was insufficient and failed to capture the severe and debilitating nature of IBS symptoms that the women in this study experienced. The use of semi-structured interviews, however, did enable rich insights into the contextual and temporal nature of IBS related dietary practices and body management, when participants experiences were explored in relation to theoretical concepts such as assemblage, affect, territory and the refrain. This enabled symptomatic experiences and food/body relations to be explored and understood as more than individual, distributed and produced through various relations within IBS eating assemblages, which impacted participants capacities to act in different ways.

Upon completion of each interview, participants were debriefed to ensure they were not left emotionally vulnerable state. Due to the personal, potentially sensitive and confidential nature of the information which may have be disclosed by participants during the interview process, it was possible that some psychological or emotional discomfort may have been experienced by some participants. For example, it was possible that a participant may have experienced an emotional response during the interview process or could have felt embarrassed or anxious when discussing certain topics. It was also possible that during subsequent data collection points, such as the digital diary exercise ([section 4.4.2](#)) and follow up interview ([section 4.4.3](#)) that participants may have experienced some discomfort when creating digital images, or when writing about and reflecting upon, their embodied experiences of living with IBS. It was also possible that participants may have experienced discomfort when talking about the digital images they had captured during the during the follow up interview. In recognition of such possibilities, a list of support services was

provided to all participants and Professor Kirsty Ross, a clinical psychologist and member of the supervision team, was available to contact any participants who experienced any distress as a result of their participation. This level of support was not required by any participants.

#### **4.4.2 Digital Photo Diaries**

Following completion of the first interview, participants were invited to take part in a secondary data collection exercise – digital photo diaries. Eleven participants chose to create digital photo diaries. Participants were provided with Digital Diary Guidelines (Appendix J) to help guide the diary creation process and highlight some of the ethical considerations which may arise in relation to the collection, and ongoing use of digital images. Due to the different ethical considerations associated with this data collection method, participants were required to provide separate written consent for this component of the study, which was obtained via a Qualtrics survey link (Appendix G).

Participants were provided with an overview of the diary process and asked to take a series of digital images over a two-week period on their own phone/camera, with the digital photo diary intending to explore how participants dietary practices assembled with bodies and symptom management across various life contexts and temporalities. Each digital photograph could be accompanied by a caption, whereby participants could outline their inspiration for capturing that particular moment, how they felt when taking the photograph or explain what the photograph meant to them. Participants were requested to produce a minimum of five digital images, but were told they could take as many images as they liked and write as much or as little as they felt was appropriate for the image they had taken. Upon completion of the exercise, participants digital diaries were uploaded into individualised and anonymised Massey University SharePoint folders.

Deleuze and Guattari (1987) describe their concept of the rhizome as being “entirely oriented to experimentation with the potential to open up possibilities for connections and remove blockages through multiple entryways” (p. 12). Through the incorporation of digital

photo diaries as a more than representational creative and emergent data collection method (Coffey, 2021, 2022), I had intended to open up new and different ways of understanding the dynamic and contextual nature of IBS related dietary practices. However, as Deleuze and Guattari (1987) caution, it is impossible to know in advance what will happen when creating the new. As such, although having provided a broad set of guidelines, it was difficult to know in advance how participants would engage with the diary exercise, what kinds of entries might be produced, what affects/intensities/becoming might be captured, and as a result how diary entries might 'open up' and 'provoke' (Coffey, 2021, 2022; Vannini, 2015).

This was evidenced through the different ways in which participants chose to engage with their diary exercise. The number of diary entries generated during this exercise varied, with some participants taking the minimum 5 digital images, others taking 14 (one for each day of the two week period) and one participant producing 31 images. The average number of images produced was 10 photos.

Some participants created 'food diaries' and photographed their meals on sequential days, with the captions submitted naming the food in their images. Whilst I had not necessarily intended for participants to create a food diary, retrospectively this was also unsurprising given that those with IBS are often create detailed food diaries as they try to establish their own trigger and safe foods. The creation of food diaries and food tracking is also undertaken during the three stages of the low FODMAP diet, as people start to reintroduce foods back into their diets and begin to establish which foods, which quantities, which combinations and how often they can eat them (Monash University, n.d.).

Surprisingly, only two participants included digital images of their bodies, with the majority instead choosing to focus on food and other aspects of IBS body management. It was also interesting to observe how participants had presented a somewhat sanitised version of their lives, choosing to display caution and adhere to social and gender norms by avoiding the inclusion of any content which might be considered disgusting or inappropriate. For example, when asked if there were any photos that participants had thought about taking but did not, Elle recalled a tramping trip with her sister where she had urgently needed to go

to the toilet behind a bush. “I suppose I could have taken a picture of a bush! (laughs)... But then again, some of these things aren’t pleasant ways of portraying it either are they... But then there’s nothing pleasant about it” (Elle).

The majority of participants chose to provide short captions to accompany their photos. Others had taken significantly more time to provide reflective and well considered personal insights. Three participants in particular (Alicia, Rosa and Scarlett) engaged with the diary exercise in rich and multi-sensory ways, producing unexpected and novel outcomes and enabling access to experiences, perspectives and illness/wellness temporalities, which would not otherwise have been obtained through interviews alone. These entries were particularly useful for exploring lines of flight (see sections [6.4.1](#), [6.4.2](#) and [8.2.2](#)) and identifying moments where intensities had become blocked and experiences of distress were being produced (see section [6.3.2](#)).

#### **4.4.3 Follow Up Interviews**

Upon submitting their diary content, the eleven participants who completed digital photo diaries were invited to take part in an optional follow-up online interview to discuss their diary entries. Four participants consented to take part in this final data collection point. I had previously prepared an interview schedule to help guide the follow-up interviews (Appendix K) yet as participants had engaged with the diary process in differing ways, some of the questions and talking points I had noted no longer felt relevant or useful and instead I adopted a more post-qualitative ‘anti-method’ approach (St. Pierre, 2017).

Follow-up interviews were conducted via Zoom utilising the screen sharing facility. Prior to interview commencement, I downloaded each participants digital images to my laptop so that I could share my screen and ensure easy and systematic viewing. Together, each participant and I discussed the digital images they had produced over the two week period in sequential order. As I shared each photo, participants described what they had taken photos of, why they had taken that particular photo, and anything else they wanted to share when reflecting on the photo and its context. However, as Tinkler (2014) notes, the

relationship between the types of photos taken what happens in an interview is not simple. Having removed any pre-conceived notions of how follow-up interviews 'should' progress (Honan, 2014; Law, 2004) opened up a range of discussions which might not otherwise have occurred.

Alicia's digital diary for example, was able to capture Alicia's surprise and embarrassment when looking back on one of her diary entries "I don't feel as strongly about it today as I did when I took this photo. I was pretty mad". Tinkler (2014) notes that there is often a temporal disjuncture between taking a digital image and reviewing the image at a later time when one is required to explain or confer meaning to the image taken. Being able to capture this moment in time therefore was valuable, highlighting the dynamic nature of affects, and relations which assembled together to produce certain intensities and ways of feeling, which later subsided "Obviously I felt a little bit more at the time when I was talking this photo, which was why I took the photo, but today I'm not feeling as emotional about it" (Alicia). When contemplating the image and caption, Alicia remarked how "it makes me feel like I'm being dramatic, but it doesn't, because they were real reactions and they're valid, but [sighs] but yeah, it's coming back to that... I shouldn't make a big deal out of it, but I kind of should, it's making me feel like the emotions again, I had none this morning" (Alicia).

The capacity of digital images to 'provoke' by reproducing previously experienced emotional intensities in ways which could be experienced anew, was highlighted during Alicia's follow-up interview. Such 're-experiencings' were also entangled with the production of new emotional responses such as the feeling of embarrassment, highlighting the need to be attuned to ethical considerations such a risk/harm as a result of this methodological potential, to ensure that participants are supported and cared for throughout, and after the follow-up interview process.

As Grosz (1994) argues 'Bodies act and react. They generate what is new, surprising and unpredictable' (p. xi). For this study, the inclusion of digital photo diaries provided a means to explore IBS related food/body practices as an emergent process, enabling participants to capture the dynamic nature of various affects and intensities across everyday

life contexts and temporalities. When used in conjunction with DeleuzoGuattarian theoretical concepts, digital photo diary entries were therefore able to be re-orientated away from representational images, or mirrors of reality, and instead be understood as affective 'potentials' with the power to provoke, affording an embodied, affective and relational methodology (Coffey, 2021).

#### **4.4.4 Data and Transcript Handling**

Primary interviews ranged in duration between 32 and 100 minutes, with follow-up interviews ranging between 36 and 58 minutes. Upon completion of each interview, participants were thanked for their time and asked if they would like to select their own pseudonym to protect their privacy. Only one participant elected to do so, with all other pseudonyms allocated by myself. All Interviews were audio recorded directly to my PC and backed up immediately upon interview termination, anonymised and password protected. Each interview was subsequently transcribed to verbatim for analysis by myself. Completed transcripts were then re-read alongside the audio to ensure accuracy and data integrity. All interview audio files, transcripts and digital diary content previously uploaded by participants to individualised and anonymised Massey University SharePoint folders were then backed up, password protected and transferred to Massey University servers for secure storage.

Seven participants elected to receive a copy of their transcripts to review. Where participants had participated in both an initial interview and follow-up interview, transcripts from both interviews were provided simultaneously. Participants were allocated a two-week time frame to provide feedback, clarification or make any desired amendments. Only one participant elected to make changes to their transcript, redacting references to additional medical information she did not wish to remain on the transcript. All other transcripts were considered final and approved for analysis. As a token of appreciation for participants time and contribution, participants received one \$40 supermarket voucher for each interview they participated in, and a \$40 Countdown voucher for creating a digital photo diary.

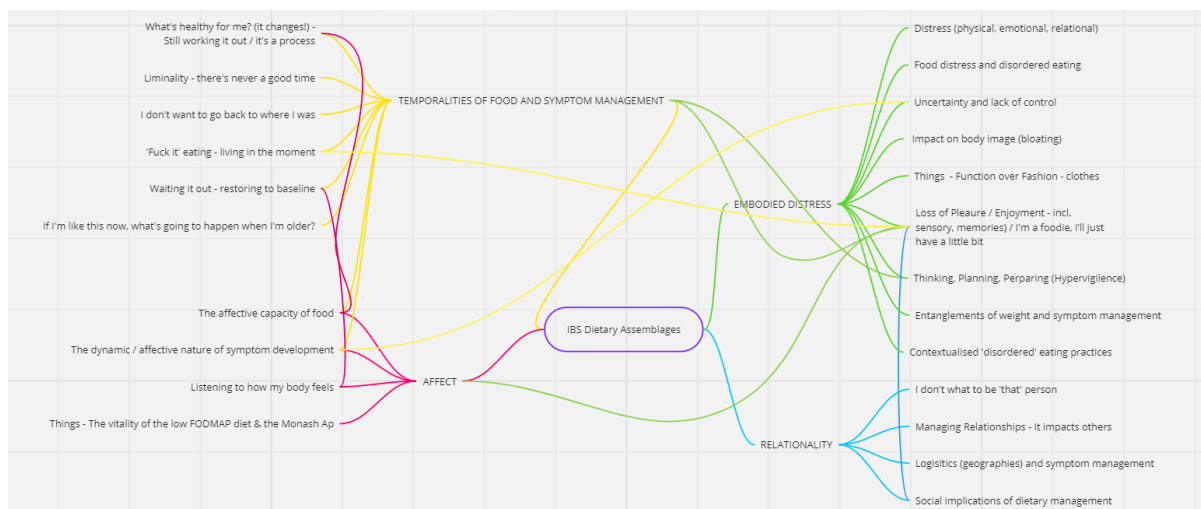


## 4.5 Analytic Process

I had initially intended to conduct a theoretically informed Reflexive Thematic Analysis (Braun & Clarke, 2006, 2019) as this was a familiar, and clearly delineated analytic method I had used before. As a result, my analytic process commenced by familiarising myself with the data by reading and re-reading interview transcripts and looking through the digital photo diaries that participants had created. Throughout this ‘immersion’ process, my initial thoughts, ‘noticings’ and overall first impressions were handwritten on participants transcripts and diary entries, and recorded in my research journal. Commonalities, differences, discrepancies and contradictions observed across participants experiences were noted, as I attempted to organise my data into various themes (Figure 1).

**Figure 1**

### *Preliminary Data Organisation*



Deleuze and Parnet (2002) however explain how “things never pass where you think, nor along the paths you think” (p. 4) and this process, which was ultimately a form of coding critiqued by St. Pierre (2016), felt quite insufficient. Participants’ experiences were unable to be neatly, or adequately separated into different themes in ways which captured their relational nature, leaving me feeling frustrated and struggling to find a way to satisfactorily move forward. MacLure (2013) notes how when using new materialist ontologies “data

cannot be seen as an inert and indifferent mass waiting to be in/formed and calibrated by our analytic acumen or our coding systems” (p. 660). Retrospectively, attempting to code and simplify the ‘becomings’ of complex multiplicities and explore the ‘cutting edges’ of participants IBS eating assemblages, was never going to be adequate way to proceed, because the “state of things are neither unities or totalities, but multiplicities... a set of lines or dimensions which are irreducible to one other” (Deleuze & Parnet, 2002, p. viii). Feeling like I had reached a dead end, I decided to start anew, re-orientating and reconfiguring my research assemblage by instead adopting a post qualitative analytic approach and started “thinking with theory” (Jackson & Mazzei, 2022).

#### **4.5.1 Thinking with Theory**

Jackson and Mazzei (2013) describe “thinking with theory” as a process methodology which requires thinking methodically and philosophically together - using theory to think with data, or using data to think with theory. Thinking with theory however, does not proceed via coding and reducing data into “thematic chunks” which are then “interpreted free of context, circumstances, other texts, theoretical concepts and so on” (Jackson & Mazzei, 2013. p. 261). Rather, data and theory are ‘plugged into’ (Jackson & Mazzei, 2013) one another through a mechanic process and ‘put to work’ in ways which are appropriate for a particular research project (St. Pierre, 2015).

There is no specific formula or method for ‘thinking with theory’, “rather it relies on a willingness to borrow and reconfigure concepts, invent approaches, and create new assemblages that demonstrate a range of analytic practices of thought, creativity and intervention” (Jackson & Mazzei, 2018., p. 717). Deleuze and Guattari (1983) argue that “thought does not need a method” (p. 110) because methods work to prohibit experimentation and creation of the new by limiting thought to the normal (what everyone knows) by capturing and constraining it to the strata (Deleuze, 1994). Thinking with theory, therefore does not follow any preconceived ideas of how to proceed, rather it can be understood as immanent and created by its own generative movement “something that

happens, paradoxically, in a moment that has already happened; something emergent, unpredictable and always rethinkable and redouble” (Jackson & Mazzei, 2022, p. 717). As such, thinking with theory, can only be described “after the fact” (St. Pierre, 2016, p. 81).

To increase the chances of creating the new, St. Pierre (2017, 2019) suggests the practice of reading philosophy rather than methodology, and reading extensively; “Read, read, read” until one ‘becomes Deleuzian’, “and has those analyses in ones bones, until one’s life becomes rhizomatic... *live* the theories... live in a different world enabled by a different ethico-onto-epistemology” (St. Pierre, 2017, p. 2). Following this advice, my analytic process re-commenced with reading Deleuze and Guattari (1987), Buchanan (2020) and various “A Thousand Plateaus” reading guides (Adkins, 2015; Sommers-Hall et al., 2018) alongside participants interview transcripts and participants digital diary content. I read as much DeleuzoGuattarian philosophy as I could, moving between different plateaus and engaging with different DeleuzoGuattarian concepts. Alongside this, I also read the work of other feminist new materialist philosophers and scholars who had used new materialist thinking and DeleuzoGuattarian concepts to explore various health and food/body related topics.

Throughout the process of “reading, thinking, writing and living with theory” (St. Pierre, 2017, p. 2) I experienced many blockages. Initially unable to grasp some concepts, I returned to the same pages over and over again, before having to move onto different passages and readings in order to become unstuck. At the same time, I also experienced many lines of flight with various DeleuzoGuattarian concepts eventually opening up new ways of thinking which enabled me to understand my data (and the world) in new, different and exciting ways.

Jackson and Mazzei (2023) describe how reading intensely works to “activate a circuit, to see what sparks, jolts, and puts thought in motion” (p. 3) and in some instances the reading, and re-reading of transcripts brought certain concepts to the fore – making themselves *felt* as a means of enabling different ways of thinking about the ways in which participants engaged with, or avoided food. In other instances, it was the reading of different

plateaus which produced these affective moments, directing my thoughts to certain participant experiences, transcript excerpts and digital images in ways which opened up new ways of understandings. Jackson and Mazzei (2013) describe this process as “a becoming that involves attunement to happenings, formations” (p. 135). It is between theory and data which the new is produced; it is a space which incites change, creates movement and enacts the transformation of thought (Jackson & Mazzei, 2022). For me, the process of thinking with theory and attempting to creating the new, involved “a very lengthy process, yet no method, no rules, no recipes” (Deleuze & Parnet, 2002, p. 8).

#### **4.5.2 Assemblage Thinking**

Parr (2010) describes how concepts “become the means by which we move beyond experience so as to be able to think anew... in other words concepts must be creative or active rather than merely representative, descriptive or simplifying” (p. 54). The DeleuzoGuattarian concepts which I felt resonated most with my data and opened up new and different ways of understanding IBS related dietary practices were assemblage, becomings/affect/intensities, territory (de/reterritorialisation), stratification, the refrain, rhizome and Deleuzian understandings of time as non-linear, and the DeleuzoGuattarian question of ‘what a body can do’.

As highlighted in chapter 2, when thinking with assemblages it is important to highlight the assemblage as the unit of analysis, rather than the individual (Fox & Alldred, 2022). In a processual sense, thinking with assemblages initially involved identifying the human and non-human components which comprised participants IBS eating assemblages. However, whilst assemblages are often equated with configurations of physical ‘props’, they are also a working arrangement with a “beating heart” (Buchanan, 2020, p. 56). As such, I commenced my analytic process by asking the Deleuzian question ‘how does it work?’ in order to explore what IBS eating assemblages do, what they function with and what they produce.

This involved thinking relationally and imminently (Jackson & Mazzei, 2018; Jackson, 2017). I ‘mapped’ relations by hand, drawing lines between various components and writing

notes on paper, and thought about how different components of IBS eating assemblages were working together, and how different dietary practices were being produced across a range of contexts and temporalities. For example, in [chapter 6](#) my analysis explored ‘social eating assemblages’ and how different social settings and contexts had the capacity to produce different ways of eating (and not eating) at different times, when assembled with IBS related dietary practices. I looked for moments of connection, whereby participants’ capacities to act were being increased or maintained through specific ways of engaging with (or avoiding) food, and where affirmative experiences of health and wellness were being produced. I also looked for blockages and disjunctures, where participants capacities were being constrained or reduced, and where food/body relations had led to experiences of severe physical illness and embodied distress which were experienced as life destroying.

I noticed where affects/intensities were being produced and followed ‘the action’ (Fox, 2024). For example in [chapter 5](#), I thought with the concepts of de/reterritorialisation and followed the bodily intensities produced through certain food/body relations which resulted in the onset of severe physical IBS symptoms IBS. These affective flows could be understood as a process of bodily deterritorialization which significantly reduced participants capacities to act, and subsequently requiring them to adopt various dietary strategies in order to reterritorialise, and restore their bodies back to health.

Thinking with the concept of rhizome became a useful analytic for mapping the long process of dietary experimentation participants embarked upon as they attempted to establish individualised ways of eating which enabled body stability; an ongoing process which had opened up moments of connection in the form of temporary symptom alleviation, yet which had also produced many dead ends with symptoms returning and participants required to start anew ([section 7.2](#)).

With all assemblages having tendencies towards both stasis and change (Deleuze & Guattari, 1987), I thought with the concepts of territory and the refrain to explore how certain dietary practices gained consistency over time ([section 7.3](#)), sometimes resulting in rigid and restricted dietary practices ([section 7.4](#)). I also identified the thresholds, or ‘cutting edges’

(Deleuze & Guattari, 1987) of participants IBS eating assemblages, to explore how in different contexts and temporalities, food/body relations were sometimes pushed to the limit. I followed lines of flight, where for example, some participants had found ways of temporarily breaking away from their usually restricted dietary practices to eat for pleasure, enjoyment and social connection, before having to reterritorialise and return to their usual dietary practices ([section 7.3.3](#)). Thinking with the concept of lines of flight alongside participants' digital photo diary entries proved particularly generative in highlighting how some participants had been able to establish new and creative ways of engaging with food, enabling them to foster and enhance social connections ([chapter 6.4](#)).

Deleuze and Parnet (2002) note, that “to extract concepts which correspond to a multiplicity is to trace the lines of which it is made up, to determine the nature of these lines, to see how they are entangled, connect, bifurcate, avoid to fail or avoid the foci” (p. viii). I thought with the concept of stratification to identify some of the stratifying lines which flowed through participants IBS eating assemblages (e.g. gender norms, social eating norms, feminine appearance ideals, healthy eating guidelines). I thought about how these lines produced intensities which impacted how participants understood and felt about themselves, their bodies and their dietary practices in both affirmative and harmful ways. For example, my analysis highlights how feminine appearance ideals worked to limit the ways in which participants could understand, and feel good about their bodies when experiencing IBS symptoms ([section 5.3](#)), and how health eating guidelines had captured understanding of healthy eating which could lead to feelings of dietary deficiency ([chapter 8](#)).

Assemblages are not fixed entities but are always in a process of becoming. As such, “The meaning of an event can be rigorously analysed, but never exhaustively, because it is the effect of an infinitely long process of selection determining that two things of all things, meet in this way at this time and place, in this world out of all possible worlds” (Massumi, 1992, p. 11). Having already collected my data via conventional humanistic methods with the intention of conducting RTA, thinking with assemblages afforded a means of re-starting in ‘the middle’ and working with qualitative interview transcripts and digital photo diary content,

in ways which were both within and outside of representational approaches. As Deleuze (1994) notes, “the new, with its power of beginning and beginning again, remains forever new, just as the established was always established from the outset, even if a certain amount of empirical tie was necessary for this to be organised” (p. 136). My analytic process therefore, required working within the limits of these different perspectives and making specific assumption about data, voice and truth and acknowledging that data is “partial, incomplete and is always in a process of retelling and remembering” (Jackson & Mazzei, 2013, p. 262).

#### **4.5.3 Immanence Vs Analytic Quality Criteria**

As there is no specific formula or method for ‘thinking with theory’, there are also no clearly delineated quality criteria to determine analytic rigor or validity. Deleuze and Guattari (1994) argue that “thought”, according to conventional research methods “needs a method, an artifice, which enables the thinking to ward off error” (p. 131). The systematic following of linear, sequential methodological steps which can be clearly delineated and replicated for example, are often used as a means of determining scientific validity, however these kinds of presuppositions are not commensurable with Deleuze and Guattari or post qualitative inquiry (St. Pierre, 2021).

As highlighted in the previous section, post qualitative approaches are immanent and as such, there are no pre-existing, formalised or systematic steps or processes to follow to ensure validity. As each study will be different, generalisations about ‘goodness’ or validity are therefore not possible (St. Pierre, 2021a). The intention instead, is not to systematically repeat a predetermined or pre-existing research processes in order to produce a recognizable outcome, but “to experiment and create something new and different that might *not* be recognizable in existing structures of intelligibility” (St. Pierre, 2021, p. 8).

At the same time new materialist approaches are not a “disciplinary free-for-all” (Thorpe et al., 2020, p. 50) and this does not mean that inventing new concepts “willy nilly”, nor the volume of “flimsy” new concepts created can be used to determine the importance,

or validity of a study (St. Pierre, 2019, p. 8). It is instead the long process of preparation and reading and thinking with concepts, such as rhizome, assemblage, territory etc. which enable different ways of thinking which are commensurable with an ontology of immanence. St. Pierre (2021) explains how “anything always goes until someone draws a line” (p. 7). It is however, our own training and positionality (and arguably the stratifying lines drawn by ethical committees and review boards which remain tethered to positivist/humanist assumptions (Thorpe et al., 2020)), which will often determine the lines we draw, and as such these lines may also be personal and subjective. I discuss some of these lines these further in the following reflexivity section.

#### **4.6 Reflexivity**

Law and Urry (2004) argue that research methods are “*performative*. By this we mean that they have effects; they make differences; they enact realities; and they can help to bring into being what they also discover” (pp. 393-394). As mentioned in the introduction section of this chapter, there are various components which comprise each stage of the research process (e.g. recruitment, data collection, analytic process etc.) which together, produce flows of affects which have the capacity to produce research (Fox & Alldred, 2015). The research methods selected can therefore be understood as a territorialisation, which shapes the affective flows within a research assemblage, enabling particular research capacities and impacting the kind of knowledge produced as a result of this “specific arrangement” (Fox & Alldred, 2015, p. 404).

The research process itself however, is also dynamic and constantly unfolding, producing its own affective flows. Whilst research assemblages produce intended outcomes (i.e. the research) they also have the capacity to produce a range of unintended outcomes (Fox & Allred, 2017). In the sections above, I have highlighted some of the unintended outcomes which emerged throughout the research process in relation to recruitment, participant demographics, challenges associated with sensory interview questions and the decision to reconfigure my analytical process; some of which produced lines of flight which



affirmatively propelled the research process along, with others creating temporary blockages and prompted the reassembling of certain components affording new ways to move forward.

As an affective component of the research assemblage myself, it is also important to acknowledge my own “messy involvement” (Thorpe et al., 2020, p. 52) and be accountable for, and transparent about the methodological choices made throughout the research process, and the implications and consequences of these ‘agential cuts’ (Barad, 2007). In this section, I situate myself as a component of this research assemblage and further discuss some of the ways in which my choices and reflective engagement shaped the research process. I also acknowledge how the research assemblage created its own affective flows which transformed me as a student researcher in affirmative ways.

#### **4.6.1 Researcher Positionality**

Deleuze and Guattari (1987) argue that “we are made of lines” (p.194) and there is a whole varied geography within people (Deleuze & Parnet, 2002). Researcher positionality is the process of outlining a researcher’s perspectives and worldviews, and making explicit the position a researcher has adopted within a research project (Goundar, 2025). Bettez (2015) describes positionality as a combination of the social groups one belongs to and personal experiences (acknowledging that experience is always interpreted individually, and that it is through such interpretation that experience is given meaning). Positionality is important, because how we understand ourselves and how others perceive us, impacts how research is conducted, the power dynamics between the researcher and participants, the ways in which data is made sense of and the results (Goundar, 2023; Rowe, 2014).

I start by positioning myself in relation to this research project (Yip, 2024). I am a middle-aged, middle-class, Australian born, New Zealand based, white heterosexual female PhD student. Academically, my research interests in day-to-day dietary practices and understandings of healthy and problematic eating stemmed from my master’s research project which explored experiences of Orthorexia Nervosa, a proposed new eating disorder characterized by an unhealthy obsession with eating healthy foods (Bratman, 1997). Using a

post structuralist theoretical lens, I explored experiences of highly significant dietary and exercise practices, which whilst considered to be healthful had paradoxically become problematic or result in dysfunction for the person instead (Lewthwaite & LaMarre, 2022).

Although not aware of assemblages or the philosophy of Deleuze and Guattari at the time, findings highlighted how understandings of healthy eating differed widely, the motivations for eating healthfully were multiple and the line between what was regarded as healthy/unhealthy was almost impossible to delineate. Such understanding however had not emerged in isolation, and the usefulness of relational approaches which were more attuned to this complexity, subsequently became apparent. It further became evident that understandings of healthy and problematic eating were lacking in relation to chronic illness contexts more specifically. Thinking with assemblages and ethology, afforded a theoretical framework through which different ways of engaging with food could be explored relationally, and understood for the capacities they enabled (and constrained), without reducing specific ways of eating (or not eating) down to categories of healthy and disordered/problematic. This research topic therefore felt like a natural extension, and a way to build upon previous work.

From a lived experience perspective, I further situate myself as having previously engaging in dietary practices which align with the proposed diagnostic criteria of orthorexia nervosa, alongside restricted eating, over exercising and weight/shape concern. Following a partial gastrectomy for the removal of a gastrointestinal stromal tumour, my food beliefs and behaviours changed dramatically to accommodate surgical stomach alterations and the pursuit of optimal 'health'. I was subsequently diagnosed with IBS approximately 10 years ago following this surgery, with my symptoms most typically aligning with the diagnostic category of IBS-C. Today my dietary practices although relatively 'normal', are ongoingly informed by the management of moderate IBS symptoms which primarily involve pain, bloating and constipation.

My IBS diagnosis positions me as both an insider and outsider of this research project (Goundar, 2025). However as Milligan (2016) argues, one is never completely an insider or outsider, and in reality one is aspects of both to different degrees across different

continuums (Katyal & King, 2014). For example, despite the heterogeneous nature of IBS symptoms, I consider myself to be an insider in relation to experiencing IBS-C related symptoms, however I have not experienced enduring IBS-D symptoms nor the distress associated with managing such symptoms. Whilst I am an insider in relation to having made dietary changes to manage IBS symptoms, the severity of my symptoms, the dietary changes I have made and the life context within which I manage my symptoms, differ to those of the participants within this study. As a student researcher, I may therefore hold some critical information as an insider, however I may not be aware of or understand participants lived experiences, also making me an outsider (Ali et al., 2022). Further, how I understand or position myself, may not necessarily align with how participants see me (Milligan, 2016). For example, as Bettez (2015) outlines how undertaking research which is “close to home” (p. 941) makes it is easy to be believe affinities will naturally create communion. Understanding positionality as fixed can therefore be problematic, and may better be understood as always partial, unfinished and continually changing in relation to different assemblages and who I as a person and student researcher is continually becoming (Bettez, 2015).

Given the stigmatised nature of bowel dysfunction, I chose to disclose my own IBS diagnosis to participants during the interview process in order to create “points of connection” (Bettez, 2015, p. 938) and a space of understanding and empathy, with the hope of enabling the sharing of what Lister (2017) describes as ‘untellable stories’ without fear of judgement. Disclosing my own IBS diagnosis proved beneficial in a number of ways. I was able to approach each interview with a level of familiarity and understanding that I felt facilitated strong rapport with participants which continued throughout the data collection process. I believe my insider status also enabled participants to feel comfortable sharing their experiences. Indeed one participant disclosed she had never told anyone about the nature of her IBS symptoms, and chose to keep her camera off during the interview process. Whilst initially feeling somewhat uncomfortable being unable to see who I was talking to, I was able to appreciate how this enabled the participant to her to share her ‘untellable story’ in a

manner which perhaps felt safer by limiting her exposure and reducing her vulnerability. This additional layer of anonymity perhaps highlighting another unforeseen benefit of online interviewing, enabling the potential for participant risk/harm to be further reduced when discussing health related issues associated with stigma, taboos and embarrassment.

The affective forces of the researcher within research assemblages also has the capacity to enable or shut down different becomings during interview encounters (Adjei & Nung Chan, 2024). The questions asked, the time of the interview, the physical/emotional state of the researcher and participant themselves, what is heard and recognised, missed or ignored, all contribute to what is produced as data during the interview process (Bodén, 2015). I therefore remained cautious of positioning myself as an 'insider' (Hellawell, 2006) and attentive to the risks associated with sharing my own experiences so as not to create affective flows which might influence participants responses, when it was essential to let them share their own unique stories (Drake, 2010). I also remained conscious so as not to let my own lived experience limit or reduce my understandings of participants experiences down to those of my own, or to make assumptions which prevented me from probe further into participant responses (Shah, 2004).

During the analytic process, I also remained attentive to my own understandings of food/body relations and how IBS symptoms *felt* and thought about what other kinds of affective flows they produced. I thought of the lines which flowed through my own IBS eating assemblage and how they were similar to some participants and how they differed to others. For example, my own experiences of IBS symptoms resonated with the body distress described by many participants in relation to the unpredictable onset of extreme bloating. As I further expand upon below, I used reflexive journalling as a means to reflect upon my how participants experiences might influence my own understandings of IBS symptoms and the ways in which food was engaged with (and sometimes avoided) and vice versa. My positionality, rather than being fixed, therefore emerged relationally throughout the research process, moving between different points in ways which I further highlight below.

#### **4.6.2 Reflexivity in Process**

As mentioned in the previous section, a reflexive journal was kept throughout the research process and used for documenting conceptual/analytic notes, thoughts and insights, workings and personal reflections to provide transparency around my decision making process (Cena et al., 2024). Engaging with reflexive journalling became a useful tool for capturing the dynamic and temporal nature of thoughts and feelings associated with the research process and reflecting upon my ongoing entanglement with the unfolding research process itself (Thorpe et al., 2020). Lumsden (2019) explains that “reflexivity focuses on the unfamiliar, the uncomfortable, the messy, difference/s, and writing up our failures” (p.15). Below I provide three examples of how I engaged reflexively throughout the research process.

##### **4.6.2.1 Data Collection**

Deleuze and Guattari (1987) note how “each of us is caught up in an assemblage” (p. 36) and with the overwhelmingly enthusiastic response I received throughout the recruitment process, I too became caught up in the affective flows of such a positive response. Afraid of losing this momentum, I adopted a ‘strike while the iron was hot’ approach, which meant that whilst I was able to secure all of my participants relatively quickly, it also produced an intensive interview schedule which meant on some days I undertook three or four interviews. The intensive nature of my interview schedule produced some notable limitations. Unfortunately on some occasions I was left with insufficient time between interviews to allow me to reflect adequately on the previous session and recalibrate personally. Whilst I had taken notes during each interview, I would have benefited from more time between each session to have engaged with my own reflexive journalling process.

Participants were also eager to commence their digital diaries immediately, however this also meant that in some instances I did not have enough time to transcribe their first interview, before finding myself conducting a follow-up interview to discuss their diary

entries. Where this was the case, I instead listened to the interview audio and made brief notes of anything I wanted to follow up on. Regrettably, this process was not optimal, and again, did not afford me sufficient time to reflect upon what had been previously said in any depth and I missed the opportunity to re-visit some of the topics I would retrospectively have liked to have discussed further as a result.

It has since been interesting to reflect upon how the prioritisation of some connections may have led to the reduction of others throughout the research process. For example, I have reflected upon whether the tight scheduling of interviews on some days may have adversely impacted the quality of some interviews. Whilst unaware of this at the time, I can also see how gender norms may have been implicated in this decision. Interestingly, after having noticed how women with IBS often put others first even when doing so did not always benefit or serve them (sections [6.2.1](#) and [6.2.2](#)), I can see how my desire to accommodate and please participants, may have played into my decision to over-extend myself in ways which did not always benefit myself or the research process.

Despite this, whilst reading and re-reading the transcripts and digital diary entries I am not necessarily sure that my data collection was adversely impacted. Certainly, there were some missed opportunities to further explore participants experiences in more depth, however, there were also instances where I made the right decision ethically to not probe further with some topics. In particular, this was the case with disclosures of disordered eating / eating disorder history, where participants made it known that their food/body distress was in the past, and that their relationship with food was now different.

#### **4.6.2.2 Analytic Process**

As highlighted in section 4.4, the decision to change analytic processes, although the right decision overall, was not without its own challenges. Although enabling me to produce a more relational, contextualised and temporal account of IBS related dietary practices, it also created a lot of additional work. St. Pierre (2017) describes how theory came too late in her own PhD, however for me it came just in time, propelling my analysis along a new

pathway. Although I was familiar with some of the Deleuze's philosophical concepts, I had not fully appreciated the interrelatedness of these concepts, nor the amount of reading required to understand these concepts in any depth.

St. Pierre (2016) explains how doing something new is not only hard work, but that scholarly work is also personal and not just academic. She describes how when her students read Deleuze and Guattari, they "*will be changed*, and they can't go back" (St. Pierre, 2015 p. 84). This was also my experience. Thorpe et al., (2020) similarly highlights how "we are always entangled with our theoretical and methodological frameworks...we act upon and are transformed through knowledge production practices" (p. 57) and for me, learning to think more conceptually with a range of different theoretical concepts was a was an incredibly transformative, and dare I say it, enjoyable experience. I found it exciting to see what emerged between theory and data when thinking with, and plugging in different theoretical concepts. Learning to trust the process, embrace the not knowing and not understanding and "work at the edge of incompetence" (Eisner, 1996, p. 412, as cited in St. Pierre, 2019) enabled me to move between various theoretical concepts, transcripts and digital images in ways which afforded great flexibility and freedom to explore different connections and disjunctions in ways which would not otherwise have been possible.

As all assemblages are political (Fox & Alldred, 2015) throughout the research process I also remained aware of the power dynamics which flowed through the research assemblage. I reflected upon how my decisions (e.g. which theoretical concepts were used, how participant 'voice' was engaged with and which quotes/images were selected for inclusion) shaped certain aspects of the research assemblage and the findings produced. I am aware that the analytical concepts I have used to think with theory might be considered "too way out there" (St. Pierre, 2019, p. 9) by others. I hope however, that my analysis and findings are received as they are affirmatively intended - by offering new insights into the embodied, contextual and temporal nature of IBS related dietary practices, when different ways of engaging with food are understood as relational and dynamically produced through various IBS eating assemblages. In [chapter 9](#), I again touch upon these reflexive and

methodological 'lines' and discuss how they shaped my analytic approach and research findings, in ways which afforded new insights, whilst also producing study limitations.

#### **4.6.2.3 Quotation Use**

I would also like to highlight my decision to draw heavily on quotations as a means of working closely with texts throughout sections of this thesis (and in this chapter more specifically). Although flagged by my supervisory team that many consider the extensive use of quotations to be lazy, I contend that this deliberate 'style' of writing was instead reflective of my deep and sustained engagement with the literature (something that St. Pierre argues is necessary for post qualitative approaches). Interestingly Deleuze and Guattari (1987) comment that they themselves "have been criticized for overquoting literary authors" (p. 4). They also argue that when one writes, what matters when plugging into other 'literary machines' is that "which other machine the literary machine can be plugged into, must be plugged into in order to work" (p. 4). I argue that in this chapter, the heavy inclusion of quotations 'works'.

However, as Deleuze and Parnet (2002) explain, concepts and intensities "may suit you or not" they may be "acceptable or aren't acceptable" (p. 4). Whilst I appreciate this approach may not be acceptable to all, I would like to explicitly state that my intention in doing so was not to avoid work. Rather, it was reflective of the significant amount of time spent immersed in the literature during the thinking with theory process, and engaging with such texts with the intention of highlighting the philosophical approaches of Deleuze and Guattari and the usefulness of their concepts for this research project. Such engagement was further reflective of my desire to engage directly and deeply with theory in ways which did not rely on secondary literature, and the personal enjoyment I derived throughout the process of 'becoming Deleuzian' (St. Pierre, 2017). Thus whilst this approach may not conform to what is acceptable or suit all readers, I do however hope the intentional and deliberate use of quotations throughout this thesis is not perceived as a deficiency, but



rather received affirmatively and for what it enabled – new ways of thinking and understanding.

#### **4.7 Chapter Summary**

In this chapter I have provided an overview of the various components which comprised my research assemblage. I have outlined the recruitment process I undertook and provided an overview of my data collection methods and the analytic processes I followed. I have highlighted some of the ethical and cultural considerations associated with this project, and some the reflexive practices I engaged in throughout the research process. In the following four chapters I present my analysis drawing on the DeleuzoGuattarian concepts of assemblage, becomings/affect/intensities, territory (de/reterritorialisation), the refrain, stratification, rhizome and Deleuzian understandings of time as non-linear and the DeleuzoSpinozist question of 'what a body can do', to explore how various IBS related dietary practices were produced through different IBS eating assemblages.

## **Chapter 5 – Becoming IBS**

The findings presented in the following analysis chapters reveal how IBS eating assemblages were comprised of multiple interconnecting relational aspects such as bodies, physical symptoms, emotions and experiences of psychological distress, as well as certain foods and specific dietary practices. These assemblages encompassed various social settings and contexts, as well as broader life circumstances such as the requirement to maintain full-time employment, care for families and nurture interpersonal relationships. Additionally, IBS eating assemblages included a range of other heterogenous components such as various materialities (e.g. bodily waste, toilets, toilet paper, medications) and discursive elements (such as social and gender norms, feminine appearance ideals, healthy eating guidelines) which were constantly being reconfigured in different ways.

As outlined in chapter 2 however, it is insufficient to simply outline the components of assemblages and define them by the elements of which they are comprised. As assemblages are purposeful and emerge in response to a specific problem, IBS eating assemblages were explored in relation to why they were required, what they functioned in connection with (the composition, aggregation and mixture of their external relations) and what was being produced (Adkins, 2015; Buchanan, 2020; Deleuze & Guattari, 1987). In the following four analysis chapters, *Becoming IBS*, *Social Eating Assemblages*, *Temporal Multiplicities*, and *a Different Kind of Healthy*, I explore how different IBS eating assemblages were actualised in response to various IBS related ‘problems’, and how they functioned across various contexts and temporalities, producing different ways of eating and feeling.

### **5.1 Chapter Introduction**

As previously outlined, assemblages are dynamic and comprised of multiple interconnecting aspects which function together for certain periods of time. Assemblages produce becomings, which determine a body’s capacity to affect and be affected, such that “a body can be affected in many ways by which it’s power of activity is increased or

decreased” (Deleuze, 1992, p. 103). Assemblages have “both territorial, or reterritorialised sides which stabilise it, and cutting edges of deterritorialisation which carry it away” (Deleuze & Guattari, 1987, p. 88). My analysis in this chapter demonstrates how the onset of IBS symptoms could be understood as a process of bodily deterritorialization which occurs within dynamic assemblages comprised of food/body relations, affects, various materialities and discourses. To make sense of this process, I draw on DeleuzoGuattarian concepts of assemblage, becoming, de/reterritorialization and stratification to illustrate how IBS was so much more than ‘a little bit’ of diarrhoea or bloating, and how different layers of IBS related distress were produced and experienced through various IBS eating assemblages when participants bodies ‘become’ symptomatic.

Three subsections form the structure of this chapter. [Section 5.2](#) demonstrates how the process of ‘becoming symptomatic’ resulted in the onset of severe and debilitating physical symptoms. For the women in this study, managing periods of severe gastrointestinal distress was profoundly impactful and entwined with experiences of emotional and psychological distress. [Section 5.3](#), then unpacks a different aspect of process of bodily deterritorialization, by focusing on experiences of severe bloating and abdominal distention. Within this assemblage, feminine appearance ideals produced powerful intensities which impacted how participants experienced and felt about their bodies in ways which were distressing.

Deterritorialization however, is inseparable from the process of reterritorialization (Deleuze & Guattari, 1987) and the final [section 5.4](#) then explores how participants engaged with, and avoided foods in strategic ways as they attempted to reterritorialise, or restabilise their bodies during, and following, periods of severe physical symptoms. However, due to the chronic nature of IBS, such attempts were not curative, but an always-unfinished attempt at ‘becoming well’ (Duff, 2014).

## **5.2 Becoming Symptomatic**

IBS symptoms can be severe and debilitating with symptom development transforming the materiality of bodies and their capacity to function 'normally'. For the women in this study, the ill-health 'affects' which emerged through certain food/body relations resulted in debilitating physical symptoms such as severe pain, diarrhoea and bloating which impacted and constrained their lives in multiple ways. I refer to this process as 'becoming symptomatic'. In following sections, I similarly use the term 'becoming' to highlight various transitions between bodily states produced through the process of deterritorialization, including becoming broken and becoming bloated.

As this section illustrates, becoming symptomatic was so much more than 'just a little bit' of diarrhoea. Many of the women in this study experienced severe and debilitating physical symptoms, which were both physically and emotionally exhausting and difficult to endure on an ongoing basis. The experience of becoming symptomatic also made expectations for normative day-to-day living difficult and sometimes unattainable, leaving participants feeling dehumanised and like their bodies were out of control, broken and working against them. Uncertain and unstable embodiments, produced through dynamic and unpredictable symptom onset, affected how participants thought and felt about their bodies, often creating experiences of distress.

### **5.2.1 Experiencing Physical Symptoms – “It was bad”**

Deleuze and Guattari's (1987) concept of deterritorialization refers to a movement which produces change, whereby the “assemblage breaks down or becomes transformed into something else” (Patton, 2004, p. 158). For those with IBS, the experience of becoming symptomatic resulted in dramatic changes in embodiment whereby bodies, often suddenly, transitioned from periods of relative stability to chaotic instability experienced with the onset of severe physical symptoms. This movement between various bodily registers, often in response to food consumption, could be understood as a process of bodily deterritorialisation or “a coming undone” (Deleuze & Guattari, 1983, p. 322). Although lines

of flight associated with deterritorialisation are often considered to be affirmative, freeing and liberating, for those experiencing the sudden onset of severe physical symptoms, the lines associated with becoming symptomatic could instead be likened to “lines of destruction” (Deleuze & Guattari, 1987, p. 510) which were deeply destabilising, physically debilitating and profoundly impactful.

The process of becoming symptomatic was heterogeneously experienced. Participants described the onset of physical symptoms and sensations as consisting of pain, cramping, faecal urgency, diarrhoea, bloating, constipation, gas, nausea, vomiting, extreme fatigue and lethargy. However, as participants shared their stories it became apparent that these words, although medically aligned with the physical symptoms they experienced, were insufficient to capture the nature and extent of ‘becoming symptomatic’ events which were experienced after eating certain foods. For participants who experienced severe diarrhoea and faecal urgency as their predominant IBS symptoms, the process of becoming symptomatic was described as a debilitating experience, whereby physical capacities to act became extremely limited or were temporarily shut down, as bodies became deterritorialised through certain food/body relations.

Cara, who had experienced severe post-infection food related IBS reactions for sixteen years, recalled periods in her life where “I was just constant diarrhoea, bloating, acid reflux, there was about a couple of months when I wasn't really functional, that's how bad it was”. Julia, similarly described periods of time where she had been completely incapacitated “there was one point where I vomited so bad I don't think I left the house for about three months”. Rosa who has “struggled for the last five years with flare ups” similarly described becoming symptomatic as “really bad, like I would in fetal position for hours, taking every single pill I can find that may help with the stomach cramps, and then just sleeping in fetal position unable to do anything”. Elle described how “when I got diarrhoea it was bad, I'd never experienced it like this before... it went on for weeks (laughs) it was like oh my god, it was terrible... I got so bad... I didn't feel I could go out, I didn't want to go out, I didn't want to go to work, it was just awful”.

For Michelle who had experienced severe food related IBS reactions for six years, becoming symptomatic and experiencing severe physical sensations associated with gastrointestinal distress was an all-encompassing embodied illness experience which left her completely incapacitated. Michelle explained how “people would hear the term IBS and they’d think you get a little bit of diarrhoea, but it’s not like that”:

When I have a reaction, it usually starts with tummy pains that are like cramping, terrible, terrible pain, and then I know I’ll need to go to the toilet, and then I’ll get, I’ll be dripping with sweat like I’ve just had a swim and the rooms spinning, and I’ve been so close to passing out before, whilst having diarrhoea and vomiting and then I’m just dehydrated and that can go on for hours (Michelle).

Michelle’s symptoms were so severe that at times she had struggled to remain conscious as she attempted to manage diarrhoea and vomiting simultaneously. The symptoms she described, such as perspiring to the extent that it felt like she had been swimming, also extended beyond the limits of normative expectations, further exacerbating the already devastating physical outcomes she experienced by creating additional symptoms in form of dehydration.

The intensities produced through certain food/body relations and their unfolding and sometimes unexpected nature, worked to highlight the embodied nature of IBS symptoms and sensations. For Julia, becoming symptomatic following a food related reaction would usually encompass:

A lot of cramping, a lot of bloating, a lot of gas (laughs) and then a lot of diarrhoea often, sometimes I could easily go eight to ten times a day, which is never particularly fun and often it’s just a lot of pain in my lower abdomen. Sometimes you get those weird symptoms, like a spasm in your bowel or this sharp pain of all sudden and you know what’s coming, so like you get a little bit of preparation, but other times you don’t get any notice and you just suddenly are just super, super, sick in the bathroom, bloated, feel a bit nauseas, depending how bad it gets, particularly if it’s really painful

I'll just feel really nauseas, and then I'll feel exhausted. The tiredness that comes after it, can be crazy. (Julia)

Deleuze and Guattari (1987) warn of the dangers associated with a sudden deterritorialisation and for Julia, the process of becoming symptomatic was rarely a gentle or subtle transition between changing bodily states. Instead, deterritorialising forces were often experienced "like a spasm in your bowel" or a "sharp pain" which was unable to be ignored. Julia described having developed an attunement to these "weird" bodily sensations which provided her with some indication of the impending symptoms she was about to experience. However, at best, these warning signs only afforded her a little time to prepare to be unwell. What was coming, was not able to be prevented with the intensities produced through certain food/body relations already in motion. Julia's experiences were reflective of how Deleuze and Guattari (1987) talk of approaching the point where an intensity transforms into something else, as "the nameless summit of agony and dread" (p. 240).

Deleuze and Guattari (1987) explain that there is "no preformed logical order to becomings and multiplicities" (p. 251) and some of the bodily intensities described by participants could be difficult to understand. Symptoms were not always understood as logical and sometimes seemed contradictory, where for example, diarrhoea and constipation occurred simultaneously. Daisy recalls finding such symptom combinations "very confusing" when your "constipated and you urgently need to go". "Like what the hell? (laughs)...this whole like diarrhoea constipation at the same time situation is so wrong (laughs) like how does that happen?" (Reese). For some, having to manage additional gastrointestinal conditions also added to the complexity of managing IBS symptoms, leaving them feeling defeated. Michelle shared how she also experienced:

Really bad haemorrhoids and fissures as well, so I feel like my body's been through the works... sometimes because I use an internal cream for the haemorrhoids, like if the IBS is playing up, than can cause some faecal incontinence so then it's like bloody hell, you just can't win. (Michelle)

For Michelle, medical materialities such as haemorrhoid cream also produced affective forces. Michelle's use of an internal cream intended to help stabilise one set of symptoms (haemorrhoids) also had the capacity to destabilise her body and produce additional symptoms (faecal incontinence) when she was experiencing IBS symptoms. Medications which might usually be expected or relied upon to provide symptomatic relief, therefore also had the potential to assemble with bodies in ways which produced something new and unexpected, leaving her with additional symptoms to manage and feeling physically and emotionally exhausted.

## Figure 2

### *Always Empty Rolls*



Inevitably the management of extended periods of diarrhoea and vomiting were entwined with materialities of toilet paper, toilets and bathrooms. The affective flows of becoming symptomatic, often displaced participants' bodies to spaces such as the bathrooms within which their IBS symptoms were experienced and managed. Julia's digital diary (Figure 2) captured the rows of empty toilet rolls in her bathroom. Julia's image



captures her experience of having to “go eight to ten times a day” when she becomes symptomatic. The number of empty toilet rolls displayed on her bathroom shelf provides an almost quantifiable depiction of Julia’s frequent toilet use. The display of empty rolls also invites us to imagine the rolls as once having been new and full of toilet paper, and then the amount of toileting which has subsequently occurred to have generated this amount of empty rolls. The visual display of empty rolls also provide a way to substantiate an experience which would otherwise remain hidden to others.

Elimination is socially understood as a bodily process which is attended to privately within enclosed spaces (Williams, 2008). The social management of bodily functions also requires the sight, smell and sounds associated with defecation, all of which are highly associated with feelings of embarrassment, disgust and stigma, to be minimised (Inglis, 2001; Weinberg & Williams, 2005). As diarrhoea and vomiting are usually experienced and managed alone in the privacy of toilets and bathrooms, participant accounts of the severity of their IBS symptoms often remained untold with their experiences flushed away. With toilets and bathrooms often shared spaces with partners and other family members, mundane materialities such as toilet cleaner and air diffusers also formed part of this assemblage and enabled the unpleasant remnants of gastrointestinal distress to be removed, hidden or masked from household others. However, the empty toilet rolls remained as a testament of what Julia has endured; their presence able to communicate in a socially acceptable way the extent and severity of her symptoms.

Deleuze and Guattari (1987) explain that although it is possible to attempt to explain becomings “to do so most certainly impoverishes the phenomenon under study... a frame of classification is quite incapable of registering these becomings” (p. 237). As demonstrated in this section, referring to IBS as just ‘a little bit’ of diarrhoea and reducing experiences of severe symptom onset to singular medical terms, fails to capture the full extent of IBS related processes of bodily deterritorialisation, and instead works to reduce experiences of IBS to mere “fragments of tales” (p. 237). For those with IBS, entering into bodily compositions with certain foods could produce life destroying effects; the onset of severe

physical symptoms could be physically destabilising, profoundly impactful and severely diminished capacities in ways which, using the language of (Deleuze & Guattari, 1987, p. 510, 1998) could be “totalizing”.

### **5.2.2 Becoming Broken – Experiencing Emotional and Psychological Distress**

Deleuze and Guattari (1994) outline that deterritorialisation can be physical, psychological or social (p. 88) and in addition to experiencing severe physical symptoms and managing shame and stigma associated with bowel dysfunction, the process of becoming symptomatic also produced ongoing experiences of emotional and psychological distress. For Michelle, becoming symptomatic and having to manage herself though severe physical symptoms felt psychologically “huge”, “It’s a thing. It does mess with your brain a bit, it does mess with your mind and emotions are a big one, fatigue is huge, that comes along with it”. Amy described how “the big impact for me is usually emotionally, it takes quite a big toll... the biggest impact would be like emotional, like negative emotional kind of feelings that result”. For Julianne, experiencing severe physical symptoms felt all consuming and often limited her capacity to be anything other than symptomatic, “it’s really draining... it takes so much mental energy, and you just feel exhausted...I find it really hard to focus on other things and be present”.

Rosa described how the process of having to experience and manage severe IBS symptoms was “draining on a variety of levels”:

It’s physically exhausting one, because if you’ve already been to the toilet three times and it’s not yet lunchtime, that’s physically exhausting... but also its emotionally exhausting because you’re sitting there and you’re like, often I’m crying...and then you’ve got all this self-talk, like I’m broken, I can’t function, I’m not functioning as a normal human being... if I had to go out to work I would not be able to do it, I would need to be on an invalids benefit, because I can’t guarantee that I’m going to function today. (Rosa)

For Rosa, becoming symptomatic was:

More than just a physical issue in that it becomes this emotional thing, in that I'm this broken being, and so all that kind of stuff comes into it...it does become a real emotional impact because you start feeling like, just how broken, and like lesser of a person because you can't function normally and, and you do internalize. (Rosa)

Under certain conditions, becoming functions as a form of power which can propel subjects in different directions and towards different ways of thinking and feeling (Buchanan, 2023). Deleuze and Guattari (1987) describe how becomings can feel like being thrown into "upheaval" in ways which can "uproot one from humanity" (Deleuze & Guattari, 1987, p. 240). This feeling of being uprooted from humanity, can further be explained by Davies (2013) who outlines how normalising forces can determine "the very terms through which we become recognizable as human, as a particular kind of human, or as less than human, as a viable or a non-viable subject" (p. 22).

Through the process of becoming symptomatic, Rosa had come to recognise herself as "broken" and "lesser of a person". Rosa's sense of brokenness had emerged through the lack of bodily control she experienced when becoming symptomatic, resulting in her feeling like she was unable to function like "normal human being". This lack of functionality however was more than digestive dysfunction and the physical exhaustion which resulted from experiencing multiple episodes of diarrhoea. The onset of symptoms also worked to destabilise taken for granted assumptions around how a normal, healthy body should function, leaving Rosa feeling defective and inadequate. Failing as normal person who should be able to control their body, failing in relation to being a contributing member of society and failing as a woman to meet normative standards of femininity, with symptoms forcing her to transcend feminine taboos around gastrointestinal distress and digestive dysfunction (see Björkman et al., 2014, for discussion of such taboos).

Other participants also outlined the emotional impact of having a body which did not function normally. Bella expressed her frustration at her body's apparent inability to "work properly". She described wishing her body would "just work properly you know, how nice it would be to be able to eat food and it just do its thing and I get energy from it and didn't

waste all this energy on it". Alica found managing a body with IBS "so annoying, it's very irritating, I'm very mad that I've got it... because it's annoying, especially when you can't control it, you know sometimes I can control it, sometimes I can't, so when its uncontrollable its very annoying".

This sense of frustration was further perpetuated, when it felt like participants bodies were working against them:

I kind of feel shit sometimes that my body doesn't work the way it's meant to, like why can't I just do the normal things that you're meant to everyday, why do I have to have medication for that, why do I flare up from all these random foods all the time. (Emma)

This sentiment was echoed by many across the data set, with Jessica describing how "it does feel like your body is intentionally hurting you, that's the best way to describe it and that can be quite mentally hard to deal with". Daisy shared how "I just felt like my body was out to get me and ruin my life essentially, I felt like I had no control over whether I was going to get to go to work or not, or whether I was going to have to spend money at the doctors or not and I really had this unhealthy narrative that my body was letting me down".

When describing these feelings, participants talked about their bodies in ways which created distance between themselves and their bodies as the agentic 'other' and the source of their distress. Broken, or ill-functioning bodies were positioned as responsible for producing intensities which resulted in severe embodied illness experiences, but also as the reason for participants own lack of agency and inability to determine the course of their own lives. This left participants feeling out of control and like their bodies were working against them. In this sense bodies felt untrustworthy, unfamiliar and functioned as something which felt separate to, and in opposition to the self.

Having to manage through periods where severe physical symptoms placed significant limitations on participants' capacities to maintain and form new connections, which also felt incredibly constraining and unfair:

There's been times that it's has been so hard that I don't, I just want to lie down all the time and that's not ideal, that's not the kind of person I am, and there's been times you

don't get anything done because you're tired and you've got to try and stop the urge to go to the toilet all the time. It's just, it's so unfair, it's been so unfair at times, you know, but what can you do other than just get through it and keep telling myself that it will be better, it'll get better, it never stays like this forever... it's either that or you just get into a deep dark hole and that's not ideal either is it. (Elle)

For Elle, the ongoing physical efforts required to resist the bodily intensities of urgency was also mentally exhausting and felt all consuming. Davies (2013) describes how the forces of normalisation work to produce those “who stand outside of the normative order, a fearful and melancholic subjectivity” (p. 21). Body instability in the form of urgency had unwillingly forced Elle outside of normative expectations for bodily control, limiting her capacity to live a normal life in ways which felt extremely unfair. Enduring ongoing body instability, also produced ruptures in Elle’s self-identify, limiting the kind of person she could be by producing a less viable, less than human version of herself, leaving her longing for a means through which she regain bodily control and become “re-cited as a viable being” (Davies, 2013, p. 24). The emotional affects associated with becoming symptomatic therefore had the potential to produce an effect of closure “as if the aggregate had fallen into and continues to spin in a kind of black hole” in which one could feel trapped (Deleuze & Guattari, 1987, p. 334).

The body however, is also a site of refusal where intensities may be resisted and endless possibilities for reterritorialisation can lead to more affirmative outcomes (Fox, 2011). Elle is able to resist the potential to fall into the “dark hole” by acknowledging life as a constant state of becoming and telling herself it will get better. Elle remains hopeful that in time, another more affirmative line of light will open up, and in [section 6.4](#) of this chapter, I highlight some of the ways in which participants sought to enact agency and reterritorialise their bodies through the adoption of various dietary practices and strategies which worked to facilitate this process, and propel “a body along a line of becoming well” (Duff, 2016 p. 59).

### **5.3 Becoming Bloated**

In this section, I further unpack the process of deterritorialization by exploring the experience of severe bloating and abdominal distention. Across the data set bloating and distention were two of the most commonly identified causes of embodied distress. It is worth noting that although two different physical symptoms, bloating and distention were often conflated and referred to interchangeably by participants as bloating.

For participants who experienced severe bloating when becoming symptomatic, the onset of severe pain, feelings of trapped gas pushing against bodily organs and extended periods of severe constipation significantly impacted how they experienced their bodies. Bloating and distention which often developed suddenly and unexpectedly, meant that participants regularly experienced dynamic changes in embodiment. In addition to experiencing uncomfortable and painful visceral sensations associated with feeling bloated, abdominal distension also altered participants' physical dimensions, expanding and enlarging bodies and changing their physical appearance in unwelcome ways, impacting how they understood and felt about their bodies. For the women in this study, distress associated with severe bloating and abdominal distension was experienced as looking pregnant without pregnancy and as a result, being pushed outside of idealised feminine appearance ideals.

#### **5.3.1 It's not just a little bit of bloating...**

Participants described being surprised by the extent of their bloating and the degree to which their physical appearance would be transformed. Many of the women likened the bodily changes they experienced to the appearance of pregnancy. Miriama tends "to bloat a lot, and it just makes me feel absolutely terrible, I mean, I'm not talking about just a little bit of bloating, I'm talking about where your stomach is like right out, you look eight months pregnant and you just feel ghastly". When bloated, Natalie similarly described looking like "I'm six months...it looks like I'm pregnant". Emma's bloating was so severe that she described having to "take multiple pregnancy tests, because it honestly looks like I'm six

months pregnant...like it's not just a little bit of bloating". Although the sudden onset of severe bloating and abdominal distention which produced the appearance of pregnancy might not logically equate to being pregnant, this dramatic change of embodiment and the bodily sensations and feelings it created, were so profound that it was enough to generate a sense of uncertainty and doubt. Emma described touching her stomach when bloated and "it would just be hard, like you're touching, you know how you touch your stomach and it will just feel hard".

The extent of Emma's bloating was such that that once she had become so bloated as to look pregnant, Emma's IBS eating assemblage expanded to include pharmaceutical items such as pregnancy tests, to rule out any doubt that she might in fact be pregnant. Having to take multiple pregnancy tests, however also created affective flows which could also be distressing. Negative pregnancy tests, although providing a sense of initial relief by ruling out future unwanted pregnancy, simultaneously produced feelings of frustration that it was not 'normal' to look pregnant or feel a 'hard to the touch' pregnant looking stomach, when not pregnant. The agency of the body and the multiplicity of sensations produced through the process of becoming bloated also pushed back against Emma's expectations of how her stomach should, and would normally look and feel; flatter and softer to touch, further emphasising the dramatic change in her embodiment when she becomes symptomatic.

Deleuze and Guattari (1987) describe how affects, as an effectuation of a multiplicity can produce the feeling of a "disrupted self" (p. 240). For women with IBS, the onset of severe bloating which resulted in the appearance of pregnancy whilst not actually being pregnant was experienced as a kind of "unnatural participation" with their own body, "an incredible feeling of an unknown nature" (Deleuze & Guattari, 1987, p. 240). Jennifer described bloating as "one of the hard symptoms...I don't know I guess especially as a female, it's hard to manage body image when that symptom in particular is bad, because your perception of yourself is very different". For Jennifer, the consumption of foods which result in her becoming symptomatic produced affective flows which altered her appearance in ways she finds confronting and difficult to reconcile. The transition from how she would

normally look as a fit and active young women, to a body shape which simultaneously feels uncomfortable and looks dramatically different “does play a bit into my self-image when I look in the mirror and it’s not how I would expect to see myself”.

Blake similarly described a disconnect between feeling “really good” and like herself when she follows a strict low FODMAP diet and then feeling “like a totally different person, a totally different person” when she becomes bloated. The sudden and dramatic change in embodiment felt like being temporarily forced to inhabit a different body. Not the body you would usually expect to see in the mirror, not a body that felt comfortable to be in and not the body you would ideally like to occupy. The sudden onset of severe bloating and distension therefore felt like an intrusion or rupture to the familiar which was experienced as a sense of estrangement from the self which worked to raise doubts over the ownership of the body. The onset of bloating also diminished participants’ sense of control over their bodies, by transforming the normal and familiar into to a liminal symptomatic body which was bloated and distended, making participants feel like were inhabiting a strange, uncomfortable and unfamiliar body. Severe bloating also disrupted notions of how bodies should look and behave, with the appearance of pregnancy without pregnancy experienced as an improper performance of the body (Attwood, 2014).

### **5.3.2 Becoming Stratified**

As outlined in Chapter 3, stratification is an inevitable phenomenon which is both beneficial and unfortunate. Stratification works by process of “giving form to matters, of imprisoning intensities or locking singularities into systems of resonance and redundancy... organizing them into molar aggregates”, strata are “acts of capture... They operate by coding and territorialization” (Deleuze & Guattari, 1987, p. 40). For those who experienced severe abdominal bloating and distention, Western feminine appearance ideals formed lines of stratification which flowed through IBS eating assemblages. Within this assemblage, cultural disgust towards fat bodies, feminine appearance ideals where a slim, toned and controlled body is valued, and weight is understood as a measure of a woman’s health,



attractiveness, femininity and morality (Riley et al., 2018) had territorialized participants' understandings of what was considered attractive and desirable. These lines, when assembled with sudden and dramatic changes in embodiment associated with severe bloating and distension, could produce unfortunate and harmful effects, propelling bodies away from normalised ideals of feminine beauty, and limiting the ways in which participants could understand and experience their bodies affirmatively.

As previously highlighted in [section 5.3.1](#), sudden and dramatic changes in embodiment could feel like experiencing an “unnatural participation” with one’s own body (Deleuze & Guattari, 1987) which felt like being temporarily forced to inhabit a different, unfamiliar and uncanny (pregnant looking) body. However, the physiological aspects of severe bloating and distention, when assembled with appearance ideals, also had the potential to produce intensities which could exacerbate body distress when perceived as sudden weight gain and experienced as feelings of fatness. Blake for example, described how painful visceral sensations, severely constipated bowels which felt full, heavy and stuck, gas and significant abdominal distention were perceived as immediate weight gain and experienced as feelings of fatness which made her feel “disgusting”, “sluggish” and like a “beached whale”:

You feel like Augustus Gloop from Charlie and the Chocolate Factory, like even though you know that you’re not, but because of the bloatedness and how absolutely like, you don’t feel fine at all, you feel like you’re about 50 kilos heavier than you are and you’re walking around, it’s just the worst, it’s super uncomfortable (Blake)

These feelings were also described by Alicia who shared how “when I’m bloated I feel worse about my body because I struggle with my weight, once you’re bloated and it’s visibly bloated, you do think I’ve gained weight, but you haven’t actually gained weight, you’re just bloated”. Although participants were able to rationalise they had not actually gained weight whilst bloated, physiological changes and resulting visceral sensations, together with altered physical appearance, *felt* like immediate weight gain.

This feeling of having suddenly become bloated, bigger and heavier, and as a result unexpectedly finding oneself pushed outside of appearance ideals, might be likened to what Deleuze and Guattari (1987) refer to as the abstract machine at work. The assembling of content and expression in such a way that makes us ask “What happened? Whatever could have happened?” (p. 192) as we are placed in relation to something which is unknowable and imperceptible, but that which moves us towards a “new reality” (Buchanan, 2020, p. 45). Buchanan (2020) explains how we are not always aware of the abstract machine, and we may not notice it until it is too late. Its appearance however, can be associated with a “certain feeling of helplessness to explain how things had come to this” (p. 47).

This experience was particularly felt by participants who described engaging in regular exercise and dietary practices which would otherwise enable them to consistently meet Western sociocultural appearance ideals of maintaining a fit, toned and slim body (Bordo, 2003; Grogan, 2021; Riley et al., 2018). This made the sudden onset of severe bloating and distention difficult to experience, when in contemporary society a women’s worth is evaluated through weight and appearance (Riley et al., 2018) and when women perceived to be overweight are positioned as unattractive, deviant, lazy, unkempt and inferior (Gailey & Harjunen, 2019). For those with IBS, the sudden onset of severe bloating and distention could therefore feel like being “organised” and locked into a system of “redundancy”, whereby participants could suddenly experience their bodies as falling outside of appearance ideals in ways which made them feel like had become gross, disgusting and fat, and left asking “what happened” (Deleuze & Guattari, 1987, p. 192).

For Jessica who self-identified as having a history of anorexia nervosa, the sudden and unpredictable nature of bloating could be particularly difficult to accommodate. Jessica shared how she “never had the best relationship with food... just being a young female I did struggle a lot growing up with sort of a lot of anorexia and stuff like that”. She described how “sometimes it was easier not to eat just for the IBS as well and the sort of, body dysmorphia types things that you get... because you get a lot of bloating and stuff like that which makes it quite hard”. Although Jessica is “much more accepting” now:

It was really hard for a while, I don't know, I was just very weight conscious and image conscious because I am still quite young and that wasn't that long ago, I was quite conscious about a lot of things because the way society kind of views women's weight and the body figure and everything like that, I found bloating very hard. (Jessica)

Deleuze and Guattari (1987) explain how strata “bind us: the organism, significance, and subjectification.... You will be organized... you will articulate your body – otherwise you're just depraved. You will be signifier and signified, interpreter and interpreted – otherwise you're just a deviant” (p. 159). Davies (2013) also describes how normalising forces work on and through us, to the extent that we come to desire, and work to preserve them. It is through this “passionate attachment” (p. 24), that those who disregard or challenge such norms, may find themselves experience strong emotions such as shame, anger or disgust “toward the one (which might include oneself) who transgresses the norms” (Davies, 2013, p. 24). The stratifying lines of idealised appearance ideals and power of normalising forces were such that Julia described wishing that someone would “cut out my intestines” so that bloating would no longer “cause a problem”:

I used to feel really, I mean I probably still do, really depressed about that the fact that I've never had a flat stomach, because even while I was quite small and skinny, I was bloated all the time and so I never felt like I looked like a lot of my friends did, who could eat whatever they wanted... they were nice little skinny sticks and all the boys thought they were wonderful and all I could see when I looked in the mirror was just the fact that sometimes my stomach looked like it was pregnant” (Julia).

For Julia, severe bloating and abdominal distension also felt like falling outside of valued femininities and sexualities, believing her “pregnant” looking stomach positioned her outside of the male gaze, making her feel invisible and unworthy of sexual attention, (Fahs & Swank, 2017). When bloated and distended, Julianne, similarly described feeling “really yuk, bloated and gross... like really unsexy, not nice”. Riley et al. (2022) explain how shame associated with falling outside of norms can erode people's sense of self-worth, making it difficult for them to believe they are valuable and worthy of being cared for. Rosa talked of

how “it would be nice to have a significant other” but wondered “who would want this?”.

Within this assemblage, shame could therefore circulate in ways which were repressive, limiting participants capacities to feel like they were worthy of, and able to form new intimate connections.

The strong desire to maintain appearance ideals, even when managing a chronic illness, was also highlighted by participants. Emma for example, described how weight/shape concern was a high, if not higher priority than her IBS symptom management in terms of her current dietary practices “I think that is probably the biggest, it's like weird because it's like IBS, but then also, that is also like a huge consideration”:

I guess they're kind of hand in hand, like normally if I'm trying to help my IBS symptoms, it will be good things for your weight as well, but I do think at the end of the day, it's probably more triggered from the look rather than feeling which is real fucked up. (Emma)

In this assemblage, the stratifying lines of feminine appearance ideals produced powerful organising forces which were so pervasive, that continuing to work towards such standards was prioritised over symptom management and feeling better. Interestingly, even when recognising the irrationality of prioritising “the look” over the “feeling”, Emma still felt compelled to pursue and conform to such norms, even when it subordinated her own health outcomes to secondary considerations. Appearance ideals could therefore function as “acts of capture” (Deleuze & Guattari, 1987, p. 40) creating black holes from within which women with IBS could become trapped, leaving them unable to understand and experience their bloated bodies more affirmatively.

The body distress associated with severe bloating and distension could also be difficult to articulate and describe in a manner which adequately captured this embodied experience and how they felt. Nicole described severe bloating as a feeling of “urgh”. “I hate that, yeah I just hate... sometimes I just feel like urgh, just urgh, I don't know how to explain it, just urgh”. This affective change in embodiment when perceived and felt as weight gain, also produced feelings of “argh” for Natalie.

Buchanan (2020) explains how affects/intensities “do not have a tangible, material, thing-like or object form, or a proper name... intensities are the agitations of the mind and body that move us... but we cannot name them” (p. 37). For Deleuze and Guattari (1987), experience is not singular, but a multiplicity of intersecting lines and whilst some aspects are able to be described, others are not (Brown & Tucker, 2010). As such, experiences of body distress in relation to severe bloating could perhaps be understood as “zones of intensity” as opposed to experiences of “rational-conscious apprehension” with “an unfinished (and uninstituted) character” which “leaks outside of subjectification as ineffable singularity” (Brown & Tucker, 2010, p. 232).

The inadequacy of language to encapsulate the experience of embodied illness experiences have similarly been observed in women with chronic illnesses such as fatigue syndrome (Moss & Dyak, 2003). Likewise, Ussher and Perz (2020) found that embodied change during the premenstrual phase for the women in their study, was not “pure” (p. 194) and was something which was beyond culture and discourse. Parton et al. (2015) also found that when women with cancer struggled to find discourses to describe their illness experiences, they instead found meaning in constructing their bodily changes as what they were not: normal. For the women in this study, becoming bloated positioned their bodies outside of digestive normality, outside of norms in relation to expectations for body stability and control, and outside of feminine idealised appearance norms – and similarly, not normal.

Deleuze and Guattari (1987) explain how “signification clings to the soul.... It is not easy to get rid of...to unhook ourselves from points of subjectification that secure us, nail us down to a dominant reality” (p. 160). Stratification in the form of appearance ideals could therefore be harmful, particularly in the context of IBS management whereby the sudden onset of symptoms could deterritorialise bodies in ways which lead to participants falling outside of feminine appearance ideals and transgressing expectations for body stability. Feeling outside of these norms, could therefore impact upon on how women with IBS understood and felt about themselves, producing feelings of shame, self-disgust and body distress creating an additional layer of distress.

Being unable to consistently meet appearance ideals could therefore work to “imprison intensities” (Deleuze & Guattari, 1987, p. 4) by blocking lines of flight which might otherwise lead to more affirmative embodiments. Participants for example, did not talk of other conditions of possibility, such as confidence culture or body positivity, which promote feeling good in your body and premise the rejection of “perfection” (Orgad & Gill, 2022), which might in other contexts enable women to interpret and experience their bodies in a different and more affirmative way. Instead, such discourses did not appear to be available to those with IBS when it felt like bodies were working against you and producing symptoms which failed to break the link between appearance and self-worth for women (Orgad & Gill, 2022).

#### **5.4 Reterritorialisation - IBS Recovery Assemblages**

As highlighted in sections [5.2](#) and [5.3](#), becoming symptomatic could be understood as a process of bodily deterritorialisation. Such deterritorialisations however, were also necessarily accompanied by compensatory reterritorializations, as participants attempted to curtail further deterritorialisation and return their bodies to a state of stability. In this section I highlight how participants used different dietary practices and strategies as a means of bodily reterritorialisation, facilitating “a reorganisation of functions and a regrouping of forces” (Deleuze & Guattari, 1987, p. 320) which enabled them to “rebuild a life” (Buchanan, 2020, p. 77). However, as Buchanan (2020) explains “all that we have and all that we are, even the most stratified aspects of our lives, are nothing but a temporary victory over the relentless forces of chaos” (p. 76) and despite participants attempts to stabilise and restore their bodies back to health, due to the chronic nature of IBS, such dietary practices were an always-unfinished process of “becoming well” (Duff, 2014, p. 108). Unable to be curative and unable to prevent participants from becoming symptomatic again in the future.

##### **5.4.1 Dietary Reterritorialisation**

Once participants had become symptomatic, food and bodies necessarily reassembled in different ways. Participants described using a range of dietary strategies to manage their

bodies when symptomatic. For many, this involved a complicated process of attempting to manage severe gastrointestinal distress which made it difficult and unappealing to eat, whilst also attempting to avoid foods which might further exacerbate existing symptoms or produce new symptoms alongside balancing the basic life requirement of eating to fuel their bodies. As Michelle explained “you know you can’t not eat!”. Although these different ways of eating were often restrictive and sometimes required the avoidance of food, such dietary practices were considered agentic in restoring bodies back to health and enabling recovery. In this sense, different ways of eating within IBS recovery assemblages were enacted as a means of bodily reterritorialization, enabling a process of restabilisation.

Often during periods of gastrointestinal distress, physical sensations such as pain, cramping, nausea, vomiting, feelings of fullness and lack of hunger, meant that participants capacities to eat became temporarily diminished, rendering eating both difficult and aversive. Julia “would go through a period of really not eating at all... it might be something really basic, like just mashed potato, just some rice... and it would probably stay that way for a few days... before it kind of settles back down”. Julianne had found “I just don’t really want to eat much, I’ll just try and eat quite plain food, and like smaller portions, I find it much harder to eat if my stomach is sore and bloated, even if I’m hungry”. Scarlett would eat “less food” and eat foods which were “plainer, I’ll have more of the white foods”.

For Bella, the sensations of fullness and severe constipation also meant negotiating multiple and conflicting bodily requirements:

I’ll avoid eating a lot like if my stomach is really sore, or if, I often get like really bad fullness, if I like... I’ve woken up still feeling as ridiculously full as I did the night before, like I usually will just kind of like avoid it as long as I can throughout the day until I feel like you know, like, obviously the body needs energy at some point, but I’m like, just do something with the stuff that’s already in there, like, and then I will put more in. (Bella)

Bella described feeling like “food is still sitting in my stomach” which made it difficult for her to eat. These affective bodily sensations produce intensities which reconfigured the ways in which Bella was able to engage with food whilst symptomatic. Within this IBS recovery

assemblage, Bella attempted to balance the necessity of eating enough to fuel her body, whilst also trying to accommodate the sensation of fullness which reduced her desire to eat when it felt like her digestive system has stopped working and was unable to accommodate or digest any additional food. During such times, Bella will often reduce her food intake down to “one meal a day as a shake, like I buy that Vitaplan stuff, like soups and shakes, to lessen what my body has to deal with”. Temporarily adjusting her diet and transitioning to easily digestible sources of energy such as soups and shakes, enabled Bella to ease the perceived burden on her digestive system, whilst also attempting to balance her own energy requirements and alleviate physical sensations of pain, fullness, bloating and constipation she experiences when symptomatic.

During periods when participants were experiencing gastrointestinal distress, IBS recovery assemblages expanded to incorporate a range of other materialities. Medications such as Buscopan, Ondansetron, Loperamide, Codeine and Panadol which enabled pain relief, cramping to subside and alleviated nausea and diarrhoea, facilitated symptom management in ways which enabled participants to feel well enough to eat, even if minimally, whilst symptoms such as pain, vomiting and diarrhoea made eating extremely difficult or unappealing:

I get diarrhoea, abdominal pain, and when my gut pain is really bad, it makes me not want to eat because my stomach is so sore, so then I'll take buscopan and then I can eat, but I'm very, very careful about what I eat. (Carey).

When experiencing symptoms, Amy's dietary strategies similarly included “things like Ondansetron when I'm feeling nauseous from it and things like that, um yeah that obviously helps with not feeling sick so you can eat again”. For Julia, medications such as Codeine, also provided a multifaceted solution; Pain relief whilst simultaneously delivering a useful secondary side-effect of constipation which aided the management of her diarrhoea: “I take buscopan, loperamide, and codeine as needed, cause the pain can be quite bad, but also the codeine helps with the pooing side of things, the diarrhoea side” (Julia). Medications therefore assembled with bodies and dietary practices in ways which created possibilities for



'becoming-well enough' to eat, enabling participants to sustain themselves until they were able to return to more normalised ways of eating.

Although capacities to eat were often diminished during periods of gastrointestinal distress, certain foods and ways of eating were also considered to be agentic in aiding recovery from severe physical symptoms. Natalie described how in the context of becoming symptomatic, the adoption of "strict" and restrictive dietary practices, become an essential tool for managing her body by producing stabilising affects which enabled her to recovery more quickly through a flare "I have to be 100% in line with my FODMAPS...I just can't have anything, I don't know whether that's a fact or not, I do find if I do go super strict I do recover quicker". In a similar manner, Daisy used the low FODMAP diet as a means of bodily reterritorialisation after having become symptomatic. Making dietary adjustments enabled her to prioritise the consumption of foods known to be safe, whilst also preventing the consumption of any additional foods which might have the capacity to maintain current symptoms, or produce additional symptoms, until she was able to restabilise her body and her symptoms improved:

There are days where I'm already experiencing pain or my bowels already clearly not happy, then I'll go back to quite a restrictive, like almost elimination phase of FODMAP, just until I'm back kind of to my baseline, and then I can start branching out again (Daisy)

For Daisy, returning to the elimination phase of the low FODMAP diet, although temporarily reducing and restricting her dietary options, was agentic in aiding her recovery, enabling her to return to "baseline", from which she could then begin to expand out her dietary options again.

Dietary practices which involved processes of cleansing and detoxification as a means of 'healing' or 'resetting' your gut, also formed part of participants' recovery assemblages, with many having described engaging in food/body practices intended to 'flush', 'cleanse' or 'clear out' their digestive systems, as a means of aiding, or expediting their recoveries. Jessica tried "to drink a lot of water" to help "flush everything" through her digestive system.

Sophie had found that “if I have a peppermint tea, maybe two or three in a row that helps flush out and helps relieve what's going on”. Blake described a process of “clearing out the system” which involved temporarily adjusting her dietary practices by consuming only vegetables and water, prepared in a manner she considered to be agentic in alleviating severe bloating and constipation and facilitating a return to normal digestive function and body stability:

What I generally do is buy a shit tonne of vegetables and then I make all the vegetables but then I drink, I do a tonne of water, because it all goes in too, all the vegetables then go into the juice thing and I'll just drink like two litres of vegetable juice, so then at night before I kind of go to bed, I'll just try and clean myself out again, but it can take three or four days easily. (Blake)

Within IBS recovery assemblages, the emergence of restricted dietary practices functioned as means of bodily reterritorialisation, whereby participants engaged with food in different ways as they attempted to re-establish body stability. Buchanan (2021) explains how the concept of territory should be understood as a “defensive concept, because it describes our means of getting out of the black holes we sometimes find ourselves in” (p. 285) (see also sections [7.3.1](#) and [7.3.3](#)). Eating in ways which participants considered to be restorative and health enabling therefore, enabled a way out of the black hole and functioned to propel “a body along a line of becoming well” (Duff, 2016, p. 59).

## 5.5 Chapter Summary

In this Chapter I have drawn on DeleuzoGuattarian concepts of assemblage, becoming, de/reterritorialization and stratification, to illustrate how IBS is so much more than ‘just a little bit’ of diarrhoea and bloating. I have demonstrated how the onset of severe physical symptoms can be understood as a process of bodily deterritorialization, which occurs within dynamic assemblages comprised of affects, various materialities and discourses, and how different layers of IBS related distress are produced and experienced through IBS eating assemblages when participants bodies ‘become symptomatic’. Becoming

symptomatic could therefore be “lifechanging” with the onset of IBS symptoms severely limiting the bodies potentials, and “what (else) a body can do” (Fox, 2012, p. 151).

The embodied illness experiences explored in this chapter provide context for the different ways in which women with IBS engaged with food to manage their bodies, which are explored in the following chapters. In the following chapter I explore some of social aspects of IBS eating assemblages and focus on how food and bodies assembled in different ways in relation to various social contexts and relationships as participants attempted to manage their bodies and avoid becoming symptomatic – sometimes in ways which had the potential to create ruptures by destabilising bodies and relationships.

## Chapter 6 – Social Eating Assemblages

### 6.1 Chapter Introduction

In this chapter, I demonstrate how bodies, food and specific social settings and contexts had the capacity to produce different ways of eating and feeling, when assembled in particular configurations. I use the term social eating to encompass eating (and not eating) which took place with others (partners, friends, family etc.) within various social and cultural settings (restaurants, cafes, family homes, maraes etc.). For the women in this study, social eating assemblages comprised of restaurants, cafes, marae, food, menus, chefs and wait staff, partners, family and friends, homes, notions of 'normal' eating, social and gender norms, cultural ways of engaging with food, symptom management, toilet logistics and emotional states such as feelings of guilt, worry, deprivation and social isolation. To develop my analysis in this chapter, I draw on the concepts of assemblage, stratification, the refrain, territory, de/territorialisation and lines of flight.

My analysis of participants' social eating assemblages comprises three subsections. The first, [section 6.2](#), demonstrates how other bodies and specific social contexts had the capacity to change the relational configurations of IBS eating assemblages, sometimes producing different ways of eating. For those with IBS, eating in social contexts could be difficult. Having to deviate away from 'safe' ways of eating in order to be polite, or align with social eating norms, had the potential to result in body instability. However declining food prepared by others, requesting dietary changes, or not eating to avoid symptom onset also placed participants at risk of being perceived as rude, difficult and different from others.

[Section 6.3](#) then focuses on family eating contexts to illustrate how participants' individualised dietary practices assembled with partners, children and the strong territorialising forces of gender norms, sometimes in ways which captured others by changing the ways in which families could eat. The incorporation of IBS related dietary practices into family eating contexts however, also had the potential to produce relational cracks or ruptures leaving some participants feeling guilty, exhausted and uncared for

themselves. For others however, finding new and different ways of engaging with food enabled participants to increase their relational capacities and transcend some of the challenges of managing a restricted diet in various social settings and relational contexts. These dietary lines of flight, which enabled new ways relating and connecting and moments of eating for pleasure and enjoyment, are explored in the final [section 6.4](#).

## **6.2 I Don't Want to be That Person**

Within social eating assemblages, food and bodies reassembled in various across different social eating contexts. Specific social settings, social relations, cultural practices which specify how to eat 'correctly' and gender norms, produced territorial forces which could make eating (and not eating) meaningful. In this section, I illustrate how three different social eating contexts produced distinct territories, each with their own intensities which structured how participants ate/avoided food and engaged socially with others.

### **6.2.1 I Would Never Say I Can't Eat That**

For women with IBS, specific social settings and contexts sometimes made it difficult to maintain preferred ways of eating and to avoid foods which would likely to result in gastrointestinal distress. Eating at friends' homes was one social context where participants would eat foods they knew would be problematic in order to be polite and prioritise social connection over their own health outcomes. As Carey explained "I would never go to someone's house and they serve a meal and I'd say to them, I can't eat that... I just deal with the consequences".

Within this social eating assemblage, home based social dining created unique affective flows which were powerful enough to deterritorialise participants usual ways of eating. Declining food, or not eating in this context, had the potential to produce negative social consequences for both the host and guest. For example, participants acknowledged and were aware of the work associated with cooking a meal for others (cleaning the house, planning the meal, purchasing, preparing and cooking the food, setting the table etc.), all of

which contributed to the valued social experience of eating at friends' homes. As a result, participants did not want to be seen as being impolite, ungrateful, or as rejecting the effort and hospitality offered, for fear of being perceived negatively, or risk rupturing a friendship.

Declining food or not eating within home based social eating contexts, also had the potential to produce embarrassment for the host by having provided food which was unsuitable or unable to be eaten, or for not having asked about dietary requirements. The power of social eating norms, when entwined with gender norms whereby women are expected to eat what is offered, not make special requests or complain, were further highlighted by participants who self-silenced their own health needs in order to maintain harmonious relationships. As Bella described:

I wouldn't go to someone's house and refuse a meal that they'd made because of it, I'd just kind of grin and bear it... that's me for the week, but I'm not gonna be like sorry...it's usually to make other people feel better, I guess explaining that which is ridiculous (Bella)

Bella still described not mentioning her own dietary limitations and prioritising the feelings of others, even when the outcome was severe gastrointestinal distress. As Bella explained, "When she realises...she's going to feel so bad and I'm going to feel bad that she feels bad, but like, which one is better?". Despite acknowledging this situation as "ridiculous", Bella's extract also captured a moment whereby the territorialising forces of social and gender norms became perceptible, but still not rejected "which one is better?". Her account highlights how difficult it can be to resist normative forces flowing through IBS eating assemblages, even when recognising they do not fully serve her or, as Davies (2013) states, "may be at odds with what we want for ourselves" (p. 21).

Nicole also described self-silencing her own health needs in order to prioritise friendships and protect the feelings of others "You always feel a little bit rude, especially if someone's made you something, like I made a cake... and I have eaten a thing like that before out of, thank you, and then paid for it later". In this assemblage, appreciating the thoughtfulness of friends and valuing acts of care and kindness, meant that foods which

would usually be avoided were consumed within this social context, even when the cost to participants personal health was significant. “I know it’s not going to kill me to eat it, I feel like me hiding away later going oh my tummy hurts so much is a bit better than shoving their thing back in their face and saying well thanks anyway” (Nicole). As Natalie similarly explained “I don’t want to be that person, so I’ll just eat it, that’s fine”.

For Miriama who is Māori, accommodating dietary restrictions within social contexts where food formed a significant component of cultural traditions and connection, made eating on the marae challenging:

We very much eat dinner as a family, food culturally is a big part of who we are, so when we go onto the marae I can hardly eat anything, or I do eat it and I’ll suffer for a week you know, because they have just glorious foods and there’s stuffing in the hangi, and there’s beautiful fried breads... it’s really, really hard when you’re on the marae, because you don’t kind of have a choice, because that’s the food that’s out, so that’s what you eat, or you just don’t eat (Miriama)

Within Māori traditional contexts, food is an integral component of collective social, cultural and communal experiences, with food shared for the purpose of enabling participation and inclusion, sustaining relationships both individually and communally and maintaining cultural traditions (Akbar, 2022). Within this social eating assemblage, tikanga which encompasses Māori customs, traditions and practices, added complexity to food and body management. Miriama described how it would be considered “rude to pull out something” rather than eat the foods which had been provided. Prioritising cultural values of interconnectedness, respect, and communal harmony could therefore make eating differently to the collective, or not eating difficult, and as a result Miriama explained that “you eat what you’re not meant to eat”.

Within this assemblage, home based social dining and eating at the marae, were two social contexts within which participants would knowingly consume foods known to adversely impact their health. The strong territorialising forces of social, cultural and gender norms, had the capacity to deterritorialise participants usual dietary practices, producing

dietary deviations which temporarily functioned to maintain such norms, and enabled participants to prioritise the fostering of social and cultural connections. However, whilst enabling these connections to flourish, such deviations simultaneously resulted in the decomposition of other compounds, experienced in the form of IBS symptom onset.

### **6.2.2 Becoming Difficult - I'm Not That Karen Lady**

Social eating assemblages which formed within the context of restaurants, also produced different ways of eating. Food, bodies and social relations assembled with a range of non-human aspects which produced affective flows, shaping participants social experiences and impacted their food choices. Chefs, waitstaff and food menus in particular, acted as territorialising forces determining which foods were available, often diminishing participants' capacities to eat. However, these forces were also provisional and the constraints of menus could sometimes be resisted by requesting to have menu items adapted or have particular ingredients omitted. Such requests however, were often laden with negative social implications which made eating in restaurants challenging for women with IBS. Much like the previous section whereby Natalie did not want to be "that person" when eating at friends' homes, the women in this section referenced a social media meme of a difficult white women, and similarly did not want to be seen as "that Karen lady" when eating in restaurants.

Onions and garlic, two significant IBS trigger foods also form the flavour base of many dishes. These ingredients were therefore difficult to remove from menu items and chefs were often reluctant to exclude at the expense of ruining the flavour of the dish. As a result, participants requests to adjust meals were often dismissed or overlooked, with Daisy illustrating how "no one likes being the person that has to take meals back, and a number of times I've been really explicit and then they bring something that so clearly has garlic and onion in it". This left participants without a means of eating out safely, despite attempting to communicate their dietary needs.



Participants described how asking questions about the menu and making dietary requests to the kitchen were often met with a lack of understanding and inaction from chefs and waitstaff. A lack of awareness in relation to the severity of IBS symptoms and IBS as a medically unexplained illness more generally, also meant that dietary requests made in relation to symptom management were often perceived as less definitive and problematic, and therefore lacking in legitimacy in comparison to more acute serious dietary requirements associated with celiac disease or food allergies which could result in anaphylaxis (also found by Nettleton et al., 2010 in their study on food intolerances). Unlike other dietary classifications such as gluten free, dairy free, vegan etc. IBS trigger foods differed between individuals and did not always fall neatly into discernible dietary categories which could easily be explained to a waiter. This worked to further compound their lack of authenticity, positioning IBS trigger foods as more of a 'moral' threat than a serious health concern (Nettleton et al., 2010).

Participants felt strongly about being perceived as difficult and an inconvenience and spoke to differentiate themselves from those who made choiceful dietary adjustments which were not associated with severe chronic illness management, in contrast to their own lack of agency. Healthy eating discourses which proliferate contemporary society in relation to eating more 'healthfully' through the omission of certain foods and food groups, often in relation to weight loss or feminine appearance ideals, meant that participants felt that their dietary requests were perceived by restaurant staff as choiceful and inconsequential in terms of adverse health outcomes, and as a result, they were just being difficult:

All those people who chose to be gluten free, their choice, they had no symptoms, they didn't do it because they were unwell, I did it because I'm so unwell...I can't help it. It's not to be difficult. I don't want to be difficult. I wish that I wasn't difficult. I wish I could eat whatever the menu says, it's better for me not to. (Elle)

This misidentification however, was difficult to accept when the physical consequences of eating trigger foods were severe and debilitating, and not necessarily details which could be politely or privately communicated to a waiter in a social setting to alter this perception.

Being miscategorised and labelled as difficult, and as a result having her dietary requirements dismissed, therefore produced another layer of distress by leaving Elle with a dispreferred and socially devalued identity.

Due to this lack of understanding, participants described feeling unfairly judged when having to making dietary requests. As Reese explained “I’m not trying to be a pain in your ass, it’s something that I’m not choosing, I’m not that Karen lady that’s coming and going I want this, and this and this, but I don’t want that and I don’t want that”. Whilst drawing on humour, Reese expressed her frustrations at being incorrectly perceived as a ‘Karen’, a stigmatised social identity which emerges in interaction and attributed to middle-aged white women who are situationally perceived to be difficult, entitled and thought to be acting rudely or inappropriately (Garcés-Conejos Blitvich, 2022; Hamad, 2024).

For many participants, having to inquire about ingredients and request menu changes to enable them to eat safely socially was associated with risk and apprehension. Participants did not want to be perceived as difficult or labelled as a ‘Karen’ and positioned as a figure of problematic femininity, when self-advocacy in the form of communicating ones dietary needs had the potential to result in social marginalisation. Having to speak up and draw attention to oneself, also assembled with traditional gender norms whereby women put others first and do not prioritise their own needs. This made inconveniencing others by, for example, asking for menu items to be adjusted, highly uncomfortable for some participants, as Rosa explained “I don’t want to create a scene, I don’t want to create a fuss”. This often made what should have been enjoyable social experiences feel stressful to the point where some participants avoided social eating contexts altogether because “it just falls into the too hard category and I won’t end up enjoying it anyway” (Cara).

### **6.2.3 Becoming Different - Disclosure / Concealment**

For those who were unable to deviate away from their usual dietary practices regardless of the social context, social eating assemblages often involved not eating. Julianne described occasions where she had gone out for dinner and “there was just literally

nothing I could eat, so I just sat there (laughs) while everyone had dinner”. Jessica similarly outlined how “generally I get to watch people eat and it’s horrible... watching people eating is quite a regular thing”. However not eating, and as a result not being able to fully participate in social eating contexts in normative ways, often attracted unwanted attention.

What we eat and do not eat, provides others with information about us which can shape perceptions of the eater (Herman et al., 2019). Not eating in social contexts had the capacity to facilitate a process of social destabilisation, whereby participants became visible and made recognisable as different. Julia described how not eating “always seems to spark up, especially if there’s new people, spark up a weird conversation, and you feel like it becomes the centre of something”. Davies (2013) describes how we can experience feelings of anxiety and fear when we understand ourselves as different, or as falling outside of normative categories or expectations. As such, participants described finding it difficult to know whether to conceal their illness, or disclose the reason why they were not eating. As Scarlett explained “if you talk to someone new or you’re in a new situation, and someone’s going why aren’t you eating the same as us, it can be quite confronting”.

Disclosure was associated with risk. Although bowel movements are a normal part of everyday life, they are also kept deeply private and not discussed (Haslam, 2012). As Inglis (2001) argues “words are dirty if they refer to dirty things, and to avoid the shame carried by the latter, one must censor the former” (p. 164). Divulging too many details about the extent, severity and impact of their symptoms could be perceived as socially unacceptable and associated with disgust and stigma. Gender norms also flowed through this aspect of the social eating assemblage. Women are generally more disgusted by bodily waste, more concerned about hiding flatulence and concealing toilet sounds and smells than men (Haslam, 2012). Women are also judged more harshly for violating toilet-related social norms in relation to cleanliness and purity (Haslam, 2012). Disclosure, particularly in social eating contexts, therefore carried a risk of resulting in a spoiled identity (Goffman, 1963). As Emily explained “that’s not how I want to put myself forward, you’ve got a certain image of who you are, and then there’s this thing”.

For Emily, choosing to explain why she was not eating also meant becoming 'captured' (Willig, 2011) by (mis)/understandings of IBS and having to talk about it. Emily had found that in a health valuing society (Crawford, 2006) everyone had an opinion on how to avoid/manage symptoms and heal you gut: "I don't want to talk about it, because you have to go into so much...everyone says they've got IBS, you don't have IBS you just need to fart, so many comments and opinions about it". Disclosure, therefore also meant having to adopt a social illness identity and whereby well-meaning 'health' advice was dispensed unproblematically by others in ways which positioned Emily as not having tried hard enough to become well.

Not eating and not disclosing IBS in social contexts however, also produced its own set of social implications:

I think it's hard because it's in some ways an invisible condition and people, they just go off what you're telling them, and if you don't want to tell them about it, through not wanting to sound like a victim or not wanting to share too much private information they don't know how difficult it is. (Michelle)

Finding the balance between disclosing the severe nature of IBS symptoms as a legitimate and necessary reason for food avoidance, without providing too much information could therefore be difficult, when aspects of both concealment and disclosure were associated with the potential of producing a problematic identity.

Buchanan (2021) describes the temptation of black holes ([section 2.4.1](#)) as the "temptation to opt of life, to refuse to participate in its daily frustrations and inconsistencies, and instead plunge into a lightless world of disengagement" (p. 87) and for four participants, negotiating the challenges associated with eating/not eating in social contexts had resulted in a different strategy altogether. Jessica and Amy, for example, would now "limit going out" and Nicole had simply decided that she couldn't "go anywhere, because I can't eat anything". In this assemblage, the temptation of the back hole was such that it enabled a line of flight away from the difficulties of having to negotiate unaccommodating social eating contexts, feelings of difference and the risks associated with IBS disclosure. Socially

withdrawing, or opting out of aspects of wider social lives, however then limited opportunities for social connection, reducing participants capacities to form new relations in ways which could further produce feelings of difference and distance.

### **6.3 Relational Ruptures**

In this section, I draw on two DeleuzoGuattarian (1987) concepts, the refrain and territory. Drawing on Deleuze and Guattari (1987), Grosz (2008) describes a refrain as a “kind of rhythmic regularity that brings a minimum liveable order to a situation in which chaos beckons” (p. 52). As outlined in [chapter 2](#), there are three interdependent components of the refrain, the determining of a centre, the drawing of a circle around this centre, and the opening of the circle towards novelty and the unfamiliar. Through their repetitions, refrains provide a sense of safety and stability, enabling a “safe plot of land” to be established (Davies, 2021, p. 76). IBS related dietary practices which were necessarily restrictive and consistently adhered to, could therefore be understood as ‘dietary refrains’. These dietary refrains functioned as territorial components of IBS eating assemblages, producing a liveable order by holding participants bodies stable and keeping the dangers of chaos at bay.

A territory however, can simultaneously contain multiple refrains. Territories and their components therefore, are always intertwined or meshed with other territories (Kleinherenbrink, 2015). For example, participants’ dietary practices were often undertaken within wider family contexts which included parents, partners and children, sometimes making their repetitive but individualised ways of eating challenging and more difficult to maintain. Deleuze and Guattari (1987) warn that the third component of the refrain, the line of flight or deterritorialization is always associated with the potential for danger, and within family eating assemblages, having to accommodate different ways of eating sometimes produced tensions which had the capacity to produce relational cracks and ruptures which left some participants feeling exhausted, uncared for themselves.

### 6.3.1 Family Dietary Refrains

Food and everyday practices, such as eating together as a family, form what becomes 'normal' everyday life (Gregory, 2005; Bernardes 1997). Normal ways of eating for families, such as which foods are eaten and when, also produce their own rhythms and consistencies which provide a sense of comfort and normality (Gregory, 2005). My analysis in this section primarily focuses on two participants, Cara and Michelle, whose experiences were reflective of other participants with children in heterosexual relationships who attempted to balance their own dietary requirements, with the provision of food and care for their families to ensure as much day-to-day family meal 'normality' as possible and full time employment. These participants were selected as they outline two different approaches to incorporating IBS related dietary practices within family contexts.

Despite their different approaches, Cara and Michelle both spoke of managing their bodies via dietary practices in relation to partners and children and identified themselves as the person within their household who planned meals, purchased food and cooked for others, even when managing periods of severe gastrointestinal distress. Within family eating assemblages, traditional gender roles which position women as responsible for providing their families with nourishing meals to ensure their good health (Kinser & Denker, 2016; Hunter & Dey, 2016; Riley et al., 2018) were highlighted as strong territorialising forces which assembled with IBS related dietary practices, often in ways which had to potential to produce relational tensions.

Cara described a number of different strategies she used to incorporate her own dietary requirements into the day-to-day life of her family. Cara who is married with two children, outlined three different categories of meals she prepared for herself and her family. "One, we eat completely different things when they're eating something I simply cannot even touch". Cara's "middle category" involved creating two different versions of the same meal - a "normal" version for the family, and an adapted version for herself which aligned with her dietary requirements. However, there are also times when Cara is too busy, too tired, or too unwell to cook multiple meals and the evening meal she provides her family necessarily

prioritises her own dietary requirements. Cara's third category is "where we'll eat exactly the same thing". The foods Cara can tolerate are few, and not always the kind of foods that children would necessarily enjoy or prefer to eat (e.g. gluten free, dairy free, sugar free foods). The meals in Cara's third category were not always well received and often met with resistance, as Cara explained "they'll moan about it, but they'll bloody well eat it".

Although family meals are idealised as convivial, connective and affirmative family experiences, they often involve power struggles which can create unhappiness and hostility for both parents and children (Le Moal, 2024; Lupton, 1998; Wilk, 2010). The provision of food in relation to 'good motherhood' also involves providing food which is enjoyed by all, even when that enjoyment requires additional work (Bryce, 2014; Kinser & Denker, 2016; Le Moal, 2024).

Such work however, is often undertaken in relation to multiple family member's needs and individual preferences in ways which can constrain or conflict with women's preferred ways of eating, with the preferences and tastes of family members prioritised over their own preferences in order to maintain emotional harmony (Kinser, 2017; Wilk, 2010; Middleton et al., 2022; Lupton 1998). Prioritising Cara's own dietary needs before others in this context, therefore had the potential to produce relational cracks which could disrupt the harmony, consistency and stability of family mealtime.

A territory can be shaped by multiple refrains (Kleinherenbrink, 2015). Making two different meals, or two variations of the same meal, therefore enabled a sense of domestic 'rhythmic regularity' (Grosz, 2008) which produced a more harmonious family meal experience. Within this family eating assemblage, dietary requirements such as those enacted for IBS symptom management were assimilated into family day-to-day dietary practices in ways which enabled a sense of continuity, or what Gregory (2005) describes as 'normality' or 'leading a normal life'. However, for Cara, prioritising the nutritional needs and preferences of her family to ensure domestic harmony, whilst simultaneously managing her own dietary requirements, also required additional work which had become expected and normalised. Sustaining dual dietary refrains therefore came at a personal cost, with the

additional work required to enable a healthy and harmonious family, often not seen, understood or appreciated by the rest of the family, making caring for families whilst also managing a chronic illness even more difficult and exhausting.

Michelle is also responsible for the provision of meals for their families works, working four days a week and cooking all of the evening meals for her husband and two children. In Michelle's family, "everybody eats what I eat for dinner, because I don't want to make two meals". Michelle has been able to incorporate her own dietary restrictions into the meals she provides for her family by making adapted versions of "regular sort of 'kiwi' meals" which suit her own "dietary needs". Michelle spoke of the importance of "sitting down together" for an evening meal, as a highly valued routine which provided her family with a sense of coherence and consistency. However, Michelle is also acutely aware of the constraints her own dietary limitations place on her family's capacity to eat more widely, and how this might impact their overall health. Due to the food groups and range of trigger foods she is currently unable to eat, Michelle expressed concerns that as a family "we're not getting enough fibre or fruit and veggies, because you just avoid stuff". "I also worry about my kids not being exposed to all the different types of foods that I'd like them to try...you know you want them to try all these different flavours and how do you do that?".

The contradictory nature of 'intensive motherhood' (Bryce, 2014; Riley et al., 2018) flowed through Michelle's family eating assemblage, highlighting how being self-focused by prioritising her own dietary requirements which enabled her to be well enough to work and care for her children, produced tensions between the simultaneous requirement for mothers to be child focused. For Michelle, this felt like she might be failing to care for her children adequately by falling below normative expectations for the kind of food related care a 'good' mother should be providing for her family (Kinser & Denker, 2016; Riley et al., 2018). These feelings of guilt and anxiety were further exacerbated by expectations for mothers to be responsible for the health and wellbeing concerns of their family (Riley et al., 2018). This was an expectation which endured even when the women in this study were unwell



themselves, and yet still expected to continue to be responsible for the care of their families and maintain employment.

Michelle also explicitly expressed concerns around the potential for her own restricted dietary practices to be replicated by her teenage daughter in ways which had the potential to be damaging:

I think it's really important to create good eating habits especially for my daughter as she grows into a teenager. I don't want to use the word diet. I don't want to use any of that sort of negatively with her, I think it's really important not to create any feelings of guilt with eating, and to enjoy what you can. (Michelle)

As further discussed in [section 8.3.2](#), the word 'diet' is 'sticky' (Ahmed, 2010) and notions of restricted dietary practices, often associated with danger in relation to weight/shape concern and the potential for disordered eating/eating disorder development, created an atmosphere of anxiety in relation to family dietary practices. Whilst families are one of the social contexts which may contribute to eating disorder development (Blodgett Salafia et al., 2015) there remains an unfortunate legacy of parental blame, particularly towards mothers, which position families as 'the' source of eating disorders (Lafrance Robinson et al., 2014).

Kinser (2016) describe how neoliberal sensibilities and discourses surrounding risk in relation to food, feeding practices and problematic eating, function together to produce a particular view of family accountability, such that maternal labour is implicated in relation to culpability, resulting in the moralisation of feeding in ways which produce maternal blame. These risk discourses create expectations for mothers to mitigate not only physical health risks through family food provision, but also psychological well-being, through narrow prescriptions for how family meals should look, and the desirable outcomes they should produce. Similar concerns around the potential for restricted dietary practices to impact upon children's understandings of normal eating were echoed by other participants, including Natalie, whose daughter had started to ask "why" her mother would eat differently to the rest of the family. Natalie worried that "my children are going to grow up with weird eating habits just because of the fact that I eat FODMAP'y food".

Having to maintain individualised IBS related dietary practices, whilst also attempting to manage the contradictory demands of 'good' parenting in relation to family meal provision, therefore further contributed to the emotional and mental load of managing IBS within family contexts for mothers. Cara, Michelle and Natalie, all worked hard to maintain a 'liveable order' (Grosz, 2008) and hold their individual and family territories stable and safe, however the provision of care for their families was also associated with contradictory tensions and an ongoing fear of tipping the family eating assemblage in ways which had the potential to destabilise others and cause harm.

### **6.3.2 Feeling Uncared For**

As highlighted in the previous section, dietary practices that were enacted for IBS symptom management were often undertaken within family contexts, whereby women were exclusively responsible for the provision of meals for their families. However, there were times when this responsibility left the women feeling exhausted, overwhelmed and uncared for themselves. This was particularly the case during periods of severe gastrointestinal distress when the care and consideration they provided to others was not always reciprocated or extended back to themselves when they needed it.

Michelle's husband does not do any of the cooking. Having to balance multiple roles which include employment, parenting and her own IBS related food/body management, often leaves Michelle feeling exhausted:

I suppose it's, sorry [tears] it's hard because no one else cooks, and I get so tired, like my husband, it's just no one else cooks for me because they don't want to take any risks with it, so it's just constant planning, exhaustion". (Michelle)

Within this family eating assemblage, perceptions of risk, gender norms and expectations for reciprocal partner care, assembled in ways which left Michelle feeling exhausted and uncared for. Michelle's husband is aware of the extreme physical reactions she experiences in response to certain foods and as a result, the risk and apprehension associated with preparing a meal which might inadvertently result in her becoming

symptomatic, makes cooking for her unappealing. However, by avoiding cooking on the basis of risk avoidance, he also reinforces gender norms by directing the responsibility for preparing all family meals back to Michelle. This leaves Michelle feeling alone and unsupported, having to manage her own restrictive dietary requirements and periods of severe gastrointestinal distress, whilst also having to provide all of the meals for her family without any help:

My husband is well aware of all my symptoms and how sick I get, I don't know, I feel like he could make an effort, just make a meal. You know, I think he thinks that's too hard, well it's not that hard, I've worked it out. (Michelle)

Michelle's desire for a more equitable relationship and contribution to the household further clashed with her current reality of inequality and insufficient support. Within this assemblage, social norms in relation to the kind of care and support a good husband should provide, further worked to produce feelings of distress by highlighting some of the ways in which Michelle's husband fell short of meeting normative expectations for being a supportive husband (Davies, 2013). With exhaustion already a daily reality, assistance with preparing the evening meal would be highly appreciated and valued domestic contribution. Recognising however, that she does not have the kind of partner who was willing to step up and contribute domestically to provide her the kind of support which would make her life easier, was therefore deeply disappointing. Whilst having avoided the potential illness risk associated with cooking for Michelle, Michelle's husband had however destabilised the relationship itself, creating a rupture which leaves Michelle feeling uncared for, resentful and angry.

Alicia's digital diary had also captured how on occasion, food and bodies assembled in ways which had left her feeling uncared for (Figure 3). Alicia works full time, lives with her partner and undertakes all of the home cooking. However, when Alicia is too unwell to prepare her own meals, she lacks family support to provide her with 'safe' food, which is the specific kind care which would be most helpful.

**Figure 3**

*Sick Day Prep*



Alicia's digital diary entry reads:

I have learnt to meal prep for when I am sick and not up for cooking. I can't rely on others to provide me food as I have no family members in my city and my in laws struggle with my diet (they are sympathetic but find it hard to understand and aren't very willing to learn). I occasionally make large batches of my food and freeze it (mostly soups so I only have to put it in a pot and defrost it). And uber eats isn't an option as I live too far away. I feel silly complaining about/making a big deal about it because it's what women in my family have been doing for generations, but I am the first one to ever have a full time job so I do find it all a little bit harder. (Alicia)

When discussing this image Alicia shared how "I was pretty mad that I have to provide this for myself when I wish someone could just provide this for me right now, but it's just too hard for someone else to do this". Due to the individualised dietary requirements associated with IBS management, low FOMDAP adapted cooking requires significantly more thought, effort

and care. Having someone able to provide safe food which meets her personalised requirements, was therefore a highly valued, meaningful and a deeply appreciated kind of care for those with IBS. However, Alicia was also conscious of the time and effort required to prepare 'her' food, and therefore she couldn't expect others "to make anything for me", for fear of being a "nuisance" to others. Without anyone to rely upon to provide her with safe food, the onus of having to be self-sufficient and plan ahead to care for herself however, was experienced as saddening and frustrating.

Although Alicia's self-sufficiency was somewhat borne through requirement, the role of food provision was also gendered "because I'm a woman I'm supposed to provide food". However, when experiencing severe symptoms such gender norms became extremely difficult to maintain, with Alicia having expressed guilt around not always having the time to prepare food in advance "I do work full time now and no one kind of gets that, and I've got this this food thing going on as well on top of that". As a result, Alicia felt like she was failing at meeting normative expectations for women to be self-sufficient and provide food, which she experienced as feelings of deficiency.

The powerful territorialising forces of gender norms flowed throughout both Alicia and Michelle's family eating assemblages, holding both women in relatively fixed and stable gender roles, specifically in relation to meal preparation and provision. When recognising that such domestic configurations did not necessarily benefit her or increase her own capacities to act, Alicia gently expressed how "there's a lot of subtle emotions kind of there (laughs), but it's hard to reach them all at once to talk about them" (Alicia). As previously highlighted in [section 6.2.1](#), noticing when normative forces become perceptible as propelling us towards realities which may be different to want for ourselves (Davies, 2013) could produce feelings which were difficult to put into words or communicate easily.

Within family eating assemblages, having become captured by gender norms could therefore feel like having become stuck in a "bad or mediocre refrain" (p. 349) which functioned to create "an effect of closure" (Deleuze & Guattari, 1987, p. 333). Within this assemblage, blocked lines of flight afforded little capacity to disassemble or resist such

norms, or to reconfigure domestic relationships in ways which might otherwise have enabled participants to feel cared to for and supported in a meaningful way. As Alicia explained, “I was feeling pretty crappy and I just kind of needed for it to be available to me”.

As previously highlighted in [section 6.2.2](#), participants also felt strongly about being perceived as difficult and an inconvenience, particularly when women are expected to put the needs of others first. For example, Michelle perceived herself as a source of inconvenience by “being a pain with the condition”, expressed guilt around the limitations and blockages her dietary restrictions already placed upon her family’s capacity to eat more widely and enjoy things such as family outings which would usually involve food. Alicia described feeling grateful that her partner was accepting of her dietary limitations and “doesn’t complain” about the meals she prepares for him “he’s pretty good, he just eats what he’s given (laughs)”. With partners already considered to be accommodating aspects of IBS management, asking for help even when required, perhaps felt like tipping the assemblage a little too far, for risk of creating a relational rupture.

#### **6.4 Attempting Dietary Lines of Flight**

In the final section of this chapter, I demonstrate how despite feeling isolated and disconnected from others due to their dietary restrictions, some participants had found new ways of connecting with food which enabled them to re-establish, maintain and in some cases enhance, social connection. The first two subsections focus on the digital diary entries of one participant, Scarlett, who had been particularly successful in experimenting with new and creative ways of enhancing social connections through food, even when not eating herself. The third section then outlines how many participants had established controlled parameters of indulgence which enabled them to eat small quantities of foods which would usually be problematic. These small dietary lines of flight, enabled a temporary escape away from restricted dietary practices to enable moments of eating for pleasure and enjoyment, whilst avoiding the risk of complete deterritorialisation.

### 6.4.1 Findings New Ways of Connecting

The open and provisional nature of assemblages means that there is always expressive potential to transform into something else (Deleuze & Guattari, 1987). Despite having to eat in individualised ways which were often restrictive and socially disconnecting, some participants described having found new ways of engaging with food which had enabled them to re-establish, maintain, and for some, enhance their social connections. These different ways of engaging with food which were more relationally focused and socially distributed, had produced new possibilities or lines of flight, which enabled new and affirmative ways of connecting bodies and food.

Baking was a food related practice that participants often described as a previously enjoyable and connective aspect of their social lives. Before being diagnosed with IBS, the act of baking assembled together notions of caring, love and connection with freshly baked treats which were eaten for pleasure and enjoyment and shared by all. However, since having made dietary changes to manage symptoms, participants had been unable to participate in the experience of baking in the same way. Michelle who used to be a “big baker” no longer found baking to be a “meaningful activity” with her inability to eat and enjoy the food alongside others, making her feel excluded from the connective experience. Nicole described having grownup “baking with my Nana. I love baking and baking was a way for me to connect with people and I love baking for people, so baking I guess is one of my love languages, making food” (Nicole). However, “not being able to sit down and be able to eat the same as everybody” had meant that baking no longer held the same joy.

Despite not being able to eat fresh homemade baking with others, some participants were able to experience food’s connective capacities in a different way. Through engaging in baking as a relational practice whereby food related connection was still able to be derived from the joy of giving to others, participants were able to focus less on deficiency and what they could not eat, and focus more on affirmative moments of connection. As Michelle explained “I like to give to others, so then I’ll still do things like that anyway, even if I can’t have it... just the enjoyment of it for someone else”.

**Figure 4**

*Big Bake*



Scarlett's digital diary entry reads:

A big batch of baking looks like this: heaps of stuff for everyone else, a couple of biscuits for me. I find that cooking more exciting things for my family helps me enjoy being in the kitchen and feel less frustrated about my restricted diet. I can still enjoy cooking a wider range of foods, even if they aren't for me to eat. (Scarlett)

Scarlett, who has a young son and a wife, described the "big bake" (Figure 4) she undertakes for her family every weekend with great pride and enthusiasm. Although she will not eat most of the food that comes out of the oven, she describes the act of baking itself as relational experience which increases her capacities to act in multiple ways, extending well beyond the act of eating itself:

Like the pleasure and satisfaction of the baking, is not tied up in the fact that I'm not going to eat it. You know, like it's sort of an outlet for some creativity but also feeling like I'm being really productive. You know, I'm doing something that I can see, I can



see a clear output, outputs which is you know, parenting and homeschooling you can't always... but this is something really concrete that I can do for my family. It doesn't matter that it's not for me, that it's not stuff that I can eat... a lot of, not my identity, but like I feel like a lot of my role in the family is tied up with you know, making food accessible for the other people in my family, and so, if there's satisfying, interesting, you know, tasty options that are easy for both of them to access, then yeah, that's really satisfying to me as well. (Scarlett)

Scarlett described the provision of food related care for her family as something which was strongly, and affirmatively tied to her identify as a mother and wife. In contrast to Michelle and Alicia who previous described feeling constrained by gender norms in heterosexual relationships in ways which could leave them feeling uncared for ([section 5.3.2](#)), Scarlett did not describe these same feelings of constraint or lack of support within her same-sex marriage.

For Scarlett, the act of baking for her family in particular was an affirmative, creative and productive process which increased her personal capacities. Having established a way to create the new by baking a range of “exciting”, “interesting” and “tasty” treats for her family each week, Scarlett had enabled a regular, although temporary, line of flight away from the “frustrations” associated with her usual restricted dietary practices and the repetition of cooking the same ‘safe’ meals. The productive nature of baking had also provided Scarlett with a means of generating regular material and observable outputs, something she described as missing from other aspects of the care she provides for her family, such as parenting and homeschooling of her son.

Within this assemblage, the pleasure Scarlett derived from baking for her family was not tied to eating as an individual physical act undertaken by the self, but rather the enjoyment she derived from others eating. Eating in this sense was experienced as a shared, or more distributed process which occurred across bodies. Lavis (2016) for example describes how the act of cooking for others emerged as a different way of eating whereby the eating, or physical act of consumption itself, could be “shared with, or perhaps delegated

to, the bodies of other people” (Lavis, 2016, p. 63). Although Lavis’s work focuses on non-eating in the context of AN maintenance, Scarlett had similarly been able to move beyond notions of individual eating bodies as having fixed boundaries and understand eating as more of a relational process. This enabled Scarlett to ‘launch forth’ (Deleuze & Guattari, 1987) just enough to enable creativity to flow, but without having to risk body destabilisation and deterritorialisation. Understanding food and bodies as more relationally focused and socially distributed therefore enabled lines of flight which resulted in new and affirmative ways of fostering social connections.

#### **6.4.2 Material and Sensory Aspects of Eating Assemblages**

Dietary practices enacted for IBS symptom management often required participants to forgo foods they liked and enjoyed eating, in order to prioritise foods which could be tolerated and those which enabled body stability. This inevitably involved missing out of some of the more pleasurable aspects of eating such as the capacity to taste and savour certain flavours and foods. However, one participant in particular had found new and creative ways to engage with, and experience certain foods she could no longer eat, by drawing on other senses such as smell, sound, colour and texture. In this section I draw again on Scarlett’s digital diary entries to demonstrate how the material and sensory aspects of food had opened up new lines of flight which had enabled wider relational connections to be enhanced, and food related enjoyment to be derived in different ways.

One Scarlett’s digital diary entry reads: *“A very autumnal haul from our fruit trees – I just have to savour the smell and emotional satisfaction, since I can’t eat them...”* (Scarlett). When providing context for this digital diary entry (Figure 5), Scarlett shared how:

This weekend we went apple picking at an orchard near us, we do it every year so it’s a real, like special occasion on the calendar, now like it’s Autumn, it’s time for apple picking, and it doesn’t matter that I can’t eat them, it’s a really fun family activity that we do with friends and it’s yeah, it’s like, it feels like a real special occasion, apple season, and then we’ve got buckets of apples that I’m turning into juicing, fruit leather, pies and

all sorts for everyone else, and I get to appreciate the smell, and also the process of feeling really connected to your food as well. (Scarlett)

**Figure 5**

*A Very Autumnal Haul*



Within this assemblage, fixed understandings of apples as a source of individual food consumption had been deterritorialised, with apples instead having become one component of a wider, relational assemblage full of affirmative and connective potential. For Scarlett, the annual event of apple picking was something to look forward to and functioned as a connective experience which was able to be shared and enjoyed amongst friends and family. However being unable to eat apples herself, Scarlett had worked to establish new ways of connecting with, and harnessing the affective capacities of apples in ways which were able to produce different and meaningful connective opportunities – both with family and friends and in ways which enabled her to feel more connected to food itself.

Scarlett described the excitement she derived from focusing on, and taking the time to appreciate the colour, texture and smell of the apples, the physical process of selecting which apples to pick, removing the apples from the tree with her hands and gently placing them into buckets. “It’s exciting to have things in the garden, and the fruit trees ... not that I can eat any of them, but that’s still really exciting and satisfying to be able to bring them in”. The creative process of then transforming “buckets” of apples into a range of different foods (juicing, fruit leather, pies) which were then able to be redistributed back to those who had participated in the picking, was also considered rewarding and provided a sense of “emotional satisfaction”.

Scarlett had therefore been able to create additional relational dimensions to a seemingly simple activity, transforming the apple picking process itself into special sensory and connective experience, and redirecting the focus away from lack or deficiency. Apples and the process of apple picking, comprised just one component of this wider social eating assemblage, with the physical act of eating no longer required to enable connective moments and affirmative relational experiences. New lines of flight had therefore been “invented” and “drawn into” Scarlett’s life in ways which enabled social connections to be fostered in ways which had enabled her to compose “a more powerful body” (Deleuze and Guattari, 1987, p. 257).

There is always an ever present potential for more, the capacity to follow a new trajectory, for greater connectivity than our current position and bodies can comprehend (Tucker, 2010). As Massumi (2015) reminds us, with greater openness and connectedness “comes a stronger sense of embeddedness in a larger field of life – a heightened sense of belonging, with other people and to other places” (p. 6). Finding other ways to appreciate, relate to and connect through, and with food for Scarlett, enabled new connections to be formed, and existing connections to be enhanced, whilst also enabling a temporary line of flight away from restricted dietary practices.

Deleuze and Guattari (1987) explain that sometimes “we must invent our lines of flight, if we are able, and the only way we can invent them is by effectively drawing them, in our

lives” (p. 202). They also note however, that “lines of flight the most difficult of all” and that “certain groups or people have none and never will” (p. 202). It is important to highlight that whilst drawing new lines had been easy for Scarlett, this had not been the case for all participants. In the section below, my analysis focuses on the majority of the participant group who instead embarked on a different kind of dietary flight – by just having one!

#### **6.4.3 I'll just have one!**

For Deleuze and Guattari (1987) chaos is an always present potentiality which is never far away. However, whilst they describe chaos as something to fear and ward off, they also emphasise that some chaos is also essential, and without any, we risk stagnation and decline. Managing the right amount however is crucial: “there is an art of dosages when it comes to chaos: one needs chaos, but only so much and not too much. One should not deterritorialise (i.e. allow chaos in) too quickly, and never completely, one needs to hold onto just enough territory to rebuild a life” (Buchanan, 2020 p. 86). In order to incorporate aspects of food enjoyment into normally restricted dietary practices, some participants described eating small quantities of certain foods they knew could be problematic, in order to be able to taste and enjoy normally avoided foods, without reaching a tipping point and risking destabilisation. As Nicole joked “I’m gluten free, 98% of time (laughs)”.

Kate still enjoyed a “hot chocolate every now and again, with full milk, to indulge”. Miriama allowed herself “one, one’s fine”. Daisy described occasions where she would have “a little tiny bit” of certain foods or “a mouthful, like that’s actually okay...it’s not going to kill me”. Blake had established her limitations “like if I’m having Pringles I’ll have five”. These controlled parameters of food indulgence produced temporary lines of flight which provided an escape from normally restricted ways to eating, and enabled moments of eating for pleasure and enjoyment. As Jennifer explained “You can still enjoy the things, maybe you just have like very small serving of that with something else, and then you can still enjoy it”.

Despite restricted dietary practices holding bodies stable and enabling symptom avoidance, dietary lines of flight enabled participants to feel less deprived and less like they

were missing out on foods they enjoyed. Davies (2018) describes how a deterritorialising movement may be so subtle that it goes unnoticed, or it can offer a joyful escape from familiar, sometimes suffocating repetitions. Eating small quantities, therefore enabled participants to eat just enough that they were able to avoid symptom onset, but just enough to experience the pleasure of eating foods they enjoyed.

With all lines of flight there is always the possibility of danger and the risk of destabilisation (Deleuze and Guattari, 1987) as Miriama described “I just have to have one, of course you have one, and then you go... just one more (laughs).... it’s just so tempting” (Miriama). The potential for the black hole to make itself felt (Buchanan, 2020) was such that dietary lines of flight needed to be carefully and delicately balanced. This required participants to “gently tip the assemblage” (Deleuze and Guattari, 1987, p. 161), as eating too much would result in unwanted consequences and feelings of regret, because “of course afterwards you don’t feel so good” (Cara). Dietary lines of flight therefore, involves balancing the chaos and letting in ‘just a little bit’.

Davies (2021) talks of a “vulnerability that arises, for any of us, when we become aware of the hairsbreadth between safety and chaos” (p. 84). For Nicole, the ever present threat of symptom onset meant that her attempts at dietary lines of flight were often abandoned, with the risk of destabilisation deemed too great:

I’ll say I feel like that for dinner, and I’ll order it then I get it, like nah, better not, you have it. You now like, oh I’ll feel all gung-ho and off we go to the local bakery to get something then we get there and then I’ll say to my husband oh I can’t, so once I’ve thought about it, I’m like oh nah, because I know that I’ll, but in saying that I’ll have a bite of my husband’s, say he’s got a cheese toasted sandwich, it smells amazing, I’ll have a bite of it but I won’t go make my own one. (Nicole)

For Nicole, food was simultaneously risky and associated with caution and restraint, and something which was also desirable and pleasurable. However, indulging in certain foods was also associated with feelings of apprehension, which made eating them difficult to enjoy.

Nicole described embarking on an 'almost' or partial line of flight, whereby the physical act of going to the bakery and thought of eating something she knows she shouldn't, enabled enough of a sense of rebellion that she was able to pull back, removing the risk of deterritorialisation. Instead, Nicole opted for a compromise in the form of "bite". This enabled her to regulate the 'dosage' of chaos she let in just enough to enjoy the taste, whilst still being able to hold her territory stable enough "to rebuild a life" (Buchanan, 2020 p. 86).

By thinking differently and engaging with food in ways which were more relationally focused and socially distributed, participants had been able to establish new lines of dietary flight which enabled them to move beyond feelings of isolation and disconnection and establish new and affirmative ways of fostering social connections. The creation of new lines also enabled some participants to temporarily escape the constraints of restricted dietary practices and eat for pleasure and enjoyment in ways which enabled them to maintain just control of their IBS eating assemblages, to avoid risking complete deterritorialisation.

## **6.5 Chapter Summary**

In this Chapter I have drawn on DeleuzoGuattarian concepts of assemblage, territorialisation, deterritorialisation and the refrain to demonstrate how bodies, food and specific social settings and contexts had the potential to produce different ways of eating and feeling for women with IBS. As highlighted, eating in social contexts could be difficult for those with IBS and having to maintain IBS related dietary practices often produced tensions between body management and adhering to social and gender norms, which left participants feeling at risk of being perceived as rude, difficult and different from others. As such, social eating contexts (friends' homes, restaurants and the marae) produced distinct territories, each with their own forces which had the capacity to reconfigure IBS eating assemblages and structure how participants engaged with food.

The incorporation of IBS related dietary practices into family eating contexts however could also be challenging, and had the potential to produce relational cracks or ruptures leaving some participants feeling guilty, exhausted and uncared for themselves. However,

exploring new and different ways of engaging with food had enabled some participants to transcend the challenges associated with managing a restricted diet by finding new dietary lines of flight. These new ways of connecting with food enabled some participants to re-establish, maintain and in some cases enhance their social connections, and provide others with moments of eating for pleasure and enjoyment. Through focusing on the material and sensory aspects of food and engaging with food in ways which were more relationally focused and socially distributed, new and affirmative ways of connecting food and bodies emerged.

In the following Chapter I explore how Deleuzian understandings of time as non-linear, assembled with food and body management. Living with IBS meant living in the past, present and future simultaneously, negotiating inconsistency and managing various temporalities, whilst simultaneously attempting to maintain bodily stability to avoid disruption.



## Chapter 7 – Temporal Multiplicities

### 7.1 Chapter Introduction

The potential for IBS symptoms to develop at any time, meant that there was always a temporal component to IBS dietary management. In this analysis chapter, I explore some of ways in which time was implicated within IBS eating assemblages and how the ever present potential for body instability was woven throughout participants lives impacting the ways in which they engaged with food. To develop my analysis, I draw primarily on DeleuzoGuattarian concepts of rhizome, territory and the refrain. To help illustrate the contextual and temporal nature of body management within different IBS eating assemblages, I also make reference to Deleuzian understandings of time as non-linear, whereby “there is no present that is not haunted by a past and a future, by a past that is not reducible to a former present, by a future that does not consist of a present to come” (Deleuze, 2005, p. 36).

This chapter comprises of three subsections. The first, [section 7.2](#) explores the long rhizomatic process of dietary experimentation that participants embarked upon as they worked towards establishing individualised ways of eating which eventually lead to more sustained periods of body stability and symptom management. This process however, had further been complicated by the dynamic nature of food/body interactions, with expectations of linear cause and effect not always able to be relied upon. Instead a more relational and emergent causality was often at work within IBS eating assemblages, with symptoms sometimes developing unexpectedly even when managing food carefully, leaving some participants feeling helpless and lacking control and autonomy.

[Section 7.3](#), then highlights some of temporal aspects of IBS eating assemblages, such as delayed eating and food avoidance as a means of maintaining body control during periods when experiencing symptoms would be particularly difficult to accommodate. Sustaining such ways of eating however, could also be challenging and the ongoing efforts

required to maintain dietary refrains which worked to hold bodies stable and the world safe are also explored. My analysis also demonstrates how participants sometimes enacted processes of de/reterritorialization by opening up 'the circle' and eating in ways which temporarily invited the 'chaos' in, through a process of choosing to eat problematic foods and in some cases, planning ahead to become unwell.

The final [section 7.4](#), illustrates how some participants had found themselves stuck with restricted dietary practices, unable to return to previous ways of eating and struggling to move forward. Due to the potential for disruption, the time required to manage processes of dietary expansion and alleviate symptoms, meant that there was never a good time to undertake some aspects of body management, often perpetuating delays in dietary expansion.

## **7.2 Attempting to Find Dietary Practices That Work**

My analysis in this section draws on the DeleuzoGuattarian concept of rhizome to explore the long process of dietary experimentation participants undertook to establish personalised dietary practices which eventually produced more sustained periods of body stability. The rhizome is unpredictable and follows a non-linear pathway of growth and reproduction, continually creating the new. The principle of asignifying rupture highlights how the rhizome may "be broken, shattered at any given spot, but it will start up again on one of its old lines, or on new lines" (Deleuze & Guattari, 1987, p. 9). Relatedly, participants described making numerous different dietary adjustments as they pursued new food/body connections, some of which had led to moments of success, but others resulting in failure, requiring them to again start anew. The process of dietary experimentation however, was further complicated by normative expectations for linear cause-and-effect pathways which were not always able to be established, with participants on occasion describing a more emergent form of causality, whereby symptoms could arise unexpectedly despite careful food/body management.

### 7.2.1 Working it Out – Rhizomatic Dietary Practices

The potential for food to destabilise bodies and produce severe embodied illness experiences meant that participants' day-to-day dietary practices had changed since their IBS diagnosis, often significantly. Although participants had expected to be able to identify problematic foods, remove these from their diets and alleviate (or at least improve) their symptoms, this process had been far from linear or straightforward. Instead, as symptom producing foods were unable to be known in advance, it was often a long and arduous process of dietary experimentation to establish which foods, could and could not be tolerated, and which ways of eating worked best for each individual. Blake for example, had seen a doctor, then a specialist, "then it was really via process of elimination and testing over time and then what works best and what didn't work... it's just trying things, not trying things, cutting things out... it's kind of been a long journey" (Blake).

For Elle the experimental process of dietary adjustments had involved the progressive omission of various food groups from her diet:

I had taken out gluten because I thought that could be a problem, and that was really hard, that was the first thing that I took out... and it did come a bit better for a while... but then it came back and so then I thought, maybe I should take out dairy, so I took out dairy, and again the same thing, but it was much easier, because I'd already taken out a food group, and so, you kind of get used to it, sometimes it's easier if you can't eat it at all, than if you can only have a little bit... I stopped the dairy, and again the symptoms sort of subsided a bit and they were okay, but then, it just got worse... so when I went to the dietitian... things were slightly better until they got worse again.... so I needed to do something else... and she told me to go vegan, so how many times do I change my life now! (laughs) (Elle)

Throughout this process, each new dietary adjustment had enabled moments of connection and success whereby symptoms were able to be partially alleviated, temporarily increasing Elle's capacities to act. However such adjustments had also been unsuccessful in providing sustained and consistent long term health improvements "the symptoms sort of subsided a

bit and they were okay, but then, it just got worse". Elle's experience illustrated how dietary practices which enabled symptom alleviation at one point in time, could later become ineffective, requiring a different dietary approach to re-stabilise her body. New dietary practices were therefore started, stopped, and restarted throughout the process of working it out, in the hope that making adjustments would eventually enable a line of flight which would result in successful, and more sustainable symptom management. Experimenting with new ways of eating, such as the omission of food groups therefore provided an opportunity for new dietary potentials to be actualised, however for Elle, this process had so far only resulted in a repeated pattern of temporary relief, blockages and dead ends, with the only new connections made resulting in the onset of further IBS symptoms.

Despite not having experienced sustained symptom alleviation, participants still described continuing along an ongoing process of dietary experimentation in an attempt to establish cause and effect pathways and find dietary practices that worked, even when they recognised this process had not yet achieved the outcomes they desired. Adkins (2015) explains how a failed experiment however, is not without value; even in failure, the new has still been created and "becomings raise the possibility of future becomings" (p. 161). For Spinoza (1985) increasing one's power involves entering into as many new combinations as possible. Elle, Emma and Cara described the almost comical nature of the number of different dietary adjustments they had made over time in an attempt to make new and successful dietary connections.

Emma described having moved through "a lot of different stages, like cutting out everything kind of stages" to the degree that "my family have this joke, oh what is it this week". Cara similarly described the multiplicity of dietary changes she has attempted since her IBS diagnosis:

I tried so many different diets or eating plans, um mostly restrictive...I've done the sugar free, I've done the gluten free, I've done a dairy free and combinations of, I've done high fat, low carb, I've done high carb low fat, I've done vegetarian, I've done (laughs) like it's been a bit ridiculous". (Cara)

For Emily, each new dietary adjustment was undertaken with a sense of potential and hope, that this might be “the right” diet which successfully enable bodily stability:

I’m still trying, I guess I hear all these stories of all these people recovering from IBS or IBD because they did this fad diet and so I’m still in this thing where I’m going to find the right diet you know, I just have to try different things and stuff... (Emily)

Deleuze & Guattari (1987) describe the rhizome as being “entirely oriented to experimentation” (p. 12) with the potential to open up possibilities for connections and remove blockages through multiple entryways. They outline how the process of experimentation should proceed by following the rupture lines and pushing to increase your territory by deterritorialisation “make it vary until you have produced the most abstract and tortured line of n dimensions and broken directions” (Deleuze & Guattari, 1987, p. 12). And as Emily described, be open to creative possibilities: “I’m investing in buying like chickens that have been raised happily, because their microbiome is good and I’m hoping that they’re healthy good microbiome will just get into mine (laughs) and heal everything” (Emily). Buchanan (2020) explains how the rhizome implies a way out, and like Emily some participants were willing to try almost any dietary practices in order to find a way of becoming unstuck and connecting their way out of a dark place. This pattern was observed across participants, with Kate for example describing how “you go down this path, it’s whatever works that your happy to try”. Michelle would similarly “do anything, anything to get better from it. I would do anything”.

In relation to materialist feminist temporalities Coleman and Ringrose (2013) argue that hope can function as a potentiality to a future which exists within the present. Although Cara was currently unable eat a wide range of foods, she also remained open to the potential that in the future she may again be able to reintroduce additional foods, by intermittently retesting just to see if things might be different this time: “there’s a lot of food I can’t eat and sometimes I’ll try something after a while just to see if I still can’t eat it”. This openness to hope and potentiality was also described by other participants. Although having

established that gluten is a trigger food for her, Nicole will still “test it out every now and then” just to “try”.

Ahmed (2014) argues that whilst remaining hopeful can be assumed to be enough to create the conditions of possibility for an affirmative future, hope is not always sufficient to produce the future one hopes for. So far Nicole’s attempts at expanding her food options and creating new affirmative food/body connections have remained a blocked dead end, with the consequential development of symptoms confirming the results of her dietary experiment “it’s never good (laughs)... it always turns out that I can’t”. Hope therefore, could also function as a reminder that the future we desire, has not yet be realised in the present. To abandon hope however, would also mean accepting that a desired future was impossible (Ahmed, 2014). Within this assemblage, past illness experiences lingering in the present, meant that the temporal nature of hope was an affective force which functioned to further propel participants along their journey of dietary experimentation, in hope of eventually opening up a line of dietary flight which would lead to transformative future health outcomes.

The dynamic and temporal nature of bodies was also highlighted throughout participants’ process of dietary experimentation. Although Blake had managed to establish “what works and what doesn’t work” for her over a 10 year period, she was also aware that her current place of food/body stability was also contingent and temporary. What could currently be eaten to enable symptoms managed, was also subject to change, and might not necessarily be the same in the future:

I just think it's a lifelong process, you know what I mean, because I feel like stuff changes all the time...like everything I'm doing now is working fine, but then... it's just like, you can't, there's no quick fix to it. (Blake)

The process of experimentation therefore was never complete or able to reach a fixed end point. Even after having established what worked for now, further vigilance was still required, with the expectation of having to make additional dietary changes in the future constantly lingering in the present. With chaos an always-present possibility, what worked for

now was therefore always only “a temporary victory over the relentless forces of chaos” (Buchanan, 2021, p. 85).

Abbots (2017) refers to the constant movement of food and body encounters “as openings and closures, formations and ruptures” made through the process of eating (p. 32). Participants bodies themselves were also always in a constant state of unfolding, impacting upon and changing what could be eaten. Nicole’s dietary process had similarly been characterised by “ups and downs” with dietary changes having been implemented “here and there” over a 40 year period. Cara’s food intolerances had also changed over time and in response to the increasing number of foods which produce symptoms for her, the range of foods she is now able to eat without consequence has also reduced:

There's times when my body suddenly decides okay, you're not going to be able to eat this anymore, so for example, from a couple of months ago, my body has decided it doesn't like chicken and that's new, and shellfish was a new thing back about five years ago. (Cara)

Despite the significant time and effort which had been invested into attempting to find a dietary solution which enabled ongoing body stability and symptom management, the process of working it out had been far from linear or stable. The outcome of dietary adjustments were unpredictable and their efficacy unable to known in advance, resulting in an ongoing experimental process of dietary adjustments. Although different ways of eating had enabled different degrees of symptom management at different times, they had also produced just as many dead ends. Dietary changes were not always successful or sustainable and the trial and error process repeatedly required participants to start anew and make different dietary adjustments in the hope that the next alteration would enable successful and more sustainable symptom management. What worked for one person, was also not necessarily successful for another, and what worked at one point in time, could not necessarily be guaranteed to continue working into the future.

### 7.2.2 Emergent and Unpredictable Reactions

As highlighted in the previous section, the process of establishing dietary practices that ‘worked’ had been far from linear and straight forward. Although most participants had been able to achieve periods of body stability throughout the ongoing process of dietary experimentation, for another group it had not always been possible to identify discrete or isolatable causes of symptom onset and sometimes symptoms seemed to develop for ‘no rhyme or reason’. Carey for example, had established that no clear cause and effect pathways between the consumption or avoidance of specific foods and the onset or alleviation of her symptoms had been able to be determined: “Over the years I’ve tried to exclude lots of things, seeing lots of health type people and just, I’ve never really got, yeah just no one thing kind of changed my symptoms as such” (Carey).

Deleuze and Guattari (1987) argue that assemblages do not contain causal infrastructure. Instead, food/body relations could be understood as unfolding processes of novel relations, which did not always follow predictable patterns or produce consistent outcomes. With bodies constantly in flux and being redefined through their relations with other bodies and forces (Coffey, 2020), IBS food related cause and effect pathways were not always able to be determined. As Carey had experienced, experimenting with different ways of eating as a means of attempting to establish linear causation, were not always successful or effective at managing her symptoms.

Inconsistent and unpredictable bodily responses to food made it difficult to know what to eat, particularly when the same food could be safe to eat on some occasions, and then produce a reaction on others. As Emma explained:

I guess where that annoying thing about this comes in, it’s like sometimes you’ll eat it, and I’ll be absolutely fine and no worries, but then other times, it will be the biggest flare ever and it will be the exact same meal, so you get so frustrated with not actually knowing what’s going on, that’s why I think I’ve come to this decision that nothing’s gonna work.... I guess it’s an unknowingness that I just find frustrating”. (Emma)



For Emma, not being able to determine the reason for inconsistent bodily responses to food was a source of immense frustration. Participants found it extremely difficult to comprehend how eating the same food at different times could result in different outcomes, making the whole process of working it out feel undermining, particularly when so much time and effort had been invested into attempting to establish ways of eating that worked.

Whilst certain foods had the capacity to produce severe embodied illness experiences for those with IBS, the agency of food does not work in isolation. Physical substances within bodies (which for those with IBS may also include the gut-brain axis and microbiome) also interact with food in unpredictable ways; often in ways which are unable to be controlled by the eater as they interact with ingested foods (Mol, 2008). Abbotts (2017) argues that although eating bodies also have agency and the capacity to re(make) themselves through the food assemblages within which they are situated, this does not mean they are always fully in control.

Bennett (2007) in her essay exploring the vital materiality of food, describes a distributed form of agency within non-linear assemblages and an emergent causality whereby particular foods (in her case Omega-3) could act “in different ways in different bodies and with different intensities, even within the same body at different times” and “may produce patterns of effects but not in ways that are fully predictable – for a small changes in the assemblage may issue a significant disruption of the pattern” (p. 137). As such, the relations between any presumed cause and effect, were always dependent upon certain conditions of possibility (Mol, 2021).

Such conditions however, were not always able to be identified. The unknowingness associated with the emergent causality which Emma described however, was difficult to experience as it removed the illusion of autonomy associated with being able to identify and then remove any causal or contributing factors which would enable her to regain a sense of bodily control. Instead, the indeterminacy and open-endedness of potential bodily responses, left her feeling out control and defeated, with no way of being able to establish a truly safe and consistent way of eating. Further, Emma felt like she unable to trust her body

from one moment to the next, with such ongoing body precarity leaving her residing in a very insecure present.

Connolly (2010) when theoretically discussing causal relations from new materialist perspectives describes emergent causality as a “dicey process” through which forces can periodically surge in novel ways enabling something new to emerge (p. 190). For Michelle, even after having established ways of eating which usually ‘worked’ the inconsistency of bodily responses continued to clash against expectations for ongoing and sustained stability and predictability, producing feelings of frustration and anxiety. Not being able to attribute a reaction consistently to a specific food further increased Michelle’s anxieties around food consumption in general, making all food feel precarious “because you don’t know what to avoid next time”. Further, the lack of identifiable causality left participants questioning whether something they did, or did not do, might have contributed to their gastrointestinal distress and tipped the assemblage, as Reese described:

I hate that, and then you’re like what the hell, I’m doing everything right, that definitely happens sometimes and again, you will sit and you’ll think what did I eat? Like, what did I drink? What have I done that is different, even though it’s not, like there’s got to be something that I have done differently. (Reese).

The desire to identify and establish linear causation so that symptoms could be avoided and prevented in the future, was such that Reese had assumed personal responsibility for the onset of symptoms, positioning herself at blame even when symptoms were unexplainable and had occurred unexpectedly. Self-blame, a form of causal attribution commonly expressed by those with chronic health conditions, reflects perceptions of personal control, responsibility and in some way fault for illness onset (Callebaut et al., 2017; Mantler et al., 2003). In the absence of a clear, concrete external factor to attribute symptom onset to, it could therefore feel like it was your fault and that something could have been done differently.

Kate similarly expressed frustration that even when she was following a diet that excluded foods which were known to be reactive for her, this was not always enough:

Even when you're trying to stick to it can be just one thing that you don't realize that has made an impact, a negative impact and you know, you've tried so hard during the day and eaten everything that's right and still you get symptoms, it's like yeah, it's pretty tough sometimes. (Kate).

For Kate and Reese, intense feelings of disappointment and personal failure were difficult to avoid when symptom onset occurred unpredictably, even when you were trying exceptionally hard to do everything “right”. Within neoliberal healthism contexts where personal responsibility for health is moralised (Crawford, 2006; Lupton, 2000) and when diet is implicated in both disease causation and avoidance (Madden & Chamberlain, 2010), feelings of failure could become intensified when attempts to manage bodies via dietary practices were not always successful. Further, within a chronic illness context where managing severe embodied illness experiences and negotiating dietary changes and food restrictions in day-to-day lives were already difficult enough, attempts to obtain bodily control which instead resulted in unpredictable surges of chaos, had the capacity to produce feelings of helplessness. Symptom development therefore could be difficult to avoid, when foods consumed in varying combinations and in relation to changing bodily states, could emerge in relation to a combination of factors, often in haphazard or incidental ways. Unpredictable symptoms onset therefore remained an ever-present reality for some participants, even when doing all the “right” things.

Making dietary adjustments and establishing individualised ways of eating that ‘worked’, was therefore not a simple, or singular event, but rather an ongoing and continuously evolving process, with multiple food/body relations and temporalities simultaneously at play. Understanding dietary changes as non-linear, unpredictable rhizomatic processes, thus enables the complex and dynamic nature of food/body relations to be highlighted, and how taken for granted assumptions such as linear cause and effect pathways, were not always applicable or able to be relied upon.

### **7.3 Creating Dietary Territories**

Drawing on two DeleuzoGuattarian concepts of territory and the refrain, my analysis in this section illustrates how the rhythmic and temporal nature of day-to-day dietary practices worked as territorial components of IBS eating assemblages. It is through the refrain that assemblages achieve stability (Adkins, 2015) and it is the 'rhythmic regularly' through which participants engaged with, or avoided food, that is the focus of this section. As outlined in chapter 2 and section 6.3, the refrain provides safety and protection, generating consistency through the drawing of 'a circle of control', delineating a territory and producing a "calm and stable centre in the heart of chaos" (Deleuze & Guattari, 1987, p. 311). Maintaining restrictive dietary practices which enabled sustained periods of body stability, therefore enabled "the forces of chaos to be kept outside as much as possible" (Deleuze & Guattari, 1987 p. 311) and functioned to produce an "order of safety that protects the body" (Grosz, 2008, p. 52). However, participants also described occasions where they would choicefully open up "the circle a crack" and knowingly eat problematic foods for pleasure and enjoyment. This enabled them to temporarily launch forth and "join with the world, meld with it" (Deleuze & Guattari, 1987 p. 311), before necessarily having to reterritorialise again and return to the 'rhythmic regularly' of their usual dietary practices.

#### **7.3.1 Defensive Territories**

Due to the capacity of food to produce IBS symptoms, day-to-day dietary practices often involved the adoption of various routines and rhythms as participants attempted to manage their food intake in ways which minimised the likelihood of food related symptom development. For many, the timing of meals had changed following their IBS diagnosis and food consumption had become more temporally related to when food could be best tolerated and least likely to produce gastrointestinal distress. For example, Taylor had established that by eating smaller, more regular meals throughout the day her symptoms could be avoided — "you can kind of control what you're eating, when you're eating".

Other participants had found that symptoms could be more effectively managed and avoided by eating only during specific windows. Eating in the morning for example, was difficult for many participants. Lily tends to “skip breakfast” because “I do find that I’m better without food in my stomach, so I find that fasting in the morning is, I feel better”. Lily, who described being “constantly being in pain” after eating, had found it easier to “just lessen a meal and kind of save it till later”:

I usually eat lunch around 2pm, and then usually before I go to bed as well for the same thing, as I like otherwise if I ate too early I was getting quite sick afterwards and I’d rather just kind of eat later and be able to go to bed soon after... otherwise I kind of have to suffer with it the whole day. (Lily)

For Julia, avoiding food in the morning was preferable for a number of reasons:

It seems to be that morning is not as good, night-time seems to a lot better, I don’t know if it’s partial anxiety you know you get this idea that maybe you’re going to get sick so if you wait until evening at least you’re at home or something, but yeah, definitely time of day, morning is not a good time to eat. (Julia)

Although Julia avoids breakfast because “it aggravates my stomach”, the onset of severe physical symptoms, also had the potential to disrupt Julia’s ability to work. It therefore felt safer to avoid eating during the day and remove the potential for symptom onset to development and ensure the wider relational aspects of her life were not disrupted. Managing food and bodies in ways which reduced risk and removed the uncertainty surrounding the potential for illness in the future, therefore involved delaying eating until such time that one could be safely and privately able to manage symptoms at home in the evening. Not eating, or delaying eating in this context was strategic, preventative, enabled feelings of safety and ensued bodily stability was able to be maintained during times when the onset of illness would be difficult or inconvenient to manage.

Deleuze and Guattari (1987) explain how “when chaos threatens, we create a territory using the resources we have to hand... if need be, I’ll put my territory on my own body, I’ll territorialize my body” (p. 320). Territories are a defensive concept, and the elements which

comprise a territory are also arranged with “territorial intent”; a “territory is not happenstance, it is produced quite deliberately with a precise set of effects in mind” (Buchanan, 2020, p. 85). Without an alternative means of effectively avoiding symptom onset, delayed eating and periods of food avoidance therefore enabled participants to create “critical distance” between themselves and the impending threat of symptom onset, with such dietary strategies acting as a means of “keeping at a distance the forces of chaos knocking at the door” (Deleuze & Guattari, 1987 p. 320). Julia explained how “if you’re not eating so don’t get the symptoms, you really do limit your food intake” because the implications of not doing so had “such a big impact on what you’re doing”. Delayed eating, as part of Julia’s IBS eating assemblage, could therefore be understood as an expressive act of attempted bodily control whereby certain ways of engaging with food, ‘the re-organising of functions’ which involved “an activity of selection, elimination and extraction” (Deleuze & Guattari, 1987, p. 311), enabled forces to be regrouped, in order to maintain her own existence.

Importantly, territories do not always consist of specific spatial dimensions; they can be “in our heads”, and purposeful such as the feeling of safety and stability they produce (Buchanan, 2020). In this sense, managing food intake in intentional ways through the adoption of specific dietary practices also enabled feelings such as the “partial anxiety” that Julia would experience if she were to eat during the day, to be avoided through enabling feelings of safety and control. Specific dietary practices enacted by those with IBS, can therefore be understood as productive acts of bodily territorialisation which enabled bodies to be held stable for durations of time, whilst also managing feeling of anxiety. Delayed eating and food avoidance were self-transformative acts, both pragmatic and psychological in effect (Buchanan, 2020) and essential for day-to-day survival. IBS related dietary practices were therefore often enacted in relation to range of different temporalities to enable feelings of safety and stability, with time comprising an important component of IBS eating assemblages.

### 7.3.2 Maintaining Dietary Refrains

Through their repetitions, refrains hold the world safe from the ever present threat of chaos and provide a sense of comfort (Davies, 2021). However, the routines and rhythms associated with maintaining dietary refrains often required significant time and ongoing effort. Managing symptoms via day-to-day dietary practices often involved thinking through dietary decisions, always having to assess the ingredient lists of food products, planning meals in advance, undertaking hours of food preparation and being vigilant towards what was being eaten, when and where. Most importantly, IBS related dietary practices involved thinking through how food decisions made in the present, had the potential to produce a reaction in the future, and how careful dietary management might enable symptoms to be avoided. Deleuzian understandings of time as non-linear and multiple, were therefore highlighted within participants accounts of dietary practices, with the past, present and future coexisting within in a “living present” (Deleuze, 1994) and producing different ways of eating.

Having to think through the potential outcomes of eating certain foods made Emma “more conscious and mindful” when making dietary decisions “like I actually have to think about, okay if I eat this, I'm going to get X reaction”. Since having changed her diet to manage her symptoms, Lily has also found that “you definitely think a bit more about what you eat (laughs)”. She describes “constantly checking what’s in stuff, what type of things I know trigger and trying to avoid it” and as a result has become “a lot more conscious of everything and I always just try and check and avoid those main triggers”.

Ensuring safe food options were always available therefore, also required considerable time investment:

I have to put a lot more thought into food than everyone else... at the start of every week I write a full sort of menu for the week and I plan out all the lunches for the week and then I have to make all the lunches for the week, because I can't just buy a sandwich... I do a lot of meal prep, so that's a lot work, like I would say I lose a full weekend day to meal prepping and all that type of thing...and then I then I have to

write up a full supermarket list of exactly what I want... its very time consuming.

(Jessica)

Jessica explained how thinking through food options, planning menus and preparing her food in advance required her “to spend a lot more time cooking at home” which she found “very, very hard”. Although having to plan ahead and prepare food in advance enabled Jessica to maintain consistent dietary routines and rhythms throughout the week which facilitated bodily stability, the time required to sustain such efforts imposed significantly on other aspects of her life, reducing her capacity to enjoy her weekends and live more fully. Time in the present was therefore traded in exchange for a healthier, symptom free future, to avoid the repetition of extreme symptomatic episodes she has experienced in the past. Future fears associated with symptom onset however, were also experienced and felt in the present. The present therefore was never a distinct, or static ‘now’, but always moving in both directions, enfolding the past, present and future, whereby past experiences and future expectations gave meaning to the present (Deleuze, 1994; Loewen Walker, 2014).

Having to make dietary adjustments had also required some participants to reconfigure previously taken for granted cooking techniques, abandon familiar flavours and recipes, and invest significant time and effort to re-learn how to cook in ways which accommodated their individualised dietary needs:

I would like to tell people how awful it is to relearn how to cook, you're taught how to cook and have a bunch of meals in your arsenal and you can just whip them out and everything and then suddenly they're gone, you can't eat them anymore, and you have to relearn... how you're cooking, you know the basics of, you put oil in the pan and you season it with onions and garlic, you can't do that anymore. (Alicia)

Having to create a new dietary territory which excluded familiar foods, favorite recipes and well-practiced cooking techniques, required re-learning new ways of cooking with fewer foods which had been associated with a sense of loss for Alicia. Territories transform not only the elements which constitute them, but also those who create and inhabit them as the primary beneficiaries of the feelings of comfort and safety they provide (Buchanan, 2020).



Participants had necessarily adapted their dietary practices and created new individualised dietary rhythms which over time acquired consistency and became territorial. However, as Buchanan (2020) notes, “we adapt our sense of homeliness to fit our circumstances and not the other way around” (p. 95) and whilst establishing new dietary rhythms afforded participants bodily stability, they also had the capacity to produce their own deterritorialising forces which did not necessarily always *feel* like home.

It is through the refrain that assemblages gain ‘consistency’ and become expressive (Deleuze & Guattari, 1987). Participants described creating and adhering strictly and rigidly to their own consistent rhythmic was of eating, because as Deleuze and Guattari (1987) explain in relation to refrains, “a mistake in speed, rhythm or harmony would be catastrophic because it would bring back the forces of chaos” (p. 311). Maintaining dietary refrains so as to enable ‘consistency’ however, was not a singular event:

I don't think people realise sometimes how much of it, like you're constantly thinking about what you are going to be eating or what is going to be available somewhere... like it's not just something that affects you once and then you're over it, it it's like a constant thing there, and like what is the ongoing impact. (Amy)

Amy highlights the chronic nature of IBS and how day-to-day dietary practices enacted to manage symptoms required constant thinking, planning and preparing to ensure bodily stability. The capacity of food to produce IBS symptoms required ongoing attention to dietary choices and bodily surveillance, which at times felt exhausting, frustrating and was associated with feelings of loss. Whilst the consistency and rhythms of day-to-day dietary refrains enabled bodily stability, they were not sustained without significant effort and sacrifice. A “territory or home is never created once and for all, nor it is ever full closed in upon itself. It's continued existence is a matter of work and change” (Kleinherenbrink, 2015, p. 221). Establishing new ways of eating was difficult, and not without their own potential to create destabilisation of a different kind.

### 7.3.3 Planning to De/Reterritorialise

With the exception of a small number of participants who did not deviate away from their day-to-day dietary practices due to the severity of their symptoms, most participants described occasions where they would eat foods which were known to be symptom-producing. This involved temporarily abandoning the day-to-day dietary rhythms and routines which would usually hold bodies stable and choosing to eat for pleasure and enjoyment even when this would likely result in symptoms and participants would be required to manage the consequences.

Opening the circle of control to enable temporary and partial lines of dietary flight associated with eating for pleasure and enjoyment took multiple forms. For Carey it was the refusal to exclude things she loved “I’ll just have whatever and deal with the consequences... I know I shouldn’t have coffee at all, but that’s a non-negotiable”. Taylor would eat symptom producing foods “because I don’t want to stop going to nice restaurants and having nice meals”. Amy would on occasion decide “I’m just gonna eat it, whatever, I like it so, you know”. Scarlett was unable to deviate away from the foods she “shouldn’t have” however she would “definitely have too much” of foods she could eat safely when eaten in controlled quantities: “I’ll eat too many chips, or I’m make ginger cookies and they’re really good, and I’ll have four, that probably won’t be great for the morning, but you know, I’ll just deal with that one” (Scarlett).

Cara had “figured out over the last couple of years exactly what my body will tolerate, most of the time, and I kind of live by that, I just know there’s times when I simply cannot afford to feel bad, and there are times when I can (laughs)”. Cara explained how she does “this thing almost psychologically, where I’m like, I don’t have anything big on tomorrow (laughs) I can afford to not be that good”:

Sometimes you know something is gonna make you sick, but you want to eat it so badly, you’ll just live with the consequences and you basically make the conscious decision, yes I’m gonna eat this donut, I know I’m not going to feel great for the next couple of days, but I’m going to... you just deal with the consequences, but you know,

for a fact there will be consequences and as long as you're okay with that, I think that's okay. (Cara)

Cara's decision to eat symptom producing foods she enjoys involved taking into consideration multiple temporalities. Eating for pleasure in the present, required thinking ahead to the future, when the consequences of having eaten problematic foods in the past would need to be managed and accommodated. This involved a process of planning to become unwell and for setting aside enough time for dietary rhythms to be re-established with Cara describing how "I will plan then, okay so what have I got coming up after this, will this be okay?".

For Sophie, making the decision to eat more freely and without restriction involved taking into consideration a range of temporal, spatial and social aspects: who she was with at the time, her location and proximity to toilet facilities, weighing up the potential consequences and assessing how adequately she was placed to "deal with things":

Yep I do that, obviously I weigh up, obviously I wouldn't be doing it when I'm driving somewhere in the car and there's no toilets around, or at some stranger's house, ideally not, but if I'm with friends that know I've got issues and stuff like that, they know that I'll just quietly disappear and deal with things (laughs). (Sophie)

Certain conditions of possibility therefore had to be met to enable safe ways of eating to be abandoned, and for participants to attempt a line of dietary flight which enabled them to eat for pleasure and enjoyment.

Making the decision to temporarily eat without restriction also had the potential to produce intensities which could have compounding affects. As Blake explained "the problem is, once your stomach turns, like not okay, then your like oh fuck it, and then you just, you know you add other things". Julia described this process as going 'big': "when I do it, I go big or I go home you know, like if I'm gonna eat it, I might as well eat a lot, or lot of it, because you know what are you gonna do?". Buchanan (2020) describes how the danger of chaos can be attractive under certain circumstances and in specific ways. The appeal of chaos was observed through participants' stories in relation to leaving the safety and stability of dietary

territories in order to eat foods for enjoyment and pleasure rather than tolerability. Eating foods which were known to be problematic, and going big in the present, enabled participants to experience feelings of normality and social connection and enjoy the temporary freedom from the restrictions and limitations of usual dietary practices, despite having to deal with future consequences,

This process however, meant temporarily functioning without a territory, “freefalling into chaos without a safety net or harness” (Buchanan, 2020, p. 89). Territories are “world-making” and “not something we can do without... we territorialise because we need to and we need to territorialise because we have to confront chaos” (Buchanan, 2020, pp. 94-98). This transition or movement between different ways of eating enabled participants to leave their relatively stable dietary territories to enjoy the temporary freedom of eating for pleasure and enjoyment, however it was immediately followed by a process of compensatory re-territorialisation in which more controlled and restricted dietary practices were reinstated in order to restore bodies back to health and reestablish bodily stability (see also [section 5.4](#) IBS Recovery Assemblages). The increased capacities that eating without restriction afforded participants therefore, were only able to be experienced temporarily before participants necessarily returned to their usual ways of eating. Going big, making the most of it, and enjoying as much food related pleasure as possible during this time was therefore prioritised, before having to return to the reality of living with IBS and dealing with the consequences.

The consequences however, did not always eventuate and Alicia described the “messy” emergent process of how eating foods which would usually produce symptoms, did not necessarily mean that symptoms were experienced every time:

It's a roll of the dice as to whether it's actually going to affect me or not, because yeah, it's not every time I have one of these things that I'm going to definitely react. It's so messy, it's not, here you're done and now you've got this affect, you've done this, you might have this affect, you might have this affect, or this affect, it just really varies. (Alicia)

Julia similarly described how “sometimes you feel fine and you can’t explain it, I don’t understand why this one time I feel great...sometimes it’s not nearly as bad”. It was therefore difficult to know in advance whether or not symptoms would emerge from eating problematic foods, even when illness experiences had been planned for in advance. It was perhaps this inconsistency, which perpetuated occasions where participants deviated from their usual diets, as sometimes it would be worth it. It was a matter of “rolling the dice” to see what happened.

Following the consumption of foods which were likely to produce symptoms, two participants described how on occasion, they had engaged in food/body practices intended to mitigate, or reduce the severity of symptom development. Reese reflected on occasions when she had self-induced vomiting to prevent foods from moving through her digestive systems, after having knowingly have eaten trigger foods which would likely produce IBS symptoms. Reese described going “through a phase of doing that, if I regretted eating something, I had to get rid of it, and so I can vomit quite easily which is annoying, but also fortunate”:

I might have had McDonald's for example and I've gone okay, no, I knew I shouldn't have had that, I need to get rid of it, soon as I got rid of it, 100% better, should have listened to my body going no don't eat it, like just this big mentality of going it's not in my system anymore, it might be like a residual effect, maybe a little bit of an issue but it's nothing, like compared to everything else, like it will just be like a little stomach ache.

(Reese)

Self-induced vomiting is a compensatory purging behaviour associated with some ED diagnostic categories such as BN and AN, undertaken as means of minimising weight gain by forcefully removing food/calories from the body (Haedt-Matt, 2016). For Reese however, self-induced vomiting was explicitly undertaken as a means to avoid IBS symptoms following eating foods known to produce symptoms. By removing the symptom producing food she has eaten from her body, she has lessened this severity of the symptoms she would otherwise have experienced.

In a similarly functional capacity, Cara similarly described using activated charcoal as a means of reducing symptoms after eating foods which were likely to produce symptoms for her:

I also do this thing now where if I'm going to eat something that I know my body won't love, that I just need to eat, I'll do this thing where I'll have activated charcoal right after, to get rid of any of the toxins, which does reduce symptoms, but also isn't a healthy practice by eating things like no one should be, so I don't do it often, but just occasionally say if I have a, you know how there's also social occasions where it's simply awkward if you don't eat something. (Cara)

Activated charcoal is sometimes used to remove toxins and chemicals from the gut, enabling them to be eliminated via stools to prevent them being absorbed by the body (Villarreal et al., 2015). Whilst Cara recognised this was not necessarily “a healthy practice” and that she should not be eating foods which resulted in symptoms, this process enabled her to prioritise the maintenance of social connections and negate the social awkwardness of not eating in the present, whilst simultaneously attempting to reduce the potential impact of the physical symptoms she will likely experience in the future. Cara's use of activated charcoal was undertaken as a preventative, and functional process of bodily reterritorialisation, intended to curtail future deterritorialisation and enabling her to maintain as much body stability as possible and enable life continuity.

#### **7.4 Becoming Liminal**

As highlighted throughout my analysis in [section 7.2](#), the rhizomatic process of dietary experimentation had often involved the omission of certain foods/food groups either temporarily or more permanently, and the adoption of various elimination style diets such as the low FODMAP. For most, this process had been useful and enabled them to identify trigger foods, reintegrate ‘safe’ foods and establish individualised dietary practices which eventually enabled sustained periods of body stability. However, a smaller group had become stuck in a state of dietary in-betweenness; unable to return to previous ways of

eating, unable to move forward with the process of reintegrating additional foods to establish new food/body connections, and unable to ‘open up the circle a crack’ and deviate away from restricted dietary practices to eat for pleasure and enjoyment. Due to the potential for disruption and the time required to manage the processes of dietary expansion and symptom alleviation, there was never a good time to address certain aspects of body management.

#### **7.4.1 Becoming Stuck**

Due to the severity of symptoms, a small number of participants described being unable to deviate away from the rigid dietary practices which enabled them to manage their symptoms. For this group, memories of past illness experiences and fears associated with uncertain and unstable futures, assembled with food and body practices in the present, sometimes in ways which left participants feeling stuck; currently unable to move forward and simultaneously unable to return to their previous, and preferred ways of eating.

Prior to Michelle’s IBS diagnosis, she described being able to eat “what I wanted for 35 years” and then “this massive change”. This ‘clean break’ from previous ways of eating, had created a new beginning, however by doing so had also destroyed “all connections to the past” (Buchanan, 2020, p. 89). Although Michelle had necessarily established a new ways of eating which facilitated symptom management and enabled continuity in her life, they were also limiting, restrictive and required rigid adherence to ensure bodily stability. These dietary changes were also undesirably different from how she would prefer to eat and associated with a loss of security and a stable, knowable and predictable past.

Buchanan (2020) describes a fear associated with deterritorialisation, such that we “speak of the old days and a call for a return to the ways things were – the fantasy of lost certainties (p. 90). Fear and risk however, were also associated with the future. The symptoms Michelle experiences are so severe that she is careful not to consume anything other than foods she knows to be safe, in order to avoid having to experience symptoms again in the future:

I'm so strict with it all, I'm not tempted to have anything I shouldn't. I think it's just that memory of how horrible I feel when I'm unwell, yeah, I'm just so strict with it... I'm really strict, I'm just, get too sick... so there's no way I risk it. (Michelle)

With the ever present threat of chaotic uncertainty, Michelle maintains ways of eating which enable consistency and control in the present. By doing so however, she also acknowledges that her currently restricted dietary practices may also be limiting future potentials for dietary expansion: "I'm so deep in avoiding so many foods that I might be avoiding foods that I could have...I know I need to introduce more foods again, I'm just too scared".

The thought of opening up the circle just a crack to re-try and re-test additional foods is thus met with fear and trepidation. Commencing a process of dietary experimentation could enable a line of flight, however as Deleuze and Guattari (1987) explain, there is no guarantee that deterritorialization will produce the new, there is always a risk that "instead of opening up the deterritorialised assemblage onto something else, it may produce the effect of closure" (p. 333). For Michelle, the anticipatory threat of the future and what might come next, was affective and experienced in the present (Masumi, 2010). Fear associated with the potential for any dietary deviations to result in severe illness, had left Michelle feeling fearful about moving forward, desperately wanting to avoid the kind of debilitating symptoms she has experienced in the past. As a result, "you end up living with this restricted diet, because your just so scared about getting sick".

Daisy had also found herself stuck with restricted dietary practices, unable to revert back to previous ways of eating and currently unable to move forward. With the guidance of healthcare professional, Daisy had adopted the LFD diet with the hope of alleviating her symptoms. However, following the elimination phase of the LFD, Daisy's capacity to tolerate certain foods had changed and she had become more sensitive and reactive to foods which had not previously been problematic for her:

The FODMAP didn't change my tummy symptoms at all, so they didn't make them less... I didn't like, have increased quality of life, but when I went to reintroduce I'd get these massive flareups so I almost felt like the FODMAP, and being so restrictive had



made my symptoms worse, in that I was getting these big flare ups that I hadn't previously had when I had trigger foods... and I felt like I am now kind of stuck on a diet that hasn't actually improved my symptoms hugely but it's just made me way more intolerant to things I was managing well. (Daisy)

Deleuze and Guattari (1987) explain how "one person's creative line is other's imprisonment" and although a line of flight may work for one individual or group, for others it may instead "block it, plug it, throw it even deeper into rigid elementarily" (p. 205). For Daisy, the line of flight she had hoped to achieve by following the LFD had instead become ineffectual and had led to a regressive transformation (Lorraine, 2010). As a result, Daisy now feels "kind of stuck", unable to return to her previous way of eating, more reactive to foods than before she commenced the low FODMAP diet and feeling like there was no clear or easy pathway to enable her to move forward.

With Daisy's IBS eating assemblage currently a closed-up formation, she was left "kicking myself in the butt for" for agreeing to carefully follow a dietary intervention which *should* have resulted in symptom improvement, but had instead created new intolerances necessitating further dietary restrictions. For Daisy, having become stuck with restricted dietary practices also assembled with healthism discourses to produce feelings of personal culpability and regret. This unintended outcome had left her questioning whether the additional intolerances she now experiences "only existed because I cut out everything out so rigidly". The elimination phase of the LFD which was meant to be transitional phase, had instead territorialised Daisy's dietary practices, leaving her stuck with restricted dietary practices, and for now, unable to leave or extend her rigid dietary territory and eat in other ways.

With ineffectual, or lost lines of flight unable to lead to the actualisation of effective and sustained symptoms reduction and greater dietary flexibility, Michelle and Daisy had found themselves captured within rigid layers of strata; unable to return to the way things were, currently unable to move forward and feeling helpless from "being sealed in, tied up, reknotted, reterritorialised" (Deleuze & Guattari, 1987, p. 229).

#### **7.4.2 There's Never a Good Time**

For those who described having become stuck, the challenges associated with finding an appropriate time to work through the extensive process of retrying, retesting and reintroducing foods also worked to maintain rigid food and body practices. The emergent and unpredictable nature of symptom onset meant that attempting dietary lines of flight was often prohibitive given the parameters of participants varied life contexts and the time required to work through the process and potential consequences of reintroducing additional foods. Put simply, there was never a good time to risk becoming unwell.

Although Michelle thinks she “should try a little bit of this or that again, I just haven’t, I just stay clear the main culprits...there's never a good time to trial any food...I don't know how I would do that”. For Michelle, a working mother with two children, finding a suitable time to risk becoming unwell was difficult “everyone’s just so busy now you don’t have time to address these problems”. With Michelle’s reactions to trigger foods extreme and often experienced over many hours, finding the time to accommodate hours of debilitating gastrointestinal distress was not only challenging due to the relational impact it would have on her children, employment, social life and health, it was also extremely unappealing. During the times Michelle could potentially accommodate periods of illness, weekends or annual leave, “I don't want to be doing that stuff”.

Knowing one should reintroduce however, was not the same as actually re-introducing, especially when the implications of doing so could be temporarily life destroying. In reality, the day-to-day contexts of family commitments and employment responsibilities enabled little movement away from restricted dietary practices which enable safety, body stability and life continuity, and instead worked to limit participants capacities to attempt new lines of dietary flight, even when they wanted to: “I just end up not doing it because I'm too busy. I think if I didn't work, I would prioritize it more” (Michelle).

Bella’s experience of becoming stuck, also highlighted a temporal disjuncture between healthcare providers’ unrealistic expectations around the timely undertaking of body

management processes, and the competing priorities of wider life contexts within which participants IBS symptoms were actually managed. Bella's doctor had provided her with a range of medications to help alleviate the severe pain and constipation she experiences, however she describes feeling anxious about taking laxatives because "in my in my mind I'm like, when do I have time to take that and then reap the effects of that?":

The Doctors will tell me off, they're like you just need to take it and I'm like I'm a teacher, I can't just be needing to run to the toilet all the time, like that's actually just not how my life works... so then I become like, I can't take it, and then this weekend I'm doing this, so then actually next weekend I'm going to have to fix it and then I know, that it's not until like three weeks' time that I can fix it. (Bella).

Medical advice which was dispensed as simplistic, straightforward and able to be adopted in an unproblematic manner was instead described as often difficult to implement in relation to the day-to-day logistics, complexities and temporalities of Bella's life. Work commitments, which for Bella involved the care of young children, did not afford the flexibility required to accommodate periods of unpredictable illness. Furthermore, foregoing the enjoyment of social events was not something one would choose or prioritise over spending the weekend in the bathroom with diarrhoea. Instead, attempting to fix severe constipation via the use of laxatives, required scheduling time in advance so that becoming unwell could be woven between aspects day-to-days lives which were unable to be changed. This sometimes meant being stuck with symptoms for weeks at a time, and having to delay the fixing process until it was more convenient: "I'm like next weekend, we'll fix it next weekend, and then you spend your whole weekend dealing with that".

Within this assemblage, Bella also described how laxatives could produce different effects at different times, making it difficult to know in advance if or when symptoms might emerge and to what intensity. This made it challenging to know how much time, if any, she might need to allocate to accommodate the fixing process. Laxatives taken today, had the potential to create chaos over a number of days, however they could also be ineffectual and lead to a dead end:

I can take the maximum amount of laxatives three days in a row and nothing will happen and then another time I could take the minimum amount and it would work in an hour, so like I can't max it out and hope for the best because I don't actually know what's gonna happen and then if nothing did happen, I'd be at work the whole next day afraid, that I, you know.... (Bella)

The dynamic nature of bodies and their unpredictable responses to medication, also produced a temporal disjuncture between Bella's healthcare providers conceptualisation of symptom alleviation as following a clear linear, sequential, timely pathway, and the rhizomatic and emergent nature of symptom onset that Bella instead described experiencing. The uncertainty surrounding potential bodily responses required Bella to plan for multiple future scenarios, in the absence of the predictable and knowable future outcome.

Bella described how not being unable to take laxatives as frequently as she required positioned her as non-compliant and at fault for not attending to her symptoms sooner:

If I do end up at the doctor they're like why did you leave it so long, and it's always my fault... I'm gonna have to explain this to the doctor who's gonna judge me for not fixing it sooner when I physically couldn't. (Bella)

Within this assemblage, neoliberal health discourses circulated in ways which could be problematic for those with IBS. Good self-managers of chronic illness are considered to take responsibility for one's health, be seen to be active and act appropriately in their own care and attend to symptoms in a timely manner (Ellis et al., 2017). Being able to attend to symptoms as soon as they arose was positioned as something within Bella's control, with any failure to do so placing her individually at fault for not having made the correct choice, and making her feel judged and like a failed moral health citizen (Crawford, 2006; Lupton, 2014). However, for Bella, fixing her symptoms was not a binary choice of whether to attend to symptoms or not, it was a matter of accommodating the process of doing so within wider relational contexts and temporalities which determined the conditions of possibility for when she was able to attend to symptoms.

Mol's (2008) logic of choice outlines how the 'choices' available to those with chronic illness often fail to take into consideration the varied contexts and messiness of lives within which self-care occurs. Ellis et al., (2017) similarly describes a moralised rhetoric of 'choice' which is often placed upon those managing chronic illness, where the complexities and challenges associated with self-care are not accounted for (Vassilev et al., 2014) and how being a good self-manager also involved making decisions at the expense of social lives and enjoyment (Ellis et al., 2017).

For those experiencing extreme IBS symptoms, prioritising the reintroduction process, taking laxatives to alleviate severe constipation, and finding the time to accommodate potential illness experiences, often required significant planning. With work, family, and social commitments temporality required to be put on hold, it was difficult to find a convenient time to be unwell. As a result, some participants had found themselves in liminal dietary spaces and unable to return to previous ways of eating, currently stuck with unwanted restricted dietary practices and finding it difficult to move forward. Finding the time to reintroduce new foods or alleviate severe constipation, was determined by multiple factors; dynamic bodily forces, various life contexts, social words, preferences for how to spend time and multiple temporalities. Attempting to become unstuck, was a messy, non-linear and complicated process.

## **7.5 Chapter Summary**

In this Chapter I have drawn on DeleuzoGuattarian concepts of rhizome, territory, the refrain and Deleuzian understandings of time as non-linear, to illustrate some of the temporal components of IBS eating assemblages which functioned to produce and maintain certain ways of eating and engaging with food. I have highlighted the long 'rhizomatic' process of dietary experimentation that participants undertook as they attempted to establish individualised ways of eating which eventually led to more sustained, although still only temporary, periods of body stability. For some, this process had further been complicated by the dynamic emergent nature of food/body relations, which made it difficult to know what to

eat to avoid symptoms, leaving participants feeling unsafe in their bodies as a result of such embodied and temporal instability.

The concepts of territory and the refrain were also used to demonstrate how the rhythmic and temporal nature of day-to-day dietary practices enabled IBS eating assemblages to gain consistency, in ways which enabled body stability and life continuity. Wider life contexts and temporal aspects of managing food/body relations, also made it challenging to find an appropriate time to work through the lengthy process of reintroducing foods and alleviating symptoms, leaving some stuck with restricted dietary practices. In contrast, other participants had embarked on processes of de/reterritorialization, planning in advance to eat foods known to be problematic in order to prioritise pleasure, enjoyment and social connection in the present, despite the likelihood of having to manage symptoms in the future.

Multiple processes of time therefore formed important affective components of IBS eating assemblages, determining the ways in which participants engaged with (and avoided) food, enabling another layer of food/body complexity to be explored. In the following chapter, I develop and expand upon another important aspect of IBS eating assemblages which has been touched on in the previous chapters, health. I highlight how new and different understandings of health and healthy eating had emerged through various IBS eating assemblages, often in ways which challenged normative, dualistic understandings of healthy dietary practices. This different way of understanding health enabling food engagement, was instead understood in relation to affects and capacities, and what specific food/body relations enabled an IBS body to do.

## Chapter 8 – A Different Kind of Healthy

### 8.1 Chapter Introduction

As outlined in chapter 2, Deleuze and Guattari's (1987) theory of the body which poses the Spinozist question of 'what a body can do', argues:

We know nothing about a body until we know what it can do, in other words, what its affects are, how they can or cannot enter into composition with other affects, with the affects of another body, either to destroy that body or to be destroyed by it, either to exchange actions and passions with it or to join with it in composing a more powerful body (Deleuze & Guattari, 1987, p. 257).

In my final analysis chapter, I connect this approach of thinking about 'what a body can do' with DeleuzoGuattarian concepts of rhizome, multiplicity stratification and deterritorialisation to explore participants' understandings of health and healthy eating.

I also draw on Buchanan's (1997) conceptualisation of health, whereby health is understood as the "actual, measurable capacity to form new relations... and whether this leads to the formation of new compounds, or the decomposition of already existing ones" (Buchanan, 1997, p. 82). Together, these concepts enabled a novel analysis by allowing me to illustrate how new and complex understandings of healthy eating, emerged through various IBS eating assemblages, when different ways of engaging with food were understood in relation to their affects and capacities (and what they enabled an IBS body to do) and adopted as a means for participants to avoid 'becoming symptomatic'.

There are three subsections in this chapter. The first, [section 8.2](#), focuses on three different ways in which participants had come to understand their IBS related practices affirmatively. As normative understandings of health eating were not always healthy for those with IBS, participants had necessarily been required to move beyond dualistic understandings of healthy/unhealthy eating, and adopt a different, more rhizomatic, embodied approach. This had involved establishing new and different ways of eating

healthfully, which were determined by which food/body relations produced 'good' or 'joyful' encounters, and those which promoted the formation of new connections and enabled 'flourishing' (Deleuze, 1992).

Being able maintain a healthier, more stable weight was also understood as a beneficial health outcome in two different ways - allowing some participants to meet feminine healthy (slim) appearance ideals, whilst enabling others to avoid unintentional weight loss associated with severe illness experiences. For one participant in particular, becoming more attuned to bodily intensities, had enabled her to establish new dietary lines of flight which had afforded greater dietary flexibility and produced feelings of health and wellness.

[Section 8.3](#), highlights how lines of stratification in the form of healthy eating guidelines flowed through IBS eating assemblages, territorialising understandings of healthy eating, even when such normative ways of understanding healthy eating did not always produce health enhancing outcomes for those with IBS. For some, these lines impacted how participants understood and felt about their own dietary practices, sometimes in ways which produced feelings of dietary deficiency. The restrictive nature of some participants dietary practices also meant that even when health enhancing, the capacities they enabled were not necessarily always recognised or understood as such by others. Further, eating in ways which facilitated symptom management, functioned to limit the conditions of possibility for some participants to choicefully engage with other dietary practices which were considered health enhancing.

In the final [section 8.4](#) I explore how histories of disordered eating / eating disorders when assembled with IBS related dietary practices, had the capacity to produce harmful tendencies by creating new food dualisms and dichotomous thinking which could perpetuate or exacerbate experiences of food/body distress for some participants.

## **8.2 What's Healthy for Me**

In this section, I explore some of the ways in which IBS related dietary practices were able to understood affirmatively, when considered in relation to what they enabled a body to



do. I firstly draw on DeleuzoGuattarian concepts of rhizome and multiplicity to explore how new and different understandings of healthy eating emerged in different configurations through various IBS eating assemblages. As foods which would typically be considered healthy in relation to population level healthy eating guidelines were not always well tolerated, those with IBS had been required to move beyond normative, dualistic understandings of healthy foods and create new and different ways of thinking about health, and health enabling dietary practices.

For some, new ways of eating healthfully allowed them to understand their own dietary practices as having become healthier. For one participant in particular, becoming more attuned to bodily intensities within IBS eating assemblages had also produced new lines of dietary flight which had afforded greater dietary flexibility and intense feelings of health and wellness. Two further groups had found that being able to maintain a more stable, healthier weight due to their current IBS related dietary practices, had enabled them to understand themselves as healthier in two different ways – looking healthier by meeting slim feminine healthy appearance ideals, and the ability to avoid unintentional sudden, unintentional weight loss associated with severe illness experiences.

### **8.2.1 What's Healthy for Me – Creating New Dietary Concepts**

Since having made dietary changes in an attempt to manage IBS symptoms, participants understandings of healthy foods and maintaining a healthy diet had somewhat changed. Foods which might normatively be considered healthy according to Aotearoa New Zealand Eating Guidelines (MOH, 2020) were not always tolerated by those with IBS and could instead produce symptoms and periods of illness. As Nicole, described “you get that funny thing, like you’re supposed to eat healthy and that, but healthy food can just not be good for me, it would make me sick”.

With Blake’s understandings of healthy eating having initially been territorialised by normative understandings of healthy eating (e.g. eating a wide range of fruits and vegetables), Blake had been surprised to learn that the healthy diet she thought she had

been following, had instead been contributing to many of the symptoms she was experiencing:

A lot of the things, I thought my diet was very healthy, were actually very reactive to my body, which I would never have picked up on, because when I saw a specialist thinking oh my diets bloody amazing and it was pretty healthy, and then when we start kind of crossing off the things that were FODMAP, it was like extraordinary actually how many things I was having in my diet that I didn't think were, what do you call them reactive, but they were. (Blake)

Due to the capacity of 'healthy' foods to produce intensities within IBS eating assemblages which could result in ill-health effects, participants had necessarily been required to move beyond normative, and dualistic understandings of foods as healthy or unhealthy, having established that such dichotomies were not always reflective of their experiences, nor were such categories necessarily applicable to their own day-to-day dietary practices. Having understood herself as a good moral health citizen who had been engaging in all the right "bloody amazing" dietary practices to ensure her own health, this deterritorialisation of normative understandings of healthy eating, had also extended to herself, having realised that the foods she had previously understood to be healthy, were not actually enabling healthy outcomes for her. As Kate similarly explained "I used to think well I'm eating healthy, what can it be, but it's this whole other world of things... there's more about food than those categories of being healthy and unhealthy and health benefits and these foods that I can't eat".

According to Deleuze and Guattari (1987) thinking with multiplicities removes binary categories through "a logic not of resemble, division and categorical consistency, but of problems" (de Beistegui, 2018 p. 20). All concepts are created in response to problems, and concepts cannot be understood outside of their problem position (Buchanan, 2020; Deleuze & Parnet, 2002). For those with IBS, the concept of healthy eating had necessarily been reconfigured and re-established in new and creative ways through a process of seeking dietary advice and dietary experimentation in response to adverse food/body relations which

produced severe illness experiences. These new ways of eating which enabled body stability and symptom management, were individualised and created in response to a logic of food/body encounters, rather than of 'recognition'. As de Beistegui (2018) explains, thinking with multiplicities "is not a matter of interpretation and expertise, but of experimentation" (p. 20).

Eating in ways which were health enabling involved overturning dominant ways of understanding the healthful properties of foods and prioritising foods which had been established as the "most useful" for enabling "compatible relations" for increasing a body's power of acting (Deleuze, 1992, p. 259). As Daisy explained, "I think that it's just made me more aware of food, and that's sounds really silly, but what's in food, how food works for us and how food works against us, how we kind of deal with food, I think that's changed the way I think about food" (Daisy). For those with IBS, eating in health enabling ways had become more complex and was instead determined by what enabled 'flourishing'. As Adkins (2015) explains "If you enter into these kinds of combinations you will flourish, or into others you will not flourish" and "for different people, the same combination may have different results" (p. 97). As such, foods which enabled affirmative outcomes such as symptom management and life continuity were considered health enabling, in contrast to foods which had the capacity to compromise body stability and severely reduce participants ability to form new productive connections.

For Bella, moving beyond healthy/unhealthy dichotomies and establishing what was "healthy for me" had also involved looking at things differently and developing a different mindset:

I think my views of healthy eating have kind of just gone along with what I've had to do. Like to an extent, I think I've developed that mindset of what's healthy for you might not necessarily be healthy for me...I have to just let you think that's healthy and just know that that would be literally toxic for my body, I think it has helped me develop that what's healthy for you might not necessarily be okay for my body. (Bella)

Deleuze and Guattari (1987) describe how thinking with multiplicities requires seeing things differently and looking at them from the middle. They also warn that “It’s not easy to see things in the middle” however if you “try it, you’ll see that everything changes” (p. 23). For Bella, the process of learning how to see things differently and cultivating a different mindset, had enabled her to become more aware of the complexity of food/body relations, and more accepting of her own dietary practices and the health benefits they afforded. For Nicole and Taylor, having established which food/body combinations temporarily allowed them to flourish, had enabled different ways of eating healthfully to be understood affirmatively. Nicole described her current diet as “the healthiest it’s ever been now, I think so anyway, what I consider to be healthy for me”. Taylor similarly considered her diet to be “healthy for two reasons, healthy for a wide range of nutrients required, but healthy for what’s healthy for my body, so both sides of it”.

As highlighted in [Section 7.2](#), the healthfulness of individual foods was not fixed, often existed across a continuum and was subject to change overtime. Multiple and different ways of eating healthfully were instead determined by the impact of food/body relations on participants’ bodies, and what different foods and food combinations eating enabled each participants’ body to do. In this sense, healthy eating for those with IBS could better be understood as an ‘open system’ whereby healthy eating concepts correspond “to events and circumstances, rather than essences” (Deleuze, 1995, p. 32). What constituted healthy eating was unable to be predetermined and emerged through the intensities produced within individualised IBS eating assemblages. When understood in relation to Deleuze and Guattari’s (1987) concepts of rhizome and multiplicity, healthy eating could be likened to a “patchwork” of haphazard lines which developed in different directions and in unforeseen ways (Holland, 2013, p. 39). What was ‘healthy for me’ was a matter of “thinking with intensities rather than extensities” (Adkins, 2015, p. 39).

### 8.2.2 Listening to Bodily Intensities - Lines of Flight

For a smaller number of participants, eating in ways which enabled feelings of health and wellness had involved becoming more attuned to their bodies and paying attention to both subtle and dynamic changes in bodily sensations. Taylor for example, described how having made dietary adjustments had made her “more aware” of her body, and the potential for different foods to produce intensities which could be *felt* as health enabling, in contrast to those which were experienced as reducing her capacities:

It's made me understand what my body needs in order to function well and because of that, being aware of the right foods and the wrong foods, like I know the difference and I can feel the difference. I think it's made me more attune to my body. (Taylor).

For one participant in particular, Rosa, eating in ways which were health enabling had also become an embodied experience:

I've learned to notice what my body needs and wants, so rather than restricting what I eat, having it become an all-consuming thing which is what it was initially, I now kind of just go with the flow, you know sometimes with better results and sometimes not so better results (laughs). (Rosa)

Rosa had established new ways of eating which afforded her greater dietary flexibility and a different way to eat healthfully. By listening to her body and noticing changes in bodily intensities, Rosa was able to adjust and adapt what she ate in response to how her body was feeling and what she felt her body needed, rather than relying on predetermined categories of healthy/unhealthy foods or more structured or restrictive ways of eating such as the LFD “absolutely what I eat is driven by how I'm feeling within my body”. Although acknowledging this dynamic approach to eating was not always successful for symptom management, in contrast to the feelings of frustration and helplessness described by participants in [chapter 7](#), it afforded Rosa a more affirmative, flexible and accepting way to manage the dynamic nature of food/body relations and their complexity.

Rosa's digital diary entry (Figure 6) was able to capture the new lines of dietary flight which emerged through eating in ways which were responsive to felt dimensions of changing bodily states which produced intense feelings of wellness.

**Figure 6**

*Perfection.*



One of Rosa's digital diary entry reads:

My body is very good at letting me know what it needs – as well as what it does **not** appreciate. The latter being a sudden, violent attack that has me running to the nearest bathroom. The former can take the shape of cravings or (like in this instance) an overwhelmingly good sensation in every cell of my body. Like all my senses are suddenly awoken and in complete extasy; enjoying every single morsel as it passes from my lips down throughout my digestive system. It isn't just a mere absence of feeling sick. It is an intense feeling of wellness. (Rosa)

Although Rosa still experiences periods of severe physical symptoms where her diet will necessarily become more restrictive in response to managing gastrointestinal distress, she had established new ways to experience and enjoy the positive health effects of food through more embodied and intuitive ways of eating at other times. By focusing on the health enabling sensations she experiences when eating what her body “needs and wants”, she is able to harness intensities which produce exceptionally affirmative feelings of health and wellness. In a similar diary entry Rosa described being able to “see and smell the freshness”, savour “delicious flavours” and “feel the goodness” of certain foods as they “moved through my digestive system”, as aspects of the eating process which enabled her to create lines of dietary flight. Healthy eating in this assemblage was therefore better understood as eating with intensities in ways which were *felt*, rather than determined by foods which had been coded as healthy/unhealthy.

### **8.2.3 I’m a Healthier Weight Now**

In addition to symptom management, the ability to maintain a stable, healthy weight was highlighted as a beneficial health outcome of IBS related dietary practices. For some, the omission of certain foods and food groups during the process of dietary experimentation, had been accompanied by weight loss, which was considered a welcome and affirmative outcome of having made dietary changes. This weight loss had further been sustained over time, enabling participants to maintain a more consistent weight, which they considered to be healthier.

For Taylor, one key benefit of having undertaken the LFD more specifically, had been weight loss. Although Taylor’s two main symptoms of nausea and constipation had improved following the dietary adjustments she had made, being able to maintain a more stable weight, was also considered an important and beneficial health outcome:

I would say that I am healthier, and have managed to maintain a more natural normal weight range, definitely from that... definitely health improvements, which is great...

It’s not a bad thing because I think honestly since I’ve been doing it, I’ve been the

thinnest, and not skinny-thin, but healthy thin, you know within a normal weight range and I think prior to changing my diet anyway, I was like fluctuating big time, so yeah, I think it's been a good thing. (Taylor)

Within this assemblage, Taylor's understanding of a healthy weight had been territorialised by post-feminist healthism discourses, whereby the body becomes an indicator of health through appearance, such that size and health are conflated with slimmer bodies read as healthier, and also understood as more attractive, particularly for women (Riley, et al., 2018, 2025). As such, the weight loss and subsequent weight stability Taylor has experienced since having made dietary adjustments, was understood as an additional affirmative health outcome, enabling her to meet healthy feminine appearance ideals and feel good about herself.

Within the current sociocultural context however, gender also intersects with health in ways which can be contradictory, and Riley et al., (2018) and Cairns and Johnston (2015) note that despite an imperative for women to work on and transform themselves, at the same time one does not want to appear too obsessed, overly restricted or too healthy. Taylor was quick to clarify that her weight loss, and now stable lower weight, were not unhealthy or problematic, by differentiating her new lower weight as 'healthy thin' and falling within a 'normal' weight range, as opposed to 'skinny-thin' which might otherwise be considered unhealthy or associated with disordered eating or body image anxieties.

Affirmative dietary outcomes in the form of weight loss, followed by the ongoing capacity to maintain a more consistent weight, were similarly highlighted by Elle. Prior to adjusting her diet, Elle had been able to "eat whatever I wanted, whenever I wanted and life was just amazing!". The dietary freedom described by Elle however, had not been without consequence and eating whatever she wanted had previously resulted in unwanted weight gain. In an attempt to maintain a more stable weight, Elle had undertaken "lots of yoyo diets because of course you eat, and you know, you put on a bit of weight, so you have to try and take it back".



Having to sustain a consistently restricted diet, which afforded little variation outside of the foods known to enable symptom management (both in terms of variety and quantity), therefore functioned to limit the conditions of possibility for eating in ways which had previously lead to weight gain. This enabled some participants to maintain a more stable, healthier weight, and avoid unhealthy dietary practices associated with cyclical processes of weight gain, followed by more restricted dietary practices in order to achieve compensatory weight loss, which had previously been undertaken to manage weight fluctuations.

A body's capacity to affect and be affected however, is always processual and never fixed or static (Deleuze & Guattari, 1987). Although Elle's current dietary practices had enabled her to maintain a lower, more stable weight, she also expressed concern that the bodily stability she was currently enjoying, had the potential to be destabilised in the future:

I've lost quite a lot of weight, and I've been at this weight for a reasonable time, but I'm a bit afraid if I stay healthy now, the weight will come back (laughs). It's always something to worry isn't it as women and we shouldn't, but we just do, we just can't help it, it must be our DNA or something, but yeah, I have lost, and I'm at the best weight that I've ever been as an adult (laughs) and I like it". (Elle)

Lines of feminine appearance ideals and the normalisation of weight concern for women flowed through this assemblage. Elle explicitly spoke of weight concern as something which was inherently part of being a woman, even whilst also acknowledging that weight was something women should not have to worry about. Although Elle recognises that perhaps weight should not be such an important consideration given the severity of the symptoms she experiences, being able to maintain the "best weight" she has ever been, had also enabled her to feel good about herself by meeting valued appearance norms of embodied femininity – a feeling she would like to maintain. Riley et al. (2018) describe how successful weight loss can elicit feelings of pleasure and triumph, particularly in a neoliberal healthist context whereby self-control and individual responsibility for health assemble with femininity, morality and attractiveness, and as Elle explained, "I like it".

Elle's extract also highlights how gender, health and appearance ideals can circulate in contradictory ways in a body anxious culture whereby a women's health and attractiveness is determined by her appearance (Riley et al., 2018). Although staying healthy and experiencing fewer symptoms, might enable Elle to eat a more varied diet and transition away from her current, health enabling restricted dietary practices, it also had the potential to disrupt her capacity to maintain a lower, more stable weight. The thought of moving away from valued appearance ideals, could therefore produce feelings of worry and apprehension, even when associated with becoming physically healthier.

In contrast, having made dietary adjustments also enabled a healthier weight to be maintained in a different way for other participants. For Michelle, who experiences extended periods of severe illness when eating trigger foods, eating in ways which facilitated symptom management, also enabled unintentional weight loss to be avoided so that a more stable, healthy weight was able to be maintained. Michelle explained that if she was unable to follow her current dietary practices:

I would be a lot less in weight, because I lost a lot of weight when I was sick until I figured out what I couldn't have, so I'd probably be 10 kgs lighter. I lost about that much, 8 to 10 kilos. I've since put it back on. (Michelle).

Although appearance was not highlighted as a concern for Michelle, weight stability was valued as a means of maintaining body control and health. Weight and health therefore assembled in different ways, with Michelle required to maintain restricted dietary practices in order to avoid unintentional weight loss associated severe food reactions, which had the capacity to result in further complications such as nutritional deficiencies and fatigue. Body stability was therefore valued over dynamism in different ways in relation to weight, both of which were considered healthier and beneficial aspects of current IBS dietary practices.

### **8.3 The Stratification of Healthy Eating Assemblages**

In this section, my analysis explores some of the ways in which the stratifying lines of health eating guidelines flowed through participants IBS eating assemblages, territorialising

understandings of healthy eating in ways which functioned to produce feelings of dietary deficiency. Deleuze and Guattari (1987) state there are no pure rhizomes “there are knots of arborescence in rhizomes, and rhizomatic offshoots in roots” (p. 20) and even in assemblages which are dominated by rhizomes, arborescent tendencies will remain; there will be mixtures and tendencies (Somers-Hall et al., 2018). Despite having established new and different rhizomatic ways of eating healthfully, when contrasted against normative understandings of healthy eating, some participants (and observing others) had come to understand their IBS related dietary practices as deficient and less healthy, even when health enabling. Eating in ways which facilitated symptom management, further functioned to limit the conditions of possibility for some participants to choicefully engage with other dietary practices which were considered health enhancing.

### **8.3.1 Feelings of Dietary Deficiency**

Despite having established new ways of eating healthfully, lines of segmentarity and stratification remained present within IBS eating assemblages, with participants referring back to Aotearoa New Zealand healthy eating guidelines (MOH, 2020) as they talked of their current dietary practices. Stratification, a process of capture which functions by way of coding and territorialisation (Buchanan, 2020) produces binary thinking and subjectivities by organising multiplicities into hierarchies, such as healthy/unhealthy. Across the data set, participants understandings of normative healthy eating had been territorialised by public health messaging, with healthy eating most commonly described by participants as consuming a wide variety of fruit and vegetables, lean proteins, whole grains and avoiding saturated fats. For some participants, the stratifying lines within IBS healthy eating assemblages meant that individualised dietary practices which had necessarily deviated away from such guidelines, functioned to produce feelings of dietary deficiency, even when enabling symptom management and healthier outcomes.

Reese felt her diet “could definitely be better, because I think the hardest part about the IBS is the amount of fruit you can’t have and the amount of vegetables it takes out of

your diet". Elle would "like to eat more fruit, fruits healthy, it's quite limiting on fruit". Natalie worries "about variety, because like.. I can't eat that... I can't eat that, so I do think that variety is probably an issue". Daisy felt like she was missing out on "prebiotics and things that do only exist through FODMAPS which I've cut out... I would just like to have a well-balanced diet". For Julia, understandings of healthy eating which had been territorialised by healthy eating guidelines functioned to highlight some of the ways in which her current dietary practices deviated away from normative healthy eating in ways which had made her feel like her current diet was "not great":

When I've seen dietitians, and also my understanding was like growing up, you eat three meals a day and five fruit and vegetables a day, but when you're quite limited to what you can have, all of a sudden it's like, I eat possibly two meals a day and I snack way more because my body tolerates it slightly better, but snack foods aren't easily as healthy cause you can't always go for the fruits and veggies for my snack, because they're either not allowed in my diet, they make me sick, or too many of them cause problems". (Julia).

Daisy similarly described how sometimes it felt like "dietary restrictions push you into choices that are actually the least healthy option". With many healthy foods unable to be eaten, safe foods such as "hot chips which are not the healthy options" were often the easiest and most accessible option. Daisy explained that although "dietary restrictions have made me much more aware of putting good stuff in my body, at the same time I actually feel like I eat just as much crap, if not more so than previously in my life".

For Daisy, having to eat in ways which were contradictory to normative understandings of healthy eating, made it difficult to understand her own IBS related dietary practices as healthy, even when facilitating symptom management. When assembled with healthism discourses which further functioned to compound the over coding of certain foods as healthy/unhealthy, having to eat foods she considered to be "the least healthy option" in order to feel physically healthier, had been difficult to rationalise and accept. This had left Daisy feeling like a failing moral health citizen for being unable to eat correctly, and

somewhat captured between competing moral and embodied understandings of healthful eating, in ways which functioned together to produce feelings of dietary deficiency.

Davies (2021) notes that the strata we find ourselves held in are not simply able to be overcome or ignored. With all assemblages possessing tendencies towards both stasis and change, despite having made dietary changes which were health enabling in terms of maintaining body stability and life continuity, participants were still drawn back to more familiar and structured ways of understanding healthy eating. Stratification can be “both fortune and unfortunate” (Adkins, 2015, p. 42), however whether it is beneficial or not however, depends upon one’s context and perspective (Buchanan, 2020). In this assemblage, referring back to healthy eating guidelines as a means of determining the healthfulness of participants current dietary practices, functioned produced feelings of dietary deficiency, by reorganising dietary multiplicities back into hierarchies of healthy/unhealthy, even when such dietary practices enabled symptom management, body stability and facilitated life continuity.

### **8.3.2 Oh My God that’s not healthy**

Although some participants felt that their dietary practices had become healthier since having made dietary adjustments, they were also aware that normative understandings of healthy eating meant that their own dietary practices might not necessarily be considered ‘healthy’ by others. The territorial forces of healthy eating guidelines could also function as ‘act of capture’ (Deleuze & Guattari, 1987) and work against those with IBS, producing negative connotations around certain dietary practices. Ways of eating which were necessarily restrictive to avoid symptom onset, were not always perceived or understood as ‘healthy’ or beneficial by those without IBS. Instead, eating in ways which were health enabling and pragmatic, could sometimes be coded as extreme, ‘unhealthy’ or problematic, leaving some participants feeling judged and at risk of being pathologised.

Although Nicole considered her current diet to be “healthy, yes 100%” she was also aware that “for other people would be like, oh my god, that’s not healthy”. Whilst also

regarding her own dietary practices as “absolutely” healthy, Blake similarly recognised that others would likely consider the way she eats to be extreme and tending towards unhealthy:

I mean it's probably not in the scheme of what normal eating would be for most people it wouldn't be at all... I would say I'd be on an extreme, extreme whatever you call it, diet I suppose, not diet, but I would be considered that, most people think that, but that's fine. (Blake)

Blake described finding “people very judgmental all the time” about the restricted nature of her current dietary practices. When asked to clarify if this judgement was based upon the kinds of food, or how much she ate she replied “Oh, for sure, for sure”:

People just think you really picky... they're like, oh, you're not eating on purpose, and it's like, no, I just don't want to.... but I also don't care because, people in general are quite unhealthy themselves, you know what I mean, they would like to probably know more about being healthy themselves, they just can't be bothered, but they're the first ones to complain that they're quite overweight, and feel like shit all the time, so I'm like, fucking point your finger back at yourself (laughs). The finger that you're pointing at me, turn it back around (laughs) its true though, oh my god. (Blake)

Although understanding her own dietary practices as health enabling in terms of symptom management and the facilitation of ‘flourishing’ (Deleuze & Guattari, 1987), normative understandings of healthy eating could make it difficult for others to understand the restricted nature of Balke’s current diet affirmatively. “Picky” eating, or “not eating” for example, could be misread, coded and interpreted as problematic, when judged in isolation and without consideration to the contextual and embodied factors shaping IBS related dietary practices.

Interestingly, postfeminist healthism discourses circulating within this assemblage were also drawn upon by Blake, to position those who might consider her own dietary practices to be extreme as unhealthy themselves. Despite saying she did not care about the judgement of others, in response to this misrecognition Blake drew on moralistic healthism discourses in an almost defensive or self-protective manner in order to reestablish herself as

a someone who was succeeding at being healthy, whilst positioning those placing judgement on her own dietary practices as lazy, overweight and less healthy themselves. Within this assemblage, the stratifying lines of healthism, normative understandings of healthy eating and the conflation of weight with health, could therefore function as 'acts of capture' (Deleuze & Guattari, 1987) producing healthy/unhealthy dichotomies and creating affective intensities which impacted how IBS related dietary practices were interpreted, understood and experienced.

Ahmed (2014) describes how emotions can become attached, or 'stick' to bodies and objects over time, shaping how they are perceived and understood. Participants spoke of how being perceived as being on a diet, and the use of word 'diet' itself, could lead to misunderstandings around the nature of IBS related dietary practices:

When you say like, I'm on a FODMAP diet, the word diet, people often assume oh, are you doing this for like weight or whatever, like for me, the FODMAP diet is like a food plan as opposed to I'm not dieting. It's just this is the range of food that I can eat. I said the "D" word! I don't want you to take it like that, I don't mean it like that, it's just that it's my gut...and there is the connotation of disordered eating that goes with dieting, that's not what's happening here. (Scarlett)

Emily similarly described how eating in ways which enabled body stability had also meant "looking like someone with an eating disorder... oh I can't have this...and they think that you're on a diet or something". Participants described feeling judged by others in relation to the territorial forces of normative understandings of healthy eating and common understandings of 'dieting' as typically being undertaken weight loss purposes, which could lead to incorrect assumptions about the nature of IBS related dietary practices. As a result, participants felt like their own dietary practices were at risk of being coded as unhealthy and categorised as "extreme" and disordered by others, rather than being understood for what they enabled; chronic illness management via a different kind of health enabling eating which "lead to the formation of new compounds" (Buchanan, 1997, p. 82).

Adkins (2015) cautions that to mistake the two tendencies of all assemblages for two different kinds of assemblages, works to re-establish judgement and morality, whereby one kind of assemblage may be judged as 'good' and another 'evil'. Categorising all restricted eating as unhealthy or problematic was not always helpful and had the potential to make those with IBS feel judged and at risk of being pathologised for eating as healthfully as they could with the dietary limitations they faced, and in relation to individual life contexts within severe and debilitating symptoms were required to be managed. Deleuze and Parnet (2002) warn that "it is not easy to be a free...to flee the plague, organise encounters, increase the power to act, to encompass a maximum of affirmation" (p. 62). Nichterlein and Morss (2016) explain that the difficulty in being free, lies not so much in confronting chaos, but in breaking away from opinion and the stratifying lines and normative forces which shape opinions and everyday understandings "for the misfortune of people comes from opinion" (Deleuze & Guattari, 1991, p. 206).

Creating new dietary concepts in a world of binaries could therefore be difficult, especially when rhizomatic dietary practices, which for many comprised of different forms and temporalities of restricted eating, enabled lines of flight, liberation and improved health, but were not necessarily always understood or recognised as such by others.

### **8.3.3 Limits to the Conditions of 'Healthy' Eating**

Although Deleuze and Guattari (1987) encourage us to create the new, there are also conditions of possibility, or limits to which new creation can take place. Adkins (2015) explains how establishing new connections sometimes requires breaking other connections and for those with IBS, eating in individualised ways which prioritised the management of IBS symptoms, also created disjunctures by limiting participants capacities to eat in other health enabling ways. Interestingly, despite describing their own dietary practices as restricted and limiting, participants expressed disappointment and frustration at not being able to adopt other kinds of restricted dietary practices for personal health and wellbeing purposes, and more specifically, for weight loss. Participants were therefore not immune



from neoliberal postfeminist healthism discourses which circulated within IBS eating assemblages, whereby the pursuit of health is tied to good moral health citizenship, weight is understood as a measure of health and appearance the measure of a women (Crawford, 2006; Riley et al., 2019, 2025), even when managing a chronic illness which limited their capacities to eat in different health enabling ways.

For three participants, having made dietary adjustments had meant they were currently unable to follow a vegetarian or vegan diet as their preferred way of eating. In addition to avoiding foods which produced symptoms, the removal of additional food groups such as meat meant that too few foods remained for such ways of eating to be sustainable. Prior to having made dietary adjustments, Elle had followed a vegetarian diet, however she was “not plant based anymore, I’ll say that now, otherwise I probably wouldn’t be eating anything (laughs)”. Jennifer had also been “fully plant based, before starting this journey” but had found “the amount of fruit and vegetables I could have” to be too “limiting”. As a result, she had been required to work “back in some dairy and occasionally a little bit of like of meat product”. Daisy would “would love to be more plant based” however she was not willing to remove additional food groups “when already things are so restricted”. Eating in ways which enabled symptom management, therefore meant having to forgo other dietary practices which aligned with participants moral, ethical and environmental values and relinquish preferred dietary identities.

Time restricted eating had also been challenging to accommodate. Nicole had discovered that despite feeling “really good fasting”, “it really wasn’t helping my constipation, and so my gastro specialist said no, because it was upsetting my system which I found really interesting, because I thought it would be really good giving me a break”. Bella in contrast, “liked it because it was the only time where I ever felt like my stomach actually emptied, before I put more food in it” however a result she also experienced “chronic fatigue” as a result of further dietary restrictions which left her “too without” food, which had become unsustainable alongside her work commitments and social life, so “it doesn’t really work... being a teacher, you kind of have to energy to deal with the kids”.

For Daisy, having to eat in ways which enabled symptom management, meant that other kinds of potentially health enabling dietary experimentation were unable to be undertaken without further restricting her current dietary practices and creating additional health risks:

Friends have been doing a challenge this month to give up sugar, and there's some really cool things that I'd love to be doing more of, but I'm just so mindful that my relationship with food isn't as healthy as I would like it to be given there's so many things that actually, I physically can't, and I'm choosing not to eat cause they make me feel so gross, that I feel like adding anything more restrictive, even if it's a good thing like giving up sugar, is just in the too hard basket or just risk creating unhealthy food patterns and food beliefs, um so I don't do as many of those things as perhaps I'd like to do as an experiment. (Daisy)

Having to eat in ways which enabled symptom management, therefore meant that other kinds of 'healthy' dietary practices which extended beyond healthy eating guidelines, were unable to be undertaken without placing further restrictions on current dietary practices, or creating additional health risks such as fatigue, nutritional deficiencies and unhealthy relationships with food. In a postfeminist healthist context whereby choice and personal responsibility for health are positioned within the individual, this could feel prohibitive when the conditions of possibility to eat in ways which were considered to be more healthful, and therefore enabled healthy subjectivities (Riley et al., 2022), were limited or had become unavailable to participants. Being unable to optimise one's diets and therefore health, or participate in, and connect with wider cultural practices which were socially understood as healthy, could therefore feel like failing at manage future health risk, being a good person and living a good life (Crawford, 2006). These feelings endured even in the context of dietary controlled chronic illness, where what was able to be eaten was beyond participants' control and certainly not choiceful.

Despite the health benefits that participants positioned other restricted dietary practices as enabling, the desire to eat in healthier ways was also tied to weight and

appearance. Although describing intermittent fasting as something she thought might provide her digestive system with a break, Nicole for example, also spoke of such 'health enabling' restricted dietary practices as pathways to weight loss which had now become blocked and were no longer available to her:

I'm missing out on some things, like I could never do keto or anything like that for like weight loss or something you know, like when people talk for weight loss you need to fast and do keto, and I'm not fasting, like I don't eat dairy and I don't eat meat...if I wanted to lose weight or stuff like that I feel that I'm at a bit of a disadvantage with what I eat, you know. (Nicole)

Despite acknowledging the restricted nature of participants own dietary practices and the limitations such restrictions imposed on wider life contexts, the food restrictions inherent in of other 'health enabling' dietary practices were often overlooked when such ways of eating were considered to improve health and enable weight loss as the primary, or adjacent outcome. Cairns and Johnston (2015) describe how contemporary healthy eating discourses work to reframe restricted dietary practices as affirmative choices for women, whereby such 'healthy' choices are considered to be empowering, even when requiring body discipline, health knowledge, self-control and the ongoing monitoring of food. Women in their study described a version of healthy eating which although restricted, was considered choiceful, even when requiring considerable effort to maintain. Following a vegan diet for example, was described by Braun and Carruthers' (2020) participants as being 'intuitively' healthy, understood to improve digestion, prevent illness, enable weight loss and was considered health optimising by improving both physical and mental health, even when inherently restrictive.

For those with IBS however, the ability to exercise agency and choose *how* to eat more healthfully had been removed, with other health enabling restricted/elimination style diets seen as more preferable ways of eating healthfully, particularly when they also enabled weight loss and the achievement of a healthier, thinner appearance. In contrast, IBS related restricted dietary practices which were highly individualised, often felt feel less healthy in

comparison to more popular and socially endorsed ways of eating healthfully (e.g. the ketogenic diet, or intermittent fasting) and lacked social legitimacy as a means of enabling health themselves (Nettleton et al., 2010). Not being able to choose how to eat healthfully, therefore worked to disempower those with IBS, creating dietary blockages and dead ends, which left participants with little capacity to experiment with other ways of healthy eating or create lines of flight to improve their overall health and wellness – even when their preferred ways to eat healthfully were also inherently restricted.

## **8.4 Assemblages of Food/Body Distress**

As previously highlighted in [section 8.3](#) there is always risk associated with creating the new, and there is no guarantee that the new will produce beneficial outcomes or enable a line of flight (Deleuze & Guattari, 1987). For participants who spoke of periods in their life where they had engaged, or were still engaging in dietary practices which were associated with food/body distress, establishing new and individualised ways of eating which were necessarily restrictive to enable body stability, had the potential to create harmful tendencies within IBS eating assemblages.

### **8.4.1 Creating New Dualisms**

For two participants, Lily and Natalie, having to establish new ways of eating and make dietary adjustments which involved the elimination and avoidance of certain foods and food groups, had been particularly difficult. The reintroduction of restrictive dietary practices such as the LFD, when assembled with backgrounds of restricted eating associated with weight/shape concern and body distress, had the potential to produce conditions of possibility which could tip some IBS eating assemblages towards the emergence of harmful tendencies. Deleuze and Guattari (1987) note that not all points in an assemblage are equal and some may work to limit, confine, territorialise or sedentrise, “rhizomes have their own, even more rigid, despotism and hierarchies” (p. 20). For Lily, dietary practices which necessarily required the elimination or avoidance of certain foods, had the potential to

produce new hierarchies of food avoidance which had made food/body management more challenging. For Natalie, aspects of weight concern and symptom management assembled in ways which reinforced food dichotomies from two overlapping perspectives, further exacerbating experiences of food/body distress.

Although Lily had worked hard to create distance between previously restrictive eating practices and establish a more flexible relationship with food, the process of establishing what was 'healthy for me' had initially involved a return to more arborescent ways of thinking about food, whereby the outcomes of eating certain foods (e.g. health enabling vs symptom producing) had the effect of reproducing binarized thinking, which had not been helpful in the past:

When I used to have an eating disorder and when I had to go low FODMAP for a while, I definitely found it was triggering some of those same restrictive habits that I used to have, when I had that eating disorder, and that way it was also quite negative because I almost felt like I was back to the stage of being super restrictive about any of food I could kind of eat, and I found it quite hard to kind of get out of that mindset I guess, cause sometimes it's quite easy to fall back into with IBS... When I had an eating disorder, I would quite often go places and I can't have this, can't have that, can't have this, cause everything was kind of seen in my eyes as bad and it's the same kind of like ideology I guess as viewing things as like bad, and definitely that's kind of why I had to stop it after a while, otherwise I would just bring me back to the same habits. (Lily)

Deleuze and Guattari (1987) explain how arborescence introduces structures of power, which can turn assemblages from dynamic collectives, into fixed, sedentary hierarchies, which can feel like a "power takeover in the multiplicity" (p. 8). For Lily, having to incorporate dietary practices which felt restricting and limiting due to the dichotomous tendencies they reproduced, worked to create feelings of blockage and closure, "I can't have this, I can't have that". The over coding of food into binaries in relation to previously restricted eating

which had been associated with food/body distress, felt dangerous and “triggering”, when lines of flight had been previously become trapped by this way of thinking.

Lily described having initially adopted the LFD to identify which foods were “more triggering than others” however having established that “there was just so many things...I felt overwhelmed to kind of cut out everything” (Lily). Despite the health benefits which were derived from avoiding symptom producing foods, Lily highlighted the need to pull back and discontinue the FLD, feeling like she might be approaching the “the limit beyond which a given multiplicity transforms into something else” (Adkins, 2015, p. 40).

Deleuze and Guattari (1987) warn that no one knows “whether a given multiplicity will or will not cross over into another multiplicity... where a line of line of flight will pass... or if it will succumb to another danger... turning into a line of abolition, annihilation, self-destruction” (p. 250) and for Lily, the risk associated with maintaining a restricted diet such as the LFD felt too precarious to sustain, with the ever present threat of becoming recaptured, “bogged down, or veering into the void” (Deleuze & Guattari, 1987, p. 251). “It was so restrictive that I just felt like I couldn't sustain on that forever, it was kind of a catch 22 I did feel a lot better, but it was just, I didn't think it was sustainable enough to continue” (Lily).

Natalie's IBS eating assemblage had also been stratified by rigid arborescent lines in relation to dual aspects of body management producing ‘double dichotomies’. For Natalie, both weight and symptom management had become entangled with day to day dietary practices, whereby food had been binarized into categories of good/bad from both a weight and symptom perspective: “I definitely think I see food as good or bad and it's both from a weight perspective, and an IBS perspective, so whatever food I'm thinking about its definitely a good/bad label on it”.

Natalie describes herself as having “a negative relationship with food” and shared how “I feel quite sorry for myself a lot of the time, and this is a weight thing as well”:

Sometimes I think that the IBS is more of a factor in my, I'll say my ‘disordered eating’ I don't know if that's the right word, but I think that's more of an impact on the way that I

eat than I think it is, if that makes sense, um because I'm very careful to not eat something that might trigger symptoms because then I'll get bloated and feel fat and see the scale go up. (Natalie)

Adkins (2015) describes how arborescent thinking, with its' stable, logical, hierarchical nature, can be so useful it can become difficult to move away from such ways of thinking. For Natalie, maintaining food dichotomies and restricted dietary practices which enabled weight management *and* symptom avoidance, provided a solution to the problem position of body instability and weight gain. As highlighted in [section 5.3.2](#), the experience of becoming bloated was associated significant body distress and for those with histories of weight/shape concern, the distress associated with the sudden onset of extreme bloating, was further exacerbated when perceived as weight gain. In this assemblage, the organization of food into categories of good/bad, provided a structure of safety which enabled body stability, whereas moving towards more 'rhizomatic' or flexible ways of eating had the potential to produce unpredictable outcomes which were associated with risk.

Duff (2014) however explains that binaries "limit a body's power of acting by regulating the field of affects and encounters such a body may legitimately experience" (Duff, 2014, p. 32). Natalie described how she would "love to be able to go to a café one day and have a scone or a piece of cake or a slice or something but I just never do, never, ever, ever", "I can't because I'll gain weight and I'll end up with terrible symptoms". The dual threat of weight gain and symptom onset, therefore worked to sedentrise and stratify food dichotomies, enabling little room for dietary deviations, greater food freedom, or the actualisation of lines of dietary flight.

#### **8.4.1 I Might as Well Just Have Everything...**

Three participants described engaging in food/body practices they labelled as 'binge eating'. This kind of eating differed to that highlighted in [section 6.3.3](#), in which participants described a process of 'going big' on occasions when they planned to become unwell and eat symptom producing foods for pleasure and enjoyment. In contrast, the 'binge eating'

practices described in this section assembled with histories of disordered eating/eating disorders and IBS symptom management in ways which could produce additional layers of food/body distress and perpetuate weight/shape concern. My analysis in this section, focuses on dietary practices described by Emily, for whom restricted dietary practices had the potential to assemble with affective states, dichotomous 'all or nothing' thinking and IBS symptom management, in ways which perpetuated binge eating practices and food/body distress.

Emily shared how she had "started turning to food" following a difficult life event in her past, where she had "started to eat a lot, like to the point where I was embarrassed and I would eat my car and then go into the flat and have another meal with my flat mates, and then have dessert by myself in my room...". This process had resulted in significant weight gain which she had experienced as distressing, however 'binge eating' was also identified an ongoing source of distress. Emily described her current dietary practices as a combination of clean eating, the GAPS diet, the Ketogenic diet and "a lot of mistakes (laughs)". Emily provided an initial example of a dietary "mistake" explaining how "last week I had a whole Whitakers slab, not a bar".

Emily described how the dietary practices she experienced as problematic were strongly related to various affective states, with the onset of emotions creating a destabilising effect, which could produce a 'binge eating' episode:

So happy, sad, excited, accomplished, every emotion is celebrated with junk food... I just go binge and, I think it's also a flood of, like a downward spiral, and then obviously you have two bites of chocolate and then you just say I might as well just have everything... how I feel hugely impacts how I eat and if I eat the wrong thing, of course that also gonna make me feel bad which is going to make me eat more, because I get to a point where I'm like I'm going to eat so much, I'm going to completely numb myself out, I'm feeling bad and I don't give a shit. (Emily)

Emily described how once experiencing an affective state, making a small deviation away from her usual restricted dietary practices, was enough to produce "a flood" of



intensities which could feel like being “drawn toward the black hole” (Deleuze & Guattari, 1987 p. 133). Unlike the participants in [section 6.4.3](#) who would ‘just have one’, Emily described a more dichotomous ‘all or nothing’ approach to eating foods she would usually avoid. Once “two bites of chocolate” had been eaten and the threshold of ‘nothing’ had been surpassed, ongoing moderate consumption or stopping eating were no longer accessible alternatives, with the forces associated with a “downwards spiral” towards eating “everything” extremely difficult to pull back from or stop.

Deleuze and Guattari (1987) warn of the dangers of a too sudden deterritorialization. Message (2010a) describes the black hole “as one possible outcome of an ill-conceived attempt at deterritorialisation that is caused by a threshold crossed too quickly, or an intensity becoming dangerous because it is no longer bearable” (p. 34). Emily described reaching a point of no return from where once she was already feeling out of control and “bad” from “eating the wrong thing”, she would then continue to eat large quantities to “numb” herself and avoid experiencing the intensification of any further uncomfortable emotions. Buchanan (2020) explains how black holes have their own directional components, and the danger of chaos can be attractive in specific circumstances. This desire to feel numb, could perhaps be understood as what Message (2010a) describes as the “lure of the black hole... the subject’s attraction toward an absolute (lack) of signification (p. 34). Binge eating in this sense, could be understood a line of flight away from temporarily experiencing emotions, however sometimes “lines of flight are already drawn towards black holes” (Deleuze & Guattari, 1987, p. 224) and instead turn out to be a way down (Buchanan, 2020).

Within Emily’s IBS eating assemblage, eating large quantities of foods she would usually avoid not only had the potential to produce symptoms, it also worked to exacerbate experiences of food/body distress in relation to weight/shape concern more specifically. Although the dietary practices Emily described more generally were largely orientated towards symptom management, the potential for weight gain resulting from increased calorie

intake during 'binge eating' episodes, was also highlighted as a significant, if not more prominent source of food/body distress:

You just don't need the weight to make you feel any worse... I know if I am bigger, I'm just not going to feel confident my body full stop, like no one's gonna change that and I just don't need that stress on top of everything...I just don't want to get bigger because it's just, getting bigger with bigger binges, will cause symptoms as well..... maybe my focus is not to gain weight. Yeah, very shallow. (Emily)

Emily's realisation that weight concern may be more of a priority than she would like to admit, was also accompanied by a sense of shame, describing herself as "shallow".

Emily described how having to sustain high levels of self-control to maintain restricted dietary practices was also "stressful" in itself. Despite having captured in great detail the time and effort required to ensure her dietary practices enabled body stability in her digital photo diary, such levels of self-control were also unrealistically sustainable. Although acknowledging her dietary practices also included "a lot of mistakes", in a health valuing society making dietary 'mistakes' could also feel like a personal failure (Crawford, 2006). This was especially the case when the consequences of making small dietary deviations had the potential to precipitate a "downward spiral" which could produce a binge eating episode resulting in a loss of control, symptom onset, weight gain and feelings of shame which could feel like being "dragged towards catastrophe" (Deleuze & Guattari, 1987, p. 161).

Deleuze and Guattari (1987) caution there is no guarantee that creating the new will be beneficial. We cannot know in advance whether an outcome will be helpful or harmful, in fact any given assemblages will have tendencies towards both (Adkins, 2015). Further, whether an assemblage is helpful or harmful cannot be made in isolation, this must be determined 'in situ' (Adkins, 2015). Although dietary restrictions enabled "the formation or new compounds" by enabling symptom management, in some IBS eating assemblages they also had the capacity to lead to the "decomposition of already existing ones" (Buchanan, 1997, p. 82). Whilst binge eating episodes could be considered a line of flight or temporary escape from the territorialising forces of restricted dietary practices, when combined with

histories of food/body distress, this could produce a “bad encounter” (Deleuze & Parnet, 2002, p. 60). In this assemblage IBS related restricted dietary practices and histories of binge eating and weight/shape concern, therefore had the capacity to produce harmful outcomes when assembled with dichotomous all or nothing thinking, various affective states, western feminine appearance ideals and postfeminist healthism discourses in ways which could perpetuate binge eating practices and exacerbated food/body distress.

## **8.5 Chapter Summary**

In this Chapter I have drawn on DeleuzoGuattarian concepts of multiplicity, stratification, deterritorialisation and ‘what a body can do’, to explore participants’ understandings of health and healthy dietary practices. I have highlighted some of the ways in which participants had come to understand their IBS related dietary practices affirmatively. These included transcending normative dualistic understandings of healthy/unhealthy and creating a different kind of healthy eating which prioritised compatible food/body relations which increased a body’s power to act (Deleuze, 1992), listening to bodily intensities to guide food engagement, and being able to maintain a more stable, healthier weight.

Despite having established a different kind of way to eat healthfully however, participants were not immune from the stratifying lines of health eating guidelines which flowed through IBS eating assemblages. These lines had the capacity to produce feelings of dietary deficiency for some, and lead to misunderstanding and judgement from observing others, even when facilitating body stability and life continuity. Dietary practices which prioritised symptom management, could also constrain the conditions of possibility to eat in other health enhancing ways, leaving some participants feeling like they were unable and optimise their diets or their health. For those with histories of disordered eating / eating disorders, IBS related restricted dietary practices also had the capacity to produce further layers of food/body distress, though the introduction of new food dualisms which encompassed both symptom management and weight/shape concern.

In the following chapter, I revisit the objectives of this study, summarise my key findings and discuss these in relation to my research questions and the existing literature. I then discuss the lines of flight this research opens up, outlining how my findings may be put to work by healthcare professionals and researchers to support more affirmative outcomes for women with IBS. I also examine the limitations of this research, and propose directions for future inquiry.

## Chapter 9 – An Exit Point: Discussion and Conclusions

### 9.1 Chapter Introduction

Although the rhizome has no beginning or end and is always “in the middle” (Deleuze & Guattari, 1987, p. 23) it is necessary to create an exit point for this thesis. In the previous four analysis chapters I have thought with assemblages and drawn on DeleuzoGuattarian concepts and feminist new materialist frameworks to explore IBS related dietary practices. This theoretical framework enabled me to move the unit of analysis away from the individual to the assemblage (Fox & Alldred, 2022), think relationally and imminently, ‘map’ relations and explore how different components of IBS eating assemblages functioned together.

I was able to explore how different dietary practices were being produced across a range of contexts and temporalities, follow affects/intensities and observe where moments of connection or blockages were being produced, and where capacities to act were being increased or decreased. I was further able to identify lines of stratification which flowed through IBS eating assemblages, such as social and gender norms, feminine appearance ideals and healthy eating guidelines, and observe where assemblages gained stability, or changed over time.

This theoretical and methodological approach enabled me to understand what different ways of engaging with (and avoiding) food ‘do’ for women managing IBS symptoms, which was the overarching aim of this research project. More specifically, my research questions sought to understand how women with IBS understood and felt about their dietary changes (what do different IBS related dietary practices actually ‘do’?), explore understandings of healthy eating within context of IBS management and identify how IBS related dietary practices were assembled with experiences of distress.

In the final chapter of this thesis I summarise and discuss the key findings and contributions which emerged through this research assemblage. As the rhizome is always “between things” (Deleuze & Guattari, 1987, p. 25) rather than address each analysis chapter sequentially, my discussion “cuts across” (p. 407) all four analysis chapters ([Chapter](#)

[5 - Becoming IBS](#), [Chapter 6 - Social Eating Assemblages](#), [Chapter 7 - Temporal Multiplicities](#) and [Chapter 8 - A Different Kind of Healthy](#)). I start by discussing how my findings address each of my three research questions and develop the existing literature, within three main subsections ([section 9.2](#), [section 9.3](#) and [section 9.4](#)). I then discuss the lines of flight this research offers, by outlining how my findings might be put to work by healthcare professionals and researchers in ways which may enable more affirmative outcomes for women with IBS in [section 9.5](#). Lastly, I outline the limitations and disjunctures of this research assemblage and offer suggestions for new lines of future inquiry in [section 9.6](#).

## **9.2 What Do IBS related Dietary Practices Do?**

Assemblages are purposeful and form in response to a specific problem (Buchanan, 2020). Within this study, thinking with assemblages provided a means through which to explore why specific food/body arrangements were required by women with IBS, what they functioned in connection with (the composition, aggregation and mixture of their external relations) and what was being produced (Adkins, 2015; Buchanan, 2020; Deleuze & Guattari, 1987). Asking the Spinozian question of what 'what a body can do' (Deleuze & Guattari, 1987), therefore enabled me to answer my first research question and outline what different IBS related dietary practices actually 'do' for women with IBS.

Whilst highly individualised IBS related dietary practices fundamentally emerged as a means of facilitating symptom avoidance, body stability and life continuity, various IBS eating assemblages were actualised across a range of different relations, contexts and temporalities in response to various IBS related problems. In addition to symptom management, these assemblages 'did' multiple things for women with IBS. Before highlighting what IBS related dietary practices enabled an IBS body to do, it is important to reemphasise the severe and impactful nature of IBS symptoms which functioned as cutting edges of de/reterritorialisation across all IBS eating assemblages.

IBS symptoms are often trivialised and dismissed by medical professionals (Björkman et al., 2013; Bjorkman et al., 2016; Håkanson et al., 2014; Nevots et al., 2023; Miller et al., 2004; Skrastins & Fletcher, 2018) and their severity and impact misunderstood and underappreciated within wider society (Dent et al., 2025; Drossman et al., 2009a; Nevots et al., 2023). Yet, many of the women within this study reported experiencing severe and debilitating physical symptoms which were extremely destabilising, and both physically and emotionally exhausting. During such periods, their physical capacities were extremely limited, making expectations for living a normative life difficult, and sometimes unachievable.

The dynamic and unpredictable nature of symptom onset further produced uncertain and unstable embodiments, affecting how women with IBS felt about their themselves, leaving some feeling dehumanised and like their bodies were out of control, broken and working against them. These findings are consistently observed across the IBS qualitative literature (Drossman et al., 2009a; Håkanson et al., 2009; Hakanson, et al., 2014; Harvey et al., 2018; Rønnevig et al., 2009; Schneider & Fletcher, 2008; Mohebbi et al., 2019).

Although severe and profoundly impactful, physical symptoms formed just one component of IBS eating assemblages. As Deleuze and Guattari (1987) explain “we are made of lines” (p. 194) and there are “multiplicities of multiplicities forming a single assemblage, operating in the same assemblage” (p. 34). Within the IBS eating assemblages discussed in this thesis for example, powerful lines of stratification in the form of social, cultural and gender norms, healthy eating guidelines, feminine appearance ideals and postfeminist healthism discourses also flowed through various contextually and temporally dependent assemblages, shaping the ways in which women with IBS engaged with (and avoided) food.

In this section, “What Do IBS related Dietary Practices Do?”, I discuss how thinking with assemblages and DeleuzeGuattarin concepts, produced novel ways of understanding what IBS related dietary practices ‘do’ for women with IBS, in ways which could produce both ‘helpful’ and ‘harmful’ outcomes (Deleuze, 1992). I summarise five key findings and

discuss how these insights expand understandings of food/body relations in the context of IBS symptom management, linking this discussion to previous research.

To do so, I draw on findings from all four analysis chapters. I firstly discuss how IBS dietary practices enabled women with IBS to create temporary stability and feelings of safety through dietary refrains and defensive territories ([section 9.2.1](#)). [Section 9.2.2](#) then outlines how different ways of engaging with (and avoiding) food enabled social and gender norms to be maintained in ways which could be both helpful and harmful for women with IBS. In [section 9.2.3](#), I discuss how IBS related dietary practices enabled some women with IBS to maintain a more stable, healthier weight, allowing them to understand their bodies more affirmatively. I also highlight two different ways in which participants had been able to establish new lines of dietary flight by eating in ways which were distributed, material and sensory ([section 9.2.4](#)) and eat for pleasure and enjoyment ([section 9.2.5](#)).

### **9.2.1 Creating Temporary Stability – Dietary Territories and Refrains**

Thinking with the DeleuzoGuattarian concepts of territory and the refrain enabled a novel, nuanced and affirmative understanding of how some IBS related dietary practices gained stability overtime, by functioning as defensive territories. These territories produced a liveable order by enabling women with IBS to avoid, or escape, the forces of chaos associated with IBS symptom onset. Dietary territories were sustained through the rhythmic, repetitious nature of dietary refrains, which comprised of different ways of engaging with (and avoiding) food in ways which functioned to produce body stability. Importantly, these different configurations of food engagement which sometimes involved not eating, produced feelings of containment, safety and predictability.

For the women in this study, different dietary territories and refrains were constructed across a range of different contexts and temporalities, in ways which were protective by keeping the world safe and liveable. By doing so, they enabled women with IBS to accomplish normative daily activities such as maintain employment, parent their children and maintain wider social connections. The functions and components of different territorial



assemblages therefore differed, depending upon each participants symptoms, capacities, life circumstances and the distinct territories they assembled.

DeleuzoGuattarian concepts of territory and refrain offer an affirmative framework through which IBS related dietary practices can be understood for what they 'do' for women with IBS, in ways which attend to the pragmatic and functional purposes that specific dietary practices serve. The concepts of territory and the refrain also provide a useful way of theorising why some IBS related dietary practices become rigid and difficult to navigate away from, when understanding that any "mistake in speed, rhythm, or harmony would be catastrophic because it would bring back the forces of chaos" (Deleuze & Guattari, 1987, p. 311). With the ever present threat of chaotic uncertainty associated with unpredictable symptom onset running through all IBS eating assemblages, it becomes easier to understand why women with IBS may be hesitant to move away from dietary practices that facilitate stability, when doing so was associated with risk, fear and uncertain and unstable futures, and the onset of IBS symptoms which could be life destroying.

Whilst the consistency and rhythms of IBS dietary refrains enabled bodily stability and life continuity, such dietary practices were not sustained without significant effort and sacrifice, which at times could feel exhausting and overwhelming. As Kleinherenbrink (2015) explains a "territory or home is never created once and for all, nor it is ever fully closed in upon itself. It's continued existence is a matter of work and change" (p. 221). For the women in this study, the work involved in maintaining dietary refrains involved thinking through dietary decisions, assessing ingredient lists, planning meals in advance, hours of food preparation and being vigilant towards what was being eaten across time and place.

Hamilakis (2017) explains how the components of a particular assemblage, produce specific temporal affordances, enabling some futures to emerge and others to disappear. IBS related dietary practices involved thinking though how food decisions made in the present, had the potential to produce a reaction in the future, and how careful dietary management might enable symptoms which had been experiences in the past, to be avoided. Thus, there was always a temporal component to stabilising dietary practices, with

the past, present and future coexisting in a “living present” (Deleuze, 1994), in ways which functioned to produce different dietary practices which enabled women with IBS to maintain a liveable order.

A small but important literature base has drawn on Deleuzian conceptualisations of time, and time as non-linear and multidimensional to expand understandings of the complex nature of food/body relations, healthy lifestyle advice and experiences of health and illness (Coleman, 2008, 2010; Jowsey, 2016; Lewis et al., 2022; Robson & Riley, 2019, 2025; Tucker, 2024; Warin et al., 2015). Together these studies have highlighted the limitations and inadequacies of normative understandings of time for making sense of lived experiences of dieting and chronic illness management and mental health. My findings contribute to this body of literature by highlighting how multiple processes of time formed important affective components of IBS eating assemblages, in ways which functioned produce and maintain certain ways of eating (and avoiding) food for women with IBS. My findings also expand temporal understandings of IBS management, by highlighting how the ever present potential for body instability was woven throughout participants lives, impacting the ways in which they engaged with food.

### **9.2.2 Maintaining Social and Gender Norms**

By thinking with assemblages and moving the unit of analysis away from the individual to the assemblage (Fox & Alldred, 2022) IBS related dietary practices were able to be understood as being relationally produced through various IBS eating assemblages, rather than individual dietary behaviours or choices. This relational nature of food engagement was made visible through mapping the formation of various social eating assemblages and identifying the lines of which they were comprised. Eating in specific social settings and contexts, assembled together a range of bodily, social, cultural and gender norms in ways which produced strong territorialising forces which had the capacity to deterritorialise participants usual dietary practices, and temporarily produce different ways of eating (and not eating).

For some, the desire to maintain body stability in social contexts, meant that it was easier to avoid eating in some locations and settings, when the onset symptoms would be difficult to manage, and embarrassing and stigmatising to experience. In contrast, the desire to uphold social and gender norms in relation to commensality, made it difficult for others to maintain 'safe' ways of eating and avoid problematic foods, when doing so could mean being perceived as rude, difficult and different from others.

For the women in this study, the stratifying lines of social and gender norms produced powerful intensities, such that maintaining social, cultural and social eating norms were prioritised, even when maintaining such norms produced harmful health outcomes. These findings highlight how different ways of eating and avoiding food in social contexts can be understood as more than individual dietary practices, and the role that social and gender norms play in shaping how women with IBS engaged with food, often in ways which came at a personal cost.

For some, this personal cost also extended into family eating assemblages, with attempts to incorporate IBS related dietary practices into relational and family contexts, often producing additional layers of relational distress and anxiety. Within family eating assemblages, traditional gender norms which position women as responsible for health and wellbeing of their family (Riley et al., 2018) functioned as strong territorialising forces. This could make the incorporation of personal dietary refrains into the daily rhythms and routines of wider family contexts even more complex and challenging for women with IBS, particularly those caring for children. For example in [section 6.3.1](#), my analysis highlights how Michelle experienced feelings of guilt and felt like she might be failing to care for her children adequately by being self-focused and prioritising her own dietary requirements. This was the case even when such ways of eating were necessary to enable her to manage her symptoms, maintain employment and care for her children.

These findings can be understood in relation to postfeminist healthism literature which has highlighted the contradictory nature of intensive motherhood, whereby a good mother is expected to be self-focused but simultaneously child focused, in ways which often involve

self-sacrifice (Bryce, 2014; Riley et al., 2018). Riley et al. (2018) explain how women's subjectivities are produced through norms in relation to mothering, individual health practices and the ways in which they care for their children. With good mothering also tied to good personhood, failing below normative expectations for the kind of care a 'good' mother should provide, can produce feelings of guilt and anxiety (Kinser & Denker, 2016; Riley et al., 2018).

These feelings of guilt and anxiety were similarly experienced by Michelle who expressed concern around the potential of her own dietary practices to limit her children's capacity to eat more widely and nutritiously. These feelings further intensified in relation to concerns around the potential for IBS related dietary practices to create conditions of possibility through which non-normative dietary practices could become normalised within family contexts, in ways which could become harmful for children. This was particularly so in relation to the potential for disordered eating / eating disorder development. My findings therefore identify how gendered notions of care could assemble with IBS related dietary practices in ways which had the potential to produce additional layers of distress for women with IBS. Attempting to incorporate IBS related dietary practices into family contexts, even when providing personal stability, could therefore produce a different kind of 'chaos' for women with IBS, and be destabilising in other ways.

Mapping social eating assemblages enabled IBS related dietary practices to be understood as complex multiplicities rather than individual dietary behaviours, which 'did' multiple things of women with IBS. Whilst enabling the maintenance of social and gender norms and facilitating social connections and provision of care, identifying some of the 'cutting edges' of social eating assemblages also highlighted how experiences of IBS related distress can be understood as being relationally produced rather than residing within the individual. The affects which emerged through social eating assemblages could therefore be helpful and harmful, enabling moments of connection whilst threatening to rupture others.

### 9.2.3 Maintaining a Healthier Weight

In the previous section, I touched upon gender norms in relation to the provision of care. In this section, I also highlight the role of gender norms in relation to weight and body image and discuss how IBS related dietary practices enabled women with IBS to maintain a more stable weight. For women with IBS, body stability over dynamism in relation to weight, was considered a welcome and affirmative outcome of IBS related dietary practices, with weight stability valued in two different health enhancing ways. For some, having to sustain a consistently restricted diet which afforded little variation outside of the foods known to enable symptom management, functioned to limit the conditions of possibility for eating in ways which had previously lead to weight gain. As a result, IBS related dietary practices had the capacity to result in initial weight loss, with a lower, more stable weight subsequently able to be maintained through day-to-day dietary practices that participants considered to be healthier.

These findings can be likened to what Duff (2016) describes as kind of “health in illness” (p. 58) whereby although managing ongoing bowel dysfunction, being able to meet feminine healthy appearance ideals, allowed women with IBS to still look and feel healthy in a socially recognised and highly valued way. Extending Duff’s (2016) analysis to consider how health/illness assemble with gender norms, these findings can further be contextualised in relation to postfeminist healthism (Riley et al., 2018, 2025). Riley et al. (2018) for example, describes how successful weight loss can elicit feelings of pleasure and triumph in a neoliberal healthist context, when self-control and individual responsibility for health assemble with femininity, morality and attractiveness. Within this assemblage, lines of stratification in the form of healthy feminine appearance ideals and post feminism healthism, functioned in ways which could produce affirmative health outcomes, by enabling women with IBS to experiences their bodies positively and feel good about themselves.

For those who endured extended periods of severe and debilitating illness, being able to sustain a more stable, healthy weight was also considered an affirmative health outcome. Within this assemblage, IBS related dietary practices functioned as means of maintaining

body stability, which enabled women with IBS to avoid bodily fluctuations which produced severe symptoms which were associated with sudden and unintentional weight loss, and a maintain a more consistent body weight over time. This sustained body stability further enabled women with IBS to maintain life continuity, as well as avoid extreme fatigue and nutritional deficiencies associated with severe symptom related weight loss.

Being able to maintain a more stable, healthier weight, could therefore be experienced as life affirming in two different ways, by enabling women with IBS to look and feel healthy by conforming with healthy feminine appearance ideals in relation to body size, and facilitating a stable body which was not constantly in flux. By creating conditions of possibility for weight stability, IBS-related dietary practices therefore enabled women with IBS to experience a different kind of “health in illness” (Duff, 2016. p. 58).

#### **9.2.4 Material, Sensory and Distributed Ways of Eating**

Beyond symptom improvement, few IBS qualitative studies have previously explored affirmative experiences of IBS related dietary change. For two participants in particular (Rosa and Scarlett), new lines of dietary flight had emerged through the rhizomatic process of attempting to establish dietary practices that allowed them to experience food/body relations more affirmatively. These lines included extending the process of eating beyond the individual, engaging with the material and sensory aspects of food and deeply attuning to embodied sensations in ways which facilitated intense feelings of wellness and enhanced social connections.

As Deleuze and Guattari (1987) note, the concept of the rhizome is “entirely oriented to experimentation with the potential to open up possibilities for connections” (p. 12). Methodologically, thinking with the concept of lines of flight alongside participants digital photo diary entries, enabled me to discover different and creative ways of engaging with food, by ‘opening up’ and ‘provoking’ (Coffey, 2021, 2022) new understandings of affirmative food/body relations. Uncovering theses dietary lines of flight, would not otherwise have been

possible through humanistic or representational data collection methods or biomedical frameworks.

These lines of dietary flight, contribute to a small but interesting anthropological literature base which has explored different ways of eating (and not eating) as more than individual embodied encounters, shaped through multiple dynamic relations between various human and non-human bodies (Abbots, 2016, 2017). The act of eating in the context of anorexia nervosa for example, might not always involve an individual enactment of ingestion and digestion, and could instead be distributed across multiple people, spaces and temporalities, and undertaken through smell, imagined taste and sight (Lavis, 2016). Joyful food connections which did not involve the physical act of eating, have also been described by Holtzman (2018) who explored how in Japan, liking sweet foods did not necessarily require eating them. Instead, sweet foods could be enjoyed corporally, by appreciating their visual appearance and qualities, or by gifting such foods to others.

Distributing the physical act of eating had also emerged as a different way of engaging with food for Scarlett. Although physically unable to eat certain harmful foods herself, Scarlett had been able to find joy in the pleasure and satisfaction of preparing such foods for others to enjoy, as both a personal creative and productive outlet and act of food related care for others. For example, in [section 6.4.2](#), Scarlett's diary entry highlighted how by drawing on senses such as smell, touch, colour and texture, she had been able to open up new lines of connective flight, which had enabled her to re-establish, maintain and enhance her social connections, and experience food related enjoyment in different ways.

My findings firstly extend understandings of more relational and distributed ways of eating in contexts whereby food was considered potentially 'harmful' or distressing for the eater, to the context of IBS related dietary symptom management. I also extend understandings of how affirmative food/body relations, may be established through by drawing on other material, sensory and embodied ways of engaging with food, such as smell, touch, colour and texture, in ways which extended beyond the physical act of eating.

By asking the Spinozist/Deleuzian question of ‘what a body can do’, and applying this to my dataset, I was able to open up new possibilities for understanding food/body connections in ways which could be creative, adaptive, sensory and embodied and foster “joyful” connections (Deleuze, 1992). Eating in ways which were distributed, sensory and embodied, in the context of IBS symptom management, therefore extends a small but growing literature base which has focused on what different ways of eating (and not eating) ‘do’ for a body, the capacities they enable, and the purposes they serve (Abbotts, 2016, 2017; Eli, 2018; Lavis, 2016, 2018; Clancy, 2022). These different ways of engaging with food which were more relationally focused, socially distributed, and focused on other material and sensory aspects of food, had produced new possibilities or lines of flight for women with IBS, enabling new and affirmative ways of connecting bodies and food.

### **9.2.5 Eating for Pleasure and Enjoyment**

Whilst IBS related dietary practices primarily facilitated body stability and life continuity, two different assemblages were temporarily actualised when participants chose to deviate away from their usual dietary practices and eat for pleasure and enjoyment. For many, establishing controlled parameters of indulgence enabled them to open up “the circle a crack” (Deleuze & Guattari, 1987 p. 311) and knowingly eat small quantities foods which would usually be problematic, but not if eaten in small “dosages” (Buchanan, 2020, p. 86). These small dietary lines of flight, enabled participants to feel less deprived by facilitating a momentary escape away from their usual dietary refrains and territories, whilst simultaneously allowing them to avoid reaching a tipping point and risking complete bodily deterritorialisation. Eating small quantities, therefore allowed participants to eat just enough to avoid symptom onset, whilst still experiencing the taste and pleasure of eating foods they enjoyed.

Others described temporarily abandoning their usually restrictive dietary practices in order to completely ‘deterritorialise’ and eat for pleasure and enjoyment, even when this would likely produce symptoms. This involved a process of planning to become unwell and



taking into consideration a range of sensory, psychological, social and spatial factors.

Temporal considerations were further foregrounded, with eating for pleasure and enjoyment in the present also requiring thought to future, so that bodies could recover and 'reterritorialise' following the consequences of the past, before more controlled and restricted dietary practices were necessarily re-established.

Eating for pleasure and enjoyment is an often under theorised but important and affective component of IBS related dietary practices. Whilst having to forgo enjoyable/preferred foods is often noted as a limitation/challenge associated with dietary change and dietary interventions such as the LFD and associated with feelings of deprivation (Harvey et al., 2018; Schneider & Fletcher, 2008; Shorey et al., 2021; Weznauer et al., 2023) less consideration has been provided to what dietary deviations actually 'do' for those required to maintain lifelong dietary practices, and how these might be better understood.

Eating for pleasure and enjoyment enabled participants to temporarily launch forth and "join with the world, meld with it" (Deleuze & Guattari, 1987 p. 311) so that they could experience feelings of normality and social connection. It also facilitated a temporary "joyful escape" (Davies, 2018) away from the repetitious restrictions and limitations of usual dietary practices, allowing women with IBS them to prioritise other sensory, embodied and affective ways of engaging with food which extended beyond function. Posing the question "what can a body do?" (Deleuze & Guattari, 1987) therefore afforded me more affirmative framework through which IBS food/body relations could be understood, by allowing different dietary practices to be considered in relation to the capacities they enabled, many of which extended beyond symptom management.

Thinking with the concepts of the refrain and territory therefore afforded a novel theoretical framework through which to understand IBS related dietary deviations could be understood affirmatively. Within the chronic illness context, dietary deviations and eating for pleasure and enjoyment are often positioned as negative or maladaptive health behaviours (Fetcher & Scheider, 2006). However, for the women in this study, 'opening up the circle'

and embarking on lines of dietary flight were experienced affirmatively, temporally increasing capacities to act and establishing 'joyful' connections (Deleuze, 1992). So much so, that some participants described maximising their lines of dietary flight and 'going big' so as to enjoy as much food related pleasure as possible, before necessarily having to reterritorialise their bodies, and return to restricted dietary practices.

It should however be noted, that those with IBS may find themselves in a unique dietary management position. Due to the lack of structural aetiology associated with IBS, eating problematic foods beyond the subsequent onset of IBS symptoms, does not produce any additional adverse health outcomes. It is therefore possible that those with IBS may eat for pleasure and enjoyment more frequently, knowing that the consumption of problematic foods is not causing, or exacerbating permanent structural damage to the gastrointestinal tract. This is not the case with other GI disorders such as inflammatory bowel disease or celiac diseases, and as such these findings may therefore not be reflective of those with other GI disorders, or other chronic illnesses more broadly.

In this section, I have discussed how thinking with assemblages and DeleuzoGuattarian concepts enabled me to answer my first research question, by opening up new and different ways of understanding "What IBS related dietary practices *do* for women living with IBS". In the following section, I summarise and discuss how my findings addressed my second research question, "What is understood as healthy eating within contexts of IBS symptom management?".

### **9.3 What is understood as healthy eating within contexts of IBS management?**

In this section, I draw on analysis chapters seven and eight to address my second research question "What is understood as healthy eating within contexts of IBS management?". I commence by discussing how through the long process of dietary experimentation, women with IBS had necessarily had to establish new and different understandings of health eating ([section 9.3.1](#)). These health enabling dietary practices however, were not always understood as healthy for all participants, and in [section 9.3.2](#) I

outline how for some, IBS related dietary practices had instead produced feelings of dietary deficiency. In [section 9.3.3](#) I then discuss how the healthy nature of IBS related dietary practices was not always recognised or understood as healthy or health enabling by others, which for some was a source of misidentification and distress.

### **9.3.1 Understanding Healthy Eating Differently**

This research highlights how for women with IBS, new and different understandings of healthy eating had necessarily emerged through various IBS eating assemblages. With each participant experiencing different food intolerances and symptomatic responses, what was understood as healthy eating was unable to be reduced down to one pre-determined way of eating. Instead, health enabling dietary practices were highly individualised, multiple and those which produced the most “compatible relations” for increasing a body’s power of acting (Deleuze, 1992, p. 259). Healthy eating in the context of IBS symptom management, could therefore look differently for women with IBS, with healthy better understood in relation to “intensities rather than extensities” (Adkins, 2015, p. 39).

With all assemblages subject to both stasis and change (Deleuze & Guattari, 1987), the temporal nature of what was healthy, was further always open and provisional. As health from a Deleuzian perspective is not defined by lack, it can never be achieved as an end point and will always be processual (Buchanan, 1997; Duff, 2014; Fox, 2012). Health enabling IBS related dietary practices were similarly always in process, continually being reconfigured through an ongoing process of dietary experimentation in response to dynamic nature of food/body relations. As such, there was no singular, fixed or correct way of eating healthfully, this could only be determined in situ.

Whilst the trial and error process involved in identifying problematic foods is noted across the biomedical and qualitative research (Kamp et al., 2022; Reed-Knight, 2016; O’Brien et al., 2021; van Tilburg & Flexi, 2013), theorising this process as rhizomatic enabled the dynamic, temporal and emergent nature of food/body relations to be foregrounded. It further emphasises how for those with IBS, the healthfulness of specific foods was not

inherent, unable to be known in advance, and only able to be established through an ongoing process of dietary experimentation.

Thinking with the DeleuzoGuattarian concept of rhizome, therefore opened up new and affirmative way of understanding healthy eating in relation to affects and capacities (and what specific ways of eating enable an IBS body to do) in ways which were able to avoid hierarchical distinctions which might otherwise code certain ways of eating through a lens of morality or deficiency. It also provided a novel and dynamic framework through which to answer my second research question, which was “What is understood as healthy eating within contexts of IBS management?”. Not all participants however, were able to understand their dietary changes affirmatively, and as I discuss in the section below, eating in ways which facilitated symptom management could also produce feelings of dietary deficiency.

### **9.3.2 Feelings of Dietary Deficiency**

Despite having established new and different ways of eating healthfully, not all participants understood their IBS related dietary practices as healthy. For some, territorialising lines in the form of healthy eating guidelines functioned to produce feelings of dietary deficiency, by reorganising dietary multiplicities back into hierarchies of healthy/unhealthy, even when such guidelines had not produced healthy outcomes for those with IBS. For others, eating in ways which facilitated symptom management and produced health enhancing outcomes, also created disjunctures by limiting the conditions of possibility for some participants to choicefully engage with other dietary practices they considered to be healthier or health optimising.

Understandings of healthier or health optimising ways of eating were however complex and contradictory, with certain ways of eating healthfully privileged over others. This was particularly the case when dietary practices considered to be healthier or health optimising (e.g. ketogenic diet, intermittent fasting) facilitated weight loss as the primary, or adjacent outcome. Despite participants describing their own dietary practices as restricted and limiting, not being able to adopt other kinds of restricted dietary practices for personal health,

and more specifically weight loss purposes, was experienced as frustrating and disappointing. In this assemblage, lines of stratification in the form of postfeminist healthism (Crawford, 2006; Riley et al., 2019, 2025) could therefore feel constraining and prohibitive, when the conditions of possibility for eating in other health enabling ways which were tied to healthy feminine appearance ideals, had become unavailable. This could feel like failing at manage future health risk, being a good person, being attractive and living a good life (Crawford, 2006; Riley et al., 2019, 2025). Interestingly, these powerful lines of stratification endured, even in the context of chronic illness management.

IBS related dietary practices could therefore feel less healthy and disempowering, when constraining individual agency and limiting the process of dietary experimentation which might otherwise enable women with IBS to eat in more socially and culturally endorsed healthful ways. IBS related dietary practices could therefore be simultaneously health enabling and constraining, and understood by women with IBS as both helpful and harmful simultaneously.

These findings highlight how not all forms of stratification were mutually beneficial for all women with IBS. Identifying and mapping relations which increased capacities for expression, and those which produced blockages and reduced capacities, afforded a means through which to account for how understandings of health and healthy subjectivities hold together in experience (Duff, 2014). Healthy subjectivities in the context of IBS dietary management, were therefore not 'given', or derived from 'essences' (DeLanda, 2006), but assembled through specific arrangements and produced through various relations, processes, affects and events which come into being (Duff, 2016).

In this assemblage, healthy eating guidelines and postfeminism healthism functioned to limit how some participants could understand and feel about themselves, their bodies and their dietary practices affirmatively. Notably, these findings contrast with those outlined in [section 9.2.3](#), whereby being able to maintain a stable weight, and as a result maintain healthy feminine appearance ideals, enabled other participants to consider their dietary practices as having become healthier. For women with IBS, stratification could therefore be

“both fortune and unfortunate” (Adkins, 2015, p. 42), however whether this enabled them to feel like their dietary practices had become more/less healthy depended on one’s context and perspective (Buchanan, 2020). This context and perspective, also extended to observing others who did not always understand IBS related health enabling dietary practices as healthy. I discuss this further in the following section.

### **9.3.3 The Misidentification of Healthy/Unhealthy Eating**

IBS related dietary practices were also not always recognised or understood as healthy or health enabling by others. Women with IBS disliked being misidentified by others as someone with an eating disorder or as being on a diet for weight loss purposes, particularly when this was not the case. This could feel pathologising, particularly when certain ways of eating (and not eating) were functional, health enabling and increased a body’s capacities to affect and be affected (Deleuze, 1992).

Being misidentified as someone who was on a diet for body image or aesthetic reasons, was also highlighted as a cause of distress for Kim and Park’s (2011) participants, who also reacted sensitively when restricted dietary practices were misunderstood. Kamp et al.’s (2022) participants similarly disliked eating socially, due to being judged for what was being eaten, and misidentified as someone with an eating disorder.

This kind of dietary misidentification however might be difficult to avoid, when women face a cultural imperative to be constantly working on, and transforming themselves in order to pursue narrow ideals of healthy embodied femininity and health perfection (Evans et al., 2020; Riley et al., 2018, 2025). This transformation imperative could further be complicated in the context of IBS dietary management, when correct ways of eating which are morally valued and proliferate understandings of healthy/unhealthy dietary practices, were unable to be undertaken by those with IBS. Instead IBS related food avoidance could appear as being too obsessed or overly restrictive, when one should be seen to care about their health and appearance, but not too much (Riley et al., 2018).

Misidentifying restricted eating and food avoidance, could therefore produce harmful outcomes, when adaptive, functional and health enabling ways of eating were coded as disordered, problematic or unhealthy by others. Such codifications functioned to obscure the complex, relational, temporal nature of IBS eating assemblages, and situate dietary practices as individual, moral choices, without providing consideration to what they actually enabled IBS bodies to do. This could have implications for how women with IBS understand and feel about themselves, their bodies and their own dietary practices, when physically unable to eat in ways which align with what is culturally determined as healthy.

In this section, I have drawn on findings from chapters seven and eight to answer my second research question “What is understood as healthy within contexts of IBS management?”. I have discussed how women with IBS necessarily developed new understandings of healthy eating through the long process of dietary experimentation. I also discussed how IBS related dietary practices were not always recognised by others as healthy or health-enabling, sometimes leading to experiences of misidentification and distress. In the following section, I extend this discussion by summarising findings which address my third and final research question, “How are IBS related dietary practices assembled with experiences of distress?”.

#### **9.4 How are IBS related dietary practices assembled with experiences of distress?**

In this section, I address my third research question “How are IBS related dietary practices assembled with experiences of distress?”. Firstly, my discussion focuses on assemblages of food/body distress and I summarise how IBS related dietary practices had the potential to produce harmful outcomes for those with histories of disordered eating and eating disorders ([section 9.4.1](#)). In [section 9.4.2](#), I then discuss how the sudden and unpredictable onset of severe bloating and abdominal distention, made it difficult for women with IBS to feel affirmatively about their bodies, producing embodied experiences of distress. Throughout this discussion, I draw on analyses presented in chapters five and eight.

#### **9.4.1 Assemblage of Food and Body Distress**

Deleuze and Guattari (1987) caution that there is always risk associated with creating the new and there is no guarantee that the new will produce beneficial outcomes. For those with histories of food/body distress, having to establish new and individualised ways of eating which had necessarily required the elimination or avoidance of certain foods or food groups, had the potential to create conditions of possibility which could produce harmful outcomes. For some, embarking on the process of dietary experimentation had the potential to reproduce dualistic ways of thinking about food which had not been helpful in the past for those with histories of disordered eating / eating disorders, by creating new hierarchies of food avoidance which made food/body management more difficult.

For others, aspects of weight concern and symptom management assembled in ways which reinforced food dichotomies from two overlapping perspectives, further exacerbating food/body distress. These 'double dichotomies' functioned to binarise food into categories of good/bad from both a symptom management and weight perspective, providing a structure of safety through which body instability and weight gain could be avoided. Moving towards more flexible ways of eating was therefore associated with risk, and had the potential to produce unpredictable and distressing outcomes. Such dichotomies however, enabled little room for increased food flexibility, freedom or the actualisation of new lines of dietary flight.

Dichotomous all or nothing thinking could also perpetuate binge eating practices. In this study, binge eating was theorised as line of flight or temporary escape from the territorialising forces of restricted dietary practices, but also a potential black hole. Deleuze and Guattari (1987) describe the black hole as a space which cannot be escaped from, a "possible outcome of an ill-conceived attempt at deterritorialisation that is caused by a threshold crossed too quickly, or an intensity becoming dangerous because it is no longer bearable" (Message, 2010. p. 34). In this assemblage, IBS related restricted dietary practices, histories of binge eating and weight/shape concern, had the capacity to produce a range of harmful outcomes. When assembled with dichotomous all or nothing thinking, various affective states, western feminine appearance ideals and postfeminist healthism, this



could perpetuate binge eating practices and exacerbated food/body distress producing a “bad encounter” (Deleuze & Parnet, 2002, p. 60).

As noted across the biomedical literature, for those with histories of disordered eating or eating disorders, the introduction of dietary restrictions following an IBS diagnosis, has the potential to configure vulnerable contexts whereby unhealthy dietary practices may re-emerge (Bellini et al., 2020; Halmos & Gibson, 2019). The findings presented in the present study expand understandings of how IBS related dietary practices have the capacity to create conditions of possibility for restricted dietary practices to reemerge, by offering both a theoretical and contextual account of how IBS related dietary practices assemble in ways which have the capacity to produce harmful outcomes for those with histories of food/body distress. Together, these findings underscore the importance of healthcare professionals carefully assessing suitability before recommending the LFD, particularly to for those with histories of food/body distress for whom the LFD may not be suitable. Findings also highlight the need for ongoing support and education throughout all three phases of the LFD dietary intervention.

#### **9.4.2 Bloating and Body Distress**

For women who experienced the sudden and often unexpected onset of severe bloating and abdominal distention, expectations for body stability, feminine appearance ideals and postfeminist healthism, formed powerful lines of stratification within IBS eating assemblages which functioned to limit the conditions of possibility for women with IBS to experience and understand their bloated bodies affirmatively.

Severe bloating, which was physically painful, highly uncomfortable and often experienced alongside constipation, produced dynamic and unwelcome changes in embodiment which drastically altered participants’ physical dimensions. When assembled with feminine appearance ideals of a flat stomach, these physiological changes had the potential to produce intensities which could feel extremely distressing, when propelling bodies away from feminine appearance ideals and leaving women with IBS feeling

unattractive and experiencing their bodies shamefully. These, feelings of distress were further exacerbated when severe bloating was perceived as immediate weight gain and experienced as feelings of fatness.

For the women in this study, the onset of severe bloating and abdominal distention, produced feelings of shame, self-abjection and self-disgust, with many describing themselves as feeling “disgusting”, “sluggish” and like a “beached whale” when bloated. The stratifying lines of feminine appearance ideals and power of normalising forces were such that one participant, Julia, described wishing that someone would “cut out my intestines” so that bloating would no longer “cause a problem” (see [section 5.3.2](#)). Similar findings have also been noted across the experiential IBS literature, with bloating leaving women with IBS feeling unattractive, self-conscious about their physical appearances, and dissatisfied with their bodies (Björkman, 2013; Farndale & Roberts, 2011; Håkanson et al., 2009; Kim and Park, 2001; Lu et al., 2009; McCormick et al., 2012; Nguyen et al., 2018; Toner & Akman, 2000).

Whilst biomedical and experiential approaches have been able to identity some of the correlates and aspects of emotional distress associated with severe bloating and distention, they also overlook how such feelings are produced relationally, and shaped by broader structural forces. Feelings of shame, abjection and body dissatisfaction associated with bodily changes which included bloating, have similarly been noted across other studies exploring women’s health, especially in the context of premenstrual embodiment (Ryan et al., 2022; Ussher & Perz, 2020). For the women in Ussher and Perz’s (2020) study, the meanings attributed to embodied changes, when considered relation to idealised femininity and the stigmatisation of fat bodies, functioned to produce negative feelings towards their bodies, resulting in feelings of distress and dehumanisation.

The findings in this study, therefore contribute to the IBS qualitative literature base and feminist approaches to women’s health such as those conducted by Ryan et al., (2022) and Ussher and Perz (2020), who have focused on embodied experiences of bloating in relation to idealised femininity and the stigmatisation of fat bodies. By highlighting how powerful lines

of stratification in the form of feminine appearance ideals and postfeminist healthism, flowed through IBS eating assemblages. These lines played a significant role in shaping women's experiences of IBS and how they understood their bodies, further emphasising how symptoms such as severe bloating and abdominal distention carry meaning beyond physical discomfort, in ways which can intensify feelings of IBS related distress.

Relating these finding back to IBS related dietary practices more specifically, it is not surprising that women who experience severe bloating and abdominal distention, actively avoid foods and specific ways of eating which have the capacity to result in bloating. Dietary practices which enabled bodies to be held stable so as to avoid severe bloating and abdominal distention, were therefore highly prioritised and valued, allowing women with IBS to align more closely with feminine appearance ideals, and avoid experiencing feelings of fatness, shame and self-disgust associated with severe bloating and abdominal distention.

Within this discussion section, I have addressed my third research question "How are IBS related dietary practices assembled with experiences of distress?" by outlining how IBS-related dietary practices had the potential to produce harmful outcomes for those with histories of disordered eating or eating disorders. I also discussed how the sudden and unpredictable nature of severe bloating and abdominal distention made it difficult for women with IBS to feel affirmatively about their bodies, producing experiences of embodied distress. In the following section ([section 9.5](#)), I outline four ways in which my findings may improve the capacity of healthcare practitioners, dietitians, and researchers to better understand IBS related dietary practices and support women with IBS.

## **9.5 What lines of flight does this research offer for clinicians?**

Nial (2017) argues that before we can intervene, we must understand how assemblages work, so that we can know how they might work differently. The therapeutic goal of assemblages is to identify those which are life affirming and the forces immanent to such arrangements (Duff, 2023). Throughout this thesis, I have identified some of these arrangements and mapped how different IBS eating assemblages mediated experiences of

health and illness for women with IBS. In this section, I offer suggestions for how the findings of this study might enrich understandings of IBS related dietary management in ways which may assist health care practitioners, dietitians and researchers to better support women with IBS.

### **9.5.1 Understanding the Severity and Impact of IBS**

The severe and debilitating nature of unpredictable symptoms and their wide reaching impact across multiple domains of life, is often under acknowledged and dismissed by healthcare professionals. Despite the deeply impactful nature of IBS conveyed across the existing IBS literature, the impact of living with uncertain and unstable embodiments, does not appear to translate to healthcare settings in ways which facilitate understanding or empathetic healthcare encounters. Instead dismissive interactions often function to perpetuate and create additional layers of IBS related distress, leaving women with IBS feeling unsupported and alone in managing their symptoms.

Thinking with assemblages and highlighting how experiences of IBS related distress can be understood as being relationally produced and comprised of multiple physical, emotional, psychological, social and temporal dynamic components, may therefore promote greater understandings of the complex and wide reaching impact of IBS. Increasing understandings is important, because IBS is often misunderstood as ‘a little bit’ of diarrhoea or bloating, which is not commensurate with the multiple levels of embodied distress which are often experienced by women with IBS, as outlined in [chapter 5](#). Despite the lack of structural etiology associated with IBS symptomology, the effects of IBS symptoms are real and deeply impact how women with IBS understand, think and feel about themselves.

As IBS symptoms are associated with stigma, shame and embarrassment, when women with IBS are not able to safely communicate the extent of their symptoms and their impact on daily life, their IBS is likely to remain an unacknowledged and misperceived condition. Fox and Alldred (2016) argue rather than increasing a body’s capacity to act, biomedical approaches to bodies and healthcare can shut down opportunities through its

individualised medical framework. The present study shows how this argument also relates to women with IBS, when ‘women’s issues’ are often dismissed or downplayed in healthcare care encounters (Fricker, 2007). Creating new and different ways of understanding the severity and impact of IBS, may therefore facilitate greater understandings and increase healthcare professionals capacity to deliver more supportive, and life affirming health care for women with IBS.

### **9.5.1 Limitations of Binary Thinking – Clinical Implications**

Binary thinking can limit a body’s capacities by constraining the range of affects that bodies can legitimately experience (Duff, 2014). In the context of IBS related dietary management, binary thinking could be limiting in ways which have clinical implications for women with IBS. As binaries produce fixed categories and sedentary hierarchies (de Beistegui, 2018), understanding the restricted nature of all IBS related dietary practices as unhealthy, potentially problematic or disordered, fails to account for the relational, complex, and temporal nature of different ways of engaging with (and avoiding) food in the context of IBS symptom management. Due to the unpredictable and emergent nature of IBS symptoms, a more ‘open’, dynamic and rhizomatic framework through which different ways of eating (and not eating) healthfully can be understood is therefore required.

Binary thinking can therefore have implications for interpreting DE/ED screening and assessment tool scores, when such tools function to isolate, classify and reduce understandings of dietary practices down to pre-established, dichotomised categories of healthy/unhealthy based upon pre-determined numerical thresholds. As IBS related dietary practices are not fixed and emerge in response to multiple IBS problems and considerations, such tools are unable to attune to complex, fluid, temporal and relational nature of IBS related dietary practices. Nor are they able to account for what different ways of engaging with (or avoiding) food ‘do’ for women with IBS in ways which may be life affirming and enable experiences of IBS related distress to be avoided or minimised.

Scarlata et al. (2025) cautions the use of disordered eating / eating disorder screening and assessment tools which have not been validated for use within GI populations. They argue that such tools have the potential to misconstrue adaptive, functional and nuanced dietary practices in the context of GI symptom management and over pathologise of dietary practices intended to alleviate and avoid symptoms. This may particularly be the case, when used in conjunction alongside elimination style dietary intentions such the LFD which are inherently restrictive (Chumpitazi et al., 2019). For example, the LFD specifies an initial FODMAP restriction phase for a duration of 2-6 weeks. Caution should therefore be exercised when interpreting the scores produced through these tools, which may function as “acts of capture” and “seize whatever comes within their reach” (Deleuze & Guattari, 1987, p. 40) in ways which have the potential to produce harmful outcomes.

Categorising adaptive and functional dietary practices as unhealthy, potentially problematic and disordered, can further impact how those with IBS feel about themselves and their dietary practices. As previously highlighted in [section 9.3.2](#), misidentifying IBS related dietary practices as disordered eating could feel pathologising for those with IBS, particularly when certain ways of eating (and not eating) facilitated healthier outcomes, and were not choiceful. This may further lead to reduced healthcare efficacy, if those with IBS are treated without consideration provided to their wider relational life contexts.

### **9.5.2 Weight/Shape Concern vs Symptom Management – Creating New Binaries?**

Studies conducted through biomedical frameworks have also sought to establish whether IBS related dietary practices may be motivated by the avoidance or mitigation of gastrointestinal symptoms, rather than being motivated by weight/shape concern (Mujagic et al., 2022; Reed-Knight et al., 2016; Satherley & Higgs 2015). Although this may be a useful distinction to identify (and one which ED/DE screening and assessments tools are currently unable to decipher), differentiating between the two may also be difficult.

For the majority of women in this study, the distinction between dietary practices motivated by the avoidance or mitigation of gastrointestinal symptoms and appearance

concerns, were not dichotomously distinct, nor easily separated. This is not surprising when appearance concern is normalised for women and weight is considered a measure of women's health and attractiveness (Riley et al., 2018; 2025).

Deleuze and Guattari (1987) argue that there are no pure rhizomes, and whilst IBS related dietary practices were fundamentally undertaken to manage symptoms, maintaining feminine appearance ideals was also a significant, and sometimes more important aspect of IBS related dietary management. This was particularly the case for women who experienced the sudden and unpredictable onset of severe bloating and abdominal distention, with IBS related dietary practices functioning to alleviate multiple layers of distress in relation to symptom alleviation and appearance concern simultaneously.

For the women in this study, there were “multiple entryways and exits” (p. 21) through which feminine appearance came up through “the middle” (p. 23) of IBS eating assemblages (Deleuze & Guattari, 1987). This may therefore make it difficult to differentiate between weight/shape concern and symptom management as binary categories, when feminine appearance ideals are entangled with understandings of health in multiple ways.

### **9.5.3 Affirmative Understandings of IBS Dietary Practices**

Given the reliance on diet to manage IBS symptoms, increasing understandings of the ways in which IBS related dietary practices might be understood affirmatively is therefore important. Whilst IBS related dietary practices are necessarily restrictive, failing to focus on affirmative aspects of dietary practices and identify where new lines of flight might be established, maintains a narrow deficit oriented approach, whereby fear of symptoms, social exclusion, loss of pleasure and enjoyment, lack of spontaneity remain the focus.

Whilst food/body encounters which produce ‘harmful’ or ‘sad’ outcomes which result in a reduction of powers and capacities (Deleuze, 1992) are important to identify and understand, thinking differently with the DeleuzoGuattarian concepts of assemblages, intensities, lines of flight and ‘what a body can do’, afforded a means through which alternative ways of thinking about IBS related dietary practices could be understood. This

enables different ways of eating, to be considered in relation to what they produce and make possible, and how other affective components of IBS eating assemblages may be fostered to generate more affirmative experiences of IBS related dietary practices.

The findings presented in this study therefore contribute more broadly to feminist new materialist approaches which have drawn on assemblage thinking and DeleuzoGuattarian concepts, to open up understandings of health and illness beyond the limitations of biomedical and humanistic approaches (Duff, 2014, 2016; McLeod, 2017). This study expands assemblage thinking into physical health and dietary managed chronic illness contexts more specifically, by highlighting how bodies in the context of IBS may be propelled a long a line of becoming well (Duff, 2016) through a range of different dietary practices which emerge through wider relational assemblages.

## **9.6 Blockages and New Lines of Inquiry**

The rhizomatic principle of “asignifying rupture” means that a “rhizome may be broken, shattered at a given spot, but it will start up again on one of its old lines, or on new lines (Deleuze & Guattari, 1987, p. 9). By creating an exit point for this research in the final chapter of this thesis, I now identify some of study limitations which may have produced moments of blockages, and offer suggestions for how these lines may be started up again in order to produce new lines of inquiry.

Whilst this study explored what IBS related dietary practices ‘do’ for women managing IBS in Aotearoa New Zealand, I had not initially intended to recruit a female/women only participant group. As previously highlighted in [chapter 4](#), it is possible that Facebook recruitment, the characterisation of IBS as a ‘women’s disease’, and the fact that women are overrepresented in IBS prevalence rates and tend to experience more severe and impactful symptoms may have influenced the demographic composition of the participant group as a whole, limiting the conditions of possibility for greater gender diversity.

Although facilitating an unexpected and affirmative line of flight which enabled to me to explore the role and gender norms, feminine appearance ideals and postfeminist healthism



as components of IBS eating assemblages, future studies would benefit from the inclusion of more gender diverse participant group. This may enable different gendered components, lines of stratification or ‘cutting edges’ of IBS eating assemblages to be identified, and mapped in relation to the affects they produce, and how these might enable or constrain different IBS related dietary practices.

As the majority of participants were recruited from IBS and dietary related (low FODMAP) Facebook groups, most participants dietary practices were informed to some degree by the low FODMAP diet. As a result, the experiences, perspectives and understandings of IBS related dietary practices which emerged through various IBS eating assemblages within this project, may therefore differ from women who have not previously engaged with, or were not familiar with the low FODMAP diet. It is also possible that Facebook as a method of recruitment may have facilitated a participant group who experienced more severe symptoms, in contrast to those who have not sought information or support through IBS and low FODMAP dietary groups. Findings should therefore be interpreted within these parameters, and may not be reflective of the experiences of all women with IBS.

Whilst a number of different ethnicities and cultures were represented across the participants group, a recent (although post recruitment) study has since observed an increase in IBS prevalence for Māori (see Law 2024). Future studies would therefore benefit from the inclusion of more Māori participants and a more culturally attuned focus on Indigenous understandings of health and healthy eating, to enhance understandings of IBS management and related dietary practices within the context of Aotearoa/New Zealand.

## **9.7 The Exit Point – Concluding Summary**

Deleuze and Guattari (1987) encourage us to think rhizomatically, to experiment and create the new. The findings which emerged through this ‘research assemblage’ (Fox & Alldred, 2015) and presented in this thesis, produced new and different ways of understanding IBS related dietary practices. By thinking with assemblages as the unit of

analysis, rather than the individual (Fox & Alldred, 2022) IBS related dietary practices were able to be understood as more than individual dietary behaviours and choices. This enabled different ways of engaging with (and avoiding) food to be understood as relationally and temporally produced through various IBS eating assemblages, which were actualised across a range of different contexts and temporalities in ways which performed a multiplicity of functions for women with IBS.

IBS related dietary practices as multiplicities, were not discrete, singular or fixed ways of eating, but were always rhizomatic, breaking off and forming new connections with other multiplicities. For the women in this study, lines of stratification in the form of social and gender norms, feminine appearance ideals, postfeminist healthism and healthy eating guidelines, produced powerful affects which shaped day-to-day dietary practices. When assembled with emergent food/body relations and the sudden unpredictable nature of severe and debilitating physical symptoms, some of these 'lines' functioned to delimit, territorialise and stratify, whilst others produced affirmative deterritorialising lines of flight (de Beistegui, 2018).

Most importantly, IBS related dietary practices were able to be understood for they 'did' for women with IBS. Asking the Spinozist/Deleuzian question of "what a body can do?" afforded an ethological framework through which hierarchical distinctions of healthy/unhealthy eating were able to be avoided. Instead, different ways of engaging with (and avoiding) food were able to be understood as health enabling, when considered in relation to the connections and capacities they increased, and what they enabled an IBS body to do. Thinking with assemblages therefore provided an affirmative framework through which IBS related dietary practices could be explored as complex and temporal multiplicities which 'did' multiple things for women with IBS, in ways which opened up the potential for more affirmative futures.

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## Appendix A

### The Low-FODMAP Diet

The low FODMAP diet<sup>5</sup> which restricts fermentable oligosaccharides, disaccharides, monosaccharides, and polyols, is recommended as a first line dietary intervention for IBS (Halmos et al., 2014; McKenzie et al., 2016; Gibson, 2017). The LFD is a diagnostic tool, rather than an avoidance diet which is used to identify tolerance to certain foods and enable patients to eliminate or include foods in their diet (Bellini et al., 2020). The LFD is designed to be implemented in three distinct phases under the supervision of a dietitian; FODMAP restriction for a duration of 2-6 weeks, reintroduction if restriction has been successful (6-10 weeks) and then personalisation whereby a less restricted and more diverse diet is adopted with the exclusion of FODMAPS which have been identified to cause symptoms (Chey et al., 2022; Lomer, 2024; Mitchell et al., 2018; Scarlata, 2025; Whelan et al., 2018). The LFD therefore is not intended to be a 'diet for life' (Whelan et al., 2018).

The LFD has been found to reduce symptoms in approximately 50-80% of people with IBS (Böhn et al., 2015; Peters et al, 2016; Halmos et al., 2014; Staudacher & Whelan, 2017). In Aotearoa New Zealand more specifically, FODMAP reduction has been found to improve IBS symptoms (Harvie et al., 2017), with 72.1% of patients satisfied with symptom improvement (De Roest et al., 2013). However, the LFD is not always a benign intervention and there remains a number of challenges associated with this dietary approach. The LFD is complex to follow. Due to the heterogeneity of food triggers and responses, clear guidelines for the reintroduction personalisation phases are lacking (Tuck & Vanner, 2018). Further due to the individualised nature of the diet, the maintenance phase may be achieved in many different ways, however these pathways are not well documented (Halmos & Gibson et al., 2019). Due to this complexity, a registered dietitian should guide this process to ensure it is undertaken safely, however many struggle to access a dietitian to help guide them through

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<sup>5</sup> Further information regarding the low FODMAP diet can be found on the following Monash University website: <https://www.monashfodmap.com/about-fodmap-and-ibs/>

this process, making it more difficult to follow (Kamp et al., 2022; Tuck, 2020). As a result, many receive inadequate education such as the provision of food lists only, little tailoring or personalisation and are required to interpret the limited information provided (Bellini et al., 2020; Trott et al., 2019). Those with IBS are therefore often required to navigate the complex process of elimination and reintroduction with minimal healthcare oversight.

It is also important to highlight that the LFD may not be suitable for everyone. Not everyone with IBS responds to the LFD and therefore not everyone experiences an improvement in symptoms. Whilst the reason for this are unclear, biological studies suggest this could be due to specific symptom profiles, or differences in gut microbiota (Lomer, 2024; Wilson et al., 2021). For others, however, the FLD may be so effective that people with IBS are not willing to reintroduce foods after the initial restriction period due to its success in alleviating symptoms (Halmos & Gibson et al., 2019). Further, some incorrectly believe that FODMAPS cause IBS, leading to unrealistic expectations that the elimination of FODMAPS from one's diet will resolve IBS (Halmos & Gibson et al., 2019). The LFD may not also be an accessible option for all, such as those experiencing food insecurity (Chey et al., 2022).

The long-term safety and efficacy of the LFD has not been well established in regard to sustained symptom alleviation, quality of life, nutritional adequacy and risk towards disordered eating development (Mitchell et al., 2018). Elimination style diets may not be suitable for those who already have dietary restrictions in place, or those with eating disorders where further restrictions would be harmful and potentially impact physical or psychological health (Halmos & Gibson., 2019). As the introduction of restrictive dietary practices may precipitate or reinforce disordered eating behaviours (Bellini et al., 2020), and as such for those with an existing eating disorder, no dietary therapy is recommended (Halmos & Gibson., 2019). To date however most studies have excluded those with histories of food/body distress, and as a result the long term impact of dietary restrictions on disordered eating development has not been evaluated (Schumann et al, 2018).

## Appendix B

### Ethics Approval Notification



6/03/2023

Dear: Melinda Lewthwaite

**Re: Ethics Application - SOA 22/58 - Exploring Entanglements of Irritable Bowel Syndrome, Dietary Practices and Disordered Eating / Eating Disorders.**

Thank you for the above application that was considered by the Massey University Human Ethics Committee:

**Ohu Matatika 1** at their meeting held on **Tuesday, 8 November 2022**

On behalf of the Committee I am pleased to advise you that the ethics of your application are approved.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Craig Johnson  
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

## Appendix C

### Participant Recruitment Poster



## Have you changed your diet to manage Irritable Bowel Syndrome (IBS)?

You are invited to participate in a research project aiming to explore experiences of people who have altered their diet to manage irritable bowel syndrome (IBS). I want to know more about people's motivations for adopting dietary changes for IBS related gastrointestinal symptom management and what this looks like on a day-to-day basis.

I am looking to interview 20-25 people who self-identify as having altered their diet to manage IBS. You may have been advised by a healthcare professional to make dietary changes, or you may have decided to make dietary changes yourself.

To take part, you will have been diagnosed with IBS, be over 18 and currently living in Aotearoa New Zealand. Your participation would involve attending an online (Zoom) interview (approx. 1 hour). You will also be invited to participate in an *optional* digital photo diary exercise and follow-up online (Zoom) interview (approx. 1 hour each).

Your time and contribution would be recognised with a \$40 voucher for each interview you attend and a \$40 voucher if you choose to create a digital photo diary.

If you are interested in participating or would like to receive more information about taking part in this study, I would love to hear from you.

Research contact: Melinda Lewthwaite  
Email: [melinda.lewthwaite.1@uni.massey.ac.nz](mailto:melinda.lewthwaite.1@uni.massey.ac.nz) // Tel: [REDACTED]



**MASSEY UNIVERSITY**  
TE KUNENGA KI PŪREHUROA  
UNIVERSITY OF NEW ZEALAND

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 22/58. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email [humanethicsoutha@massey.ac.nz](mailto:humanethicsoutha@massey.ac.nz).

## Appendix D

### Permission to Post Recruitment Graphic

Dear **Administrators Name**

My name is Melinda Lewthwaite and I am a PhD student at Massey University. I am currently conducting a research project under the supervision of Prof Sarah Riley and Dr Andrea LaMarre.

My research aims to explore experiences of people who have altered their diet to manage irritable bowel syndrome (IBS). People with IBS manage food in different ways. Sometimes these feel functional and help them feel healthy and enable them to live their lives in ways that work for them. Other times, these ways of managing food can feel challenging or limiting. These could also both be true for the same person. I want to know more about people's motivations for adopting dietary changes for IBS related gastrointestinal symptom management and what this looks like on a day-to-day basis.

I am currently recruiting for participants to take part in our research project and would like to ask your permission to post a digital recruitment image (provided below) on your **social media page / online group or platform** during our recruitment period of April to June 2020.

Whilst there is no obligation for you to agree, your permission to do so would be greatly appreciated. If you do provide permission and would later like the post to be deleted at any time, please contact me and I will do so immediately.

If you have any questions or would like any further information, please feel free to contact myself or my supervisor on the details provided below.

Thank you for your time and consideration.

Yours sincerely

Melinda Lewthwaite



## Project Contacts:

### Melinda Lewthwaite

School of Psychology, Massey University  
Auckland Campus

### Supervisor

Prof. Sarah Riley  
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### Supervisor

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Auckland Campus  
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### Supervisor

Dr. Andrea LaMarre  
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### Clinical Support

Dr. Kirsty Ross  
School of Psychology  
Massey University  
Palmerston North Campus  
Email: [K.J.Ross@massey.ac.nz](mailto:K.J.Ross@massey.ac.nz)

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application SOA 22/58. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email [humanethicsoutha@massey.ac.nz](mailto:humanethicsoutha@massey.ac.nz).

## Recruitment Graphic

**Have you changed your diet to manage Irritable Bowel Syndrome (IBS)?**

You are invited to participate in a research project aiming to explore experiences of people who have altered their diet to manage irritable bowel syndrome (IBS). I want to know more about people's motivations for adopting dietary changes for IBS related gastrointestinal symptom management and what this looks like on a day-to-day basis.

I am looking to interview 20-25 people who self-identify as having altered their diet to manage IBS. You may have been advised by a healthcare professional to make dietary changes, or you may have decided to make dietary changes yourself.

To take part, you will have been diagnosed with IBS, be over 18 and currently living in Aotearoa New Zealand. Your participation would involve attending an online (Zoom) interview (approx. 1 hour). You will also be invited to participate in an optional digital photo diary exercise and follow-up online (Zoom) interview (approx. 1 hour each).

Your time and contribution would be recognised with a \$40 voucher for each interview you attend and a \$40 voucher if you choose to create a digital photo diary.

If you are interested in participating or would like to receive more information about taking part in this study, I would love to hear from you.

Research contact: Melinda Lewthwaite  
Email: [melinda.lewthwaite.1@uni.massey.ac.nz](mailto:melinda.lewthwaite.1@uni.massey.ac.nz) // Tel: [REDACTED]

 **MASSEY UNIVERSITY**  
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UNIVERSITY OF NEW ZEALAND

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 22/58. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email [humanethicsoutha@massey.ac.nz](mailto:humanethicsoutha@massey.ac.nz).

## Appendix E

### Information sheet



## Have You Changed Your Diet to Manage Irritable Bowel Syndrome (IBS)?

### INFORMATION SHEET

#### Researcher Introduction and Invitation to Participate

My name is Melinda Lewthwaite and I am a PhD candidate from the School of Psychology at Massey University. I am conducting this research for my PhD thesis entitled "Exploring entanglements of irritable bowel syndrome, dietary practices and disordered eating / eating disorders" under the supervision of Prof. Sarah Riley, Dr. Andrea LaMarre, Dr. Kathryn McGuigan and Dr. Kirsty Ross.

You are invited to participate in this research, which aims to explore experiences of people who have altered their diet to manage irritable bowel syndrome (IBS). People with IBS manage food in different ways. Sometimes these feel functional and help them feel healthy and enable them to live their lives in ways that work for them. Other times, these ways of managing food can feel challenging or limiting. These could also both be true for the same person. I want to know more about people's motivations for adopting dietary changes for IBS related gastrointestinal symptom management and what this looks like on a day-to-day basis.

#### Who Can Participate?

I am aiming to speak with 20-25 individuals who self-identify as having altered their diet to manage IBS. You may have been advised by a healthcare professional to make dietary changes, or you may have decided to make dietary changes yourself. To take part, you will have been diagnosed with IBS, be 18 years or older and currently living in Aotearoa New Zealand. Interviews will be conducted in English, so proficiency in English is also required.

#### What Does Participation Involve?

There are several ways you can participate in this study. The first is to participate in an online (Zoom) interview of approximately one hour. During the interview you will be asked questions about your day-to-day dietary practices and how they relate to managing IBS. Depending upon your experience, this may include talking about the positive aspects of your day-to-day dietary practices or how changing your diet has been beneficial or successful for you. It may also include talking about experiences which have been challenging, the things you have found difficult or problematic, or aspects which might be associated with feelings of distress. You will also be asked to provide some demographic information.

At the end of this interview, you will be asked if you would like to participate further by creating a digital photo diary. This is an **optional** exercise and would involve taking a range of digital photos across a two-week period and writing a caption about each of your photos. You would be required to take a minimum of 5 photos if you choose to participate. You may take as many additional photos as you like and write as much or as little as you like about each of your photos. Digital photo diaries are designed to capture moments in your day-to-day life where

your dietary practices and gastrointestinal symptoms may impact each other, other aspects of your life or how you feel. Creating a digital photo diary would take approximately one hour, however may take longer depending upon how many additional photos you choose to take.

Once you have completed and submitted your digital photo diary online, you will then be invited to participate in a final, **optional**, follow-up online (Zoom) interview to discuss 5-10 of the photos you have selected and diary entries you have created. This interview session would take approximately one hour.

Secure Wi-Fi/mobile data will be required to participate in Zoom interviews and to submit digital photo diaries. If you do not have access to Wi-Fi/mobile data and would like to participate, please contact me and we can provide a credit contribution to enable your participation.

#### **Possible Benefits and Incentives**

This research may contribute to expanding the field of knowledge around the relationship between day-to-day dietary practices and gastrointestinal disorder management. As a token of appreciation, participants will be provided with a \$40 voucher for each interview they participate in and a \$40 voucher for participating in the digital photo diary exercise.

#### **Possible Risks and Discomfort**

It is possible you may experience feelings of distress or discomfort during your participation in this research due to the nature of the topics being discussed during your interview (e.g. dietary practices and experiences of living with IBS symptoms), whilst taking photos / writing about your photos or reflecting upon your experiences.

If you experience distress at any time during your participation and would like to seek further support, a list of support services is provided on the last page of this document. Whilst treatment and/or counselling is not able to be provided to participants, if you become highly distressed or I am concerned about you, I can organise (with your consent) for a registered senior clinical psychologist experienced in both health conditions and eating distress to give you a call at a mutually suitable time to check in with you to ensure you are safe and OK.

#### **Data Management**

All interviews will be audio recorded and transcribed. If you would like to receive a copy of your transcripts to review, please select this option on your consent form and you will have two weeks to provide feedback and/or amendments. Any amendments or revisions made by participants will be incorporated into the transcripts. If you do not respond by the specified return date, your transcripts will be considered final.

If you further choose to participate by creating a digital photo diary, the photos and text you generate for this project will be used for analysis and may be published. The online consent process will outline a range of options regarding the management and use of your digital photos. You may also specify your own preferences in addition to these options. Potential privacy and confidentiality issues associated with digital images and options for managing these will also be discussed with you.



Your demographic details, audio files, transcripts, digital photos and text submissions will be securely stored and anonymized. You may choose a pseudonym so that you cannot be identified, or one will be chosen for you. If you agree, your anonymized data may be placed in an official archive for the purpose of providing legitimacy to the study findings if published and to contribute to a global publicly accessible database. This means that your anonymized transcripts/images/text can be viewed by anyone searching the public archive it has been uploaded to. You do not need to agree to your data being archived to participate in the study and these options will be discussed with you and outlined on the consent form. If your data is not archived, it will be stored for 5 years and then securely destroyed.



Research findings will be used for my PhD thesis, academic publications, presentations and other plain language knowledge sharing pieces and activities such as reports, articles, webinars, blog posts or podcasts. If you would like to receive a copy of the research findings upon completion of this research, please select this option on your consent form and a summary of the findings will be emailed to you on the address you have provided at the bottom of your consent form.

#### Participant's Rights

There is no obligation to accept this invitation to participate. If you do choose to participate, you have the right to:

- decline to answer any particular questions you are not comfortable with, and/or ask for the audio recording to be stopped at any time during the interview process.
- You may withdraw from the study at any time up until 2 weeks after your interview or two weeks after having received your transcripts back for review if you have chosen this option.
- For those choosing to create a digital photo diary, you may withdraw from the study at any time up until two weeks after submitting your digital photo diary.

You are also welcome to ask questions about the study at any time during participation and will receive a summary of research findings once concluded.

Thank you for your time and interest.

#### Project Contacts

If you have any questions or concerns, or would like any further information, please contact myself or my supervisors:

Melinda Lewthwaite: Email: Melinda.Lewthwaite.1@uni.massey.ac.nz  
School of Psychology, Massey University, Auckland Campus

##### Supervisor

Prof. Sarah Riley  
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##### Supervisor

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**Supervisor / Clinical Support**

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No conflicts of interest are identified with this research.

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 22/58. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email [humanethicsoutha@massey.ac.nz](mailto:humanethicsoutha@massey.ac.nz).

**SUPPORT SERVICES**

**EDANZ**

Phone: 0800 2 EDANZ or (09) 5222679  
Email: [info@ed.org.nz](mailto:info@ed.org.nz)  
<https://www.ed.org.nz/>

**Lifeline**

0800 543 354 (0800 LIFELINE)  
or free text 4357 (HELP) 24/7

**1737 Need to Talk?**

Free call or text 1737 for support from a trained counsellor

**Depression Helpline**

0800 111 757 or text 4202

**Anxiety Helpline**

0800 269 4389 (0800 Anxiety)

**Healthline**

0800 611 186

**Albany Psychology Clinic – Massey University**

Level 3  
North Shore Library Building (off Kell Drive)  
229 Dairy Flat Highway  
Albany Village, Auckland  
Tel: (09) 213 6095  
Fax: (09) 414 7328  
Email: [Centreforpsychology@massey.ac.nz](mailto:Centreforpsychology@massey.ac.nz)

**Massey Health and Counselling Centre (For Massey Students)**

09 213 6700  
[Studenthealth@massey.ac.nz](mailto:Studenthealth@massey.ac.nz)  
[https://www.massey.ac.nz/massey/student-life/services-and-resources/health-counselling-services/counselling/counselling\\_home.cfm](https://www.massey.ac.nz/massey/student-life/services-and-resources/health-counselling-services/counselling/counselling_home.cfm)

A full list of mental health crisis teams is available here: <https://www.health.govt.nz/your-health/services-and-support/health-care-services/mental-health-services/crisis-assessment-teams>

## Appendix F

### Online Consent Form – Semi-Structured Interviews



## Have You Changed Your Diet to Manage Irritable Bowel Syndrome (IBS)?

### INDIVIDUAL PARTICIPANT CONSENT FORM - DIGITAL INTERVIEWS

I have read and understand the Information Sheet for this study. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time up until 2 weeks after the date of my interview. If I elect to have my transcripts returned to me for review, I may withdraw at any time up until two weeks after my transcripts have been returned to me for review.

I agree to participate in this study under the conditions set out in the Information Sheet  
I agree to my interview(s) being sound recorded  
I would like to have my transcripts returned to me for review  
I agree to having my anonymized interview transcripts placed in an official archive. The purpose of doing so is to provide legitimacy to the study findings if published and to contribute to a global publicly accessible database. This means that your anonymized transcript can be viewed by anyone searching the public archive it has been uploaded to. You do not need to agree to having your data archived to participate in the study. If you say yes, you will also have an opportunity to review your decision before your transcripts are archived.  
I would like to receive a summary of the research findings

Y/N

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If you have elected to receive a copy of the research findings or would like to review your transcripts, please provide an email address for these documents to be sent to:

\_\_\_\_\_

#### Declaration by Participant:

I \_\_\_\_\_ [print full name] hereby consent to take part in this study.

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

Massey University  
School of Psychology  
Level 3, North Shore Library Building  
229 Dairy Flat Highway  
Albany Village Auckland 0632  
New Zealand

## Appendix G

### Online Consent Form – Digital Photo Diaries and Follow-up Interview



#### INDIVIDUAL PARTICIPANT CONSENT TO PARTICIPATE IN CREATING A DIGITAL PHOTO DIARY AND A FOLLOW UP ONLINE INTERVIEW

I have read and understand the Information Sheet and the Digital Photo Diary Guidelines for this study. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study. I understand participation is voluntary and that I may withdraw from the study at any time up until two weeks after submitting my digital photo diary. If I choose to participate in a follow-up interview, I understand that I may withdraw from the study at any time up until two weeks after my interview. If I have elected to review my transcripts, I may withdraw from the study at any time up until two weeks after receiving my transcripts.

Y/N

#### DIGITAL PHOTO DIARY

I agree to participate in this study under the conditions set out in the Information Sheet and the information provided in the Digital Photo Diary Guidelines

I agree to having the images/text I have generated for this research being used for analysis

I agree to having the images/text I have generated for this research being used for publication (e.g. academic journal articles) or other public forums (e.g. conference presentations, reports, blog articles). I acknowledge that images chosen for publication will be edited to remove identifiable features through the use of pixelation, blurring or cropping tools.

I would like to be contacted to discuss the use of my images/text for analysis/publication or would like to specify different preferences for the use of my images/text as indicated in the space below (a text box will be provided in the Qualtrics form if yes).

I agree to having the images/text I have generated for this research being placed in an official archive. The purpose of doing so is to provide legitimacy to the study findings if published and to contribute to a global publicly accessible database. This means that your anonymized images/text can be viewed by anyone searching the public archive it has been uploaded to. You do not need to agree to this to participate in the study. If you say yes, you will also have an opportunity to review your decision before your photos/text are archived.

I would like to receive a summary of the research findings

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229 Dairy Flat Highway  
Albany Village Auckland 0632  
New Zealand

## FOLLOW-UP INTERVIEW

I agree to take part in a follow-up interview to discuss the diary content I have generated and my experience of creating a digital photo diary.

I agree to my interview being sound recorded

I understand that whilst the digital images I have selected to share for discussion during this interview will be displayed on screen during the session, a visual recording will not be made of the interview.

I would like to have my transcripts returned to me for review

I agree to having my anonymized interview transcripts placed in an official archive. The purpose of doing so is to provide legitimacy to the study findings if published and to contribute to global publicly accessible database. This means that your anonymized transcript can be viewed by anyone searching the public archive it has been uploaded to. You do not need to agree to having your data archived to participate in this study. If you say yes, you will also have an opportunity to review your decision before your transcript is archived.

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## Declaration by Participant:

I \_\_\_\_\_ [print full name] hereby consent to take part in this study.

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

Massey University  
School of Psychology  
Level 3, North Shore Library Building  
229 Dairy Flat Highway  
Albany Village Auckland 0632  
New Zealand

## Appendix H

### Personal Details Forms



**MASSEY UNIVERSITY**  
**TE KUNENGA KI PŪREHUROA**  
**UNIVERSITY OF NEW ZEALAND**

#### PERSONAL DETAILS

So that we may learn about the range of people participating in this research, it would be greatly appreciated if you could answer the following personal information questions below.

Any information you choose to provide will not be individually identifiable and will only be used to describe everyone who is taking part in this research as a group.

|    |                                                                                   |  |
|----|-----------------------------------------------------------------------------------|--|
| 1. | How old are you?                                                                  |  |
| 2. | What is your gender identity?                                                     |  |
| 3. | What is your current occupation?                                                  |  |
| 4. | What ethnicity(s) do you identity with?                                           |  |
| 5. | Are there any other demographic details you would like to provide about yourself? |  |

To protect your identity, your pseudonym will be allocated for you by the researcher, or you may choose to use your real name.

If you would like to select your own pseudonym (fake name) please advise the name you would like to use \_\_\_\_\_.

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## Appendix I

### Semi-Structured Interview Schedule



### INTERVIEW QUESTION SCHEDULE

#### Establishing diagnostic background / how dietary changes came to be made

|    |                                                                                                                         |
|----|-------------------------------------------------------------------------------------------------------------------------|
| 1. | How did you come to understand that you might be living with IBS?                                                       |
| 2. | How did you come to change the way you eat after becoming aware you might have IBS (or after being diagnosed with IBS?) |

#### Dietary Related Questions

|     |                                                                                                                                                                                                                                                                            |
|-----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 3.  | Are you following a particular diet at the moment?                                                                                                                                                                                                                         |
| 4.  | What would a 'usual' day of eating look like for you?                                                                                                                                                                                                                      |
| 5.  | How might this differ from how you would have previously eaten before IBS?                                                                                                                                                                                                 |
| 6.  | What would 'healthy' eating look like for you in your day-to-day life context?                                                                                                                                                                                             |
| 7.  | Have you experienced any benefits of the way you currently eat?<br>If so, what have those been?                                                                                                                                                                            |
| 8.  | Have you experienced any limitations or difficulties in relation to having changed the way you eat?                                                                                                                                                                        |
| 9.  | Has changing your diet impacted your life in other ways? If so, what ways?                                                                                                                                                                                                 |
| 10. | If you were unable to follow your preferred / required way of eating – how would this impact you?<br><br><i>Prompt: Would you do anything differently the next meal / day / week etc. if you didn't or weren't able to follow your preferred / required way of eating?</i> |
| 11. | Is there ever a time when you don't eat in the way you usually do?<br><br><i>Prompt: why / how does that go?</i>                                                                                                                                                           |

\*CHECK IN POINT – How is participant feeling, do they need a break, are they OK to proceed?

### IBS // Embodiment Related Questions

|     |                                                                                                                                                                                                                                                                                                            |
|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 12. | Are there any IBS specific treatment factors (other than diet) which impact how you eat on a day-to-day basis?                                                                                                                                                                                             |
| 13. | How does the way your body feels impact your food choices or the way you eat?<br><i>Are there any body sensations in particular that impact your food choices or the way you eat? // What does it feel like when things are not quite right? // What does it feel like when things are going smoothly?</i> |
| 14. | Have you noticed that your body might respond differently to food in different ways at different times?                                                                                                                                                                                                    |
| 15. | What does a symptomatic response feel like in your body?<br><i>If you have eaten something and your experience a symptomatic response how might that impact you and how you feel?</i>                                                                                                                      |
| 16. | Are there times when the way you experience your body might impact you in other ways?                                                                                                                                                                                                                      |
| 17. | How does living with IBS impact the way you think about food?                                                                                                                                                                                                                                              |
| 18. | How does living with IBS impact the way you feel food?                                                                                                                                                                                                                                                     |
| 19. | Are there any questions you would like to be asked?                                                                                                                                                                                                                                                        |
| 20. | Is there anything else you would like to talk about that we haven't already covered?                                                                                                                                                                                                                       |
| 21. | How are you feeling now after having talked about food and symptoms and bodies for the past hour?                                                                                                                                                                                                          |

\*CHECK IN POINT – How is participant feeling, debrief, support check.



## Appendix J

### Digital Photo Diary Guidelines



## DIGITAL PHOTO DIARY GUIDELINES

Thank you for your time so far. I warmly invite you to continue your participation and consider creating a digital photo diary. The digital photo diary exercise intends to capture your experience of living with IBS and how this relates to your day-to-day dietary practices.

### **What do I need to do?**

If you would like to participate, you will be invited to take a series of digital photos over a two-week period which capture your experience of living with IBS and how this might impact on or influence your day-to-day dietary practices. If you would like to, you are also welcome to write a caption to accompany each of the photos you take.

### **How many photos should I take and how much should I write?**

If you choose to participate I would appreciate it if you took a minimum of 5 photos. You may take as many additional photos as you like. You may decide to capture an image on some days but not on others, or there may be days where you choose to take multiple images. You may choose to write only a few words (or none) for some images and many for others.

### **What should I take photos of and what should I write?**

This exercise is about your experience. You can take photos of whatever you feel captures your embodied experience of living with IBS and how this relates to your day-to-day dietary practices. The photos you choose to take might relate to your day-to-day food choices or the dietary advice you follow, your experience of living with a gastrointestinal disorder, how you feel about food or your body at certain times, or anything you feel is important about your experience of having made dietary changes to manage your gastrointestinal symptoms. If you choose to write a caption for your photo, you might like to write about your inspiration for capturing that image in that moment, how you felt when taking the photo, how your body was feeling at this time, any sensations you were experiencing, what the image means to you or anything else you would like to write about and share.

### **Guidelines for Taking Digital Photos // Including Identifiable Others**

As the digital photos captured for this project have the potential to contain personal identifying features (such as faces, other people, locations) there are a number of guidelines that need to be followed. These relate to ethical considerations such consent, privacy, anonymity and confidentiality of anyone who might appear be in your images.

- If your digital image contains another person who can be identified in the image (e.g. a family member and their face is visible), you must obtain permission from that person before the image can be taken and submitted with your digital diary.
- The person must be told why the photo is being taken (for the purposes of participation in this study) and what the photo will be used for (analysis and publication).

- If the person then agrees to appearing in your image, they will need to provide their consent via one of the following methods:
  - An online Qualtrics link: [CONSENT LINK](#)
  - Complete a hard copy consent form which can be photographed and submitted with your digital diary.
  - The consent form may also be read aloud by the person, audio recorded on your phone and submitted with your digital diary.
- Any photos selected for publication containing identifiable features such as faces or location names will be anonymised through the use of blurring or pixelation.
- Please do not produce any digital images which depict anyone in an undignified, demeaning or discriminatory manner or capture images that may infringe upon another person's privacy.

### **Returning your Digital Photo Diary**

There are a number of ways you can return your digital photo diary. You may either submit individual diary entries (image and accompanying text) 'as you go' or you can submit all of your diary entries together at the end of the two-week period. Submissions can be made via SharePoint – you will be sent a link to a secure and individualised folder where you can upload your photos and text. If you are uploading multiple photos and text, please number each photo and each text submission so it is clear which text corresponds to which photo.

### **Follow Up Interview – Photo Sharing and Discussion**

After submitting your digital diary, you will be invited to participate in an *optional* follow up interview to discuss the experience of creating your diary and the digital images you have taken. If you would like to participate, you will be invited to choose 5-10 photos that we can talk about together. These 5-10 images would be shared via Zoom screen sharing during the interview. This interview will be audio recorded so that a transcript of the interview can be produced, but not visually recorded.

### **Consent to Participate and Options for Digital Photo Images**

Before commencing your digital photo diary, I will need to obtain your written consent via the following Qualtrics link [to be inserted]. This consent form also outlines a number of options that you may select which relate to the submission, use and potential publication of the photos/text that you produce for this research project. You may also specify your own preferences for the use of your photos on this link.

### **Questions?**

If you have any questions, please feel free to contact me via email:  
Melinda.Lewthwaite.1@uni.massey.ac.nz

## Appendix K

### Digital Photo Diary Follow Up Interview Schedule



### DIGITAL PHOTO DIARY INTERVIEW QUESTION SCHEDULE

#### Digital Image Selection

|    |                                                                                                             |
|----|-------------------------------------------------------------------------------------------------------------|
| 1. | Can you tell me about this image<br>What was happening in this moment? / Where was it taken / Who is in it? |
| 2  | What moved / motivated you to take this photo?                                                              |

#### Embodiment Focus

|  |                                                                         |
|--|-------------------------------------------------------------------------|
|  | Can you recall what you were thinking at the time?                      |
|  | Can you recall what you were feeling when you took the image?           |
|  | What symptoms were you experiencing (if any?) when you took this image? |
|  | Do you remember what you did before or after taking the photo?          |

#### Discussing Photos During the Interviews

|  |                                                                                                                                                                         |
|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | Looking back now on the photos you have taken, how do these image make you feel about the way you eat on a day-to-day basis?                                            |
|  | Hav shared these photos today, have they brought up any other memories or experiences you'd like to share?                                                              |
|  | Was there anything you would have liked to have taken a photo of but didn't?<br>What stopped you from taking that photo?                                                |
|  | Is there anything else you would like to share about having changed your diet to manage IBS which isn't depicted in your photos?                                        |
|  | Is there anything you would like others to know (friend, family healthcare professionals) to know about what it is like having to have changed your diet to manage IBS? |