With different modes of care come different modes of living

Embodied Cartographies of Eating Disorders Care and Recovery

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Abstract

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In this dissertation, I take up the question of how women who were diagnosed with an eating disorder experienced the processes and outcomes of undergoing treatment within a contemporary Spanish context. I explore the care articulated within treatment systems, how it feels, and how it shapes later recoveries. I examine when systems fail to hold people in recovery and how to better support them in their trajectories towards wellness. I also investigate how recovery looks and feels like and how their experiences challenge dominant discourses about what it means to recover.

To this end, I conduct interviews with ten women (24-33) from Catalonia, Spain, about their experiences navigating eating disorders treatment systems and their recoveries. Participants explored feeling mistrusted, and their personal needs disregarded during treatment but also expressed feeling seen and validated. Surveillance prominently featured in participants' stories both during treatment and once in recovery. The multiple and diverse ways participants live their recoveries points toward the need to render visible other, more realistic stories about what it means to be recovered.

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It has been a long, challenging journey. Luckily, I have had company along the way. I want to express my gratitude to Alba, for her constant support, and her ability to find better words to untangle my most knotted sentences.

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Introduction

What is good care in eating disorders treatment? And how should we go about achieving it? In which ways does eating disorders' care generate possibilities or impossibilities of recovery? How does eating disorders recovery look like? We might say that, in the context of eating disorders, what constitutes good care are all those practices that foster recovery. However, after decades of research, eating disorders recovery still remains an elusive concept and it is argued to be poorly defined. If we are still in the dark in regard to what recovery looks like, how do we assess good care? In this thesis, I tackle the processes of healing from eating disorders and their possible outcomes through the experience of women who have undergone treatment. I depart from their embodied experiences in order to enrich what we know about eating disorders and challenge various discourses producing them.

I seek to address two different questions with regard to eating disorders. The first has to do with its care and the latter with its elusive cure. Concerning care, I aim to investigate how practices of care deployed in eating disorders treatment may open or foreclose possibilities of recovery. For this purpose, I retrospectively arrange an ethnography of daily care in an eating disorders treatment centre to explore how participants' lived experiences of healing from eating disorders might trouble dominant prescriptions and possibilities for its recovery. I join women who once were treated traveling through their memories to the places where this care took place. I sit at the table during lunchtime, engage in ambivalent supportive relations, follow strict rules and experience life under total surveillance to articulate the various tensions - sometimes silent embodied ones - that come with specific modes of caring.

The point of this research is not to prove care practices right or wrong. Care always carries ambivalence - it does not assume universal moral principles, but it focuses on how various courses of action work differently in specific situations -. Thus, care might mean and do different things to diverse individuals in various moments of their lives. Instead, I intend to reflect on how with different modes of caring come different modes of living.

In a context where recovery remains poorly defined and clinically assessed in terms of nutritional and/or weight restoration and symptom remission, different modes of living might be a better goal to strive for in treatment than recovery itself. However, despite the lack of scientific consensus over what constitutes recovery, the concept is already imbued with different meanings that gate-keep access to it. Thus, this thesis's second interest is to explore how mainstream ideas around recovery acquired during healing processes are challenged and renegotiated in participants' own ways of inhabiting and understanding the experience.

Dominant discourses that shape what we know about eating disorders almost exclusively inform treatment systems and their care practices as well as representations around recovery. By centring the lived, embodied experience of women who have undergone an institutionalized healing process with different outcomes, I aim to analyze how their care and recovery experiences challenge various discourses about what we know about the distress. For this reason, in chapter one, I provide an overview of clinical approaches to eating disorders throughout history to form a genealogical idea of how the dominant discourse is produced and sustained. This allow me to show how clinical explanations of eating disorders inform unquestioned ideas about its care and recovery, and later assess how these might be problematized when making space for patient's voices and embodied experiences.

Next, I expand on how these dominant clinical views have been challenged or reformulated from different feminist approaches while also exploring the problems they might pose. The main currents that I analyze are structuralist, poststructuralist and new materialist feminist accounts on eating disorders. Each of these adds a particular value to the discussion on eating disordered experiences and bodies while also providing alternative possibilities for understanding care and recovery processes. This is important in a context in which the term 'recovery' remains poorly defined in what respects to mental health issues. Different definitions and expectations of eating disorders and its recovery shape different methods and practices of care. Thus, from a feminist standpoint, it is a priority to problematize definitions that do not take embodied experience and situatedness as a point of departure.

Lastly, I briefly touch upon the concepts of care and recovery to engage in a number of relevant problematizations. Here I explore how the process towards recovery might be better grasp if we understand it through a space-based metaphor rather than a time-based one. I also explore biopedagogies of recovery and recovery assemblages to unveil how recovery is always a situated and relational process. Finally, I lay out different approaches to care that might be useful to rethink how to strive for good care in eating disorders treatment.

Objectives

In this thesis, I aim to contribute to the scarce literature exploring stories about healing and recovering from eating disorders told by individuals who have experienced them. While much has been said on the what, why and how of eating disorders, less research has been conducted on the experience of recovering and recovery itself. The lack of literature is even more striking regarding the experience of recovery from patients' own voices. Hearing stories about eating disorders recovery that do not fit popular representations is even rarer. Filling the gap left by stories told in first-person, this research employs a qualitative method to give voice to women who once engaged in an institutionalized recovery process from eating disorders. I explore these stories using semi-structured interviews to illuminate the unique perspective of those most affected. Through their stories, I hope to answer the following questions.

- How do experiences of care in treatment open or forecloses possibilities of recovery?
- How women who have been diagnosed with eating disorders understand and experience recovery.

Further expanding on these two main research questions, this research is also interested in interrogating the body not as a passive object but as an active agent in the healing journey. Since the process of recovery fosters a radical mind-body disconnection while also intensely targeting the body as a passive vessel waiting to be nutritionally stabilized, this research also seeks to unveil in which ways the body mediates the process of living and healing from eating disorders.

Chapter 1: Literature Review

Eating disorders (EDs) are a relatively modern concept. It was not until the end of the XIX century when anorexia nervosa emerged as a medical diagnosis as the first out of a broader spectrum of EDs. However, practices currently associated with modern eating disorders, such as fasting, appear in virtually the history of all religions as an ascetic discipline for both genders (Sayers, 2009, p. 27). It was not until the nineteenth century that the religious construction of fasting was gradually supplanted by a medical, scientific discourse by which starvation - a practice later identified with anorexia - came to be diagnosed as a symptom of hysteria (p.27). Since then, anorexia has been linked to sexual frustration - Lasègue and Freud - amongst many other interpretations. In this chapter, I aim to outline the process of medicalization through which current clinical diagnosis of eating disorders got to be understood. I consider this a necessary exercise for this thesis's aim, as eating disorders care and their recovery are deeply entangled with the evolving definition of the distress.

Feminist views on the matter have argued that the clinical literature on eating disorders has concentrated on description, classification and the elaboration of the pathology (Bordo, 1993). This particular focus led to a disembodied understanding of the distress on the part of the clinic's discourse; a reading that tries to distil its workings from the person's experience to pack it into a coherent entity, a disorder, something that exists on its own, outside of its context. From its modern appearance with the emergence of anorexia as a medicalized notion by the end of the XIX century (Brumberg, 1988), until its contemporary, all-encompassing denomination of *Feeding and Eating Disorders* (APA, 2013), EDs have been subjected to an ongoing process of redefinition and resignification. Moreover, other critical views writing from cultural, social and feminist critique positions have argued for other theorizations of the experience claiming that it needs to be understood otherwise. In many senses, EDs have remained at the centre of a contested debate. But, as important socio-cultural analysis has been, dominant understandings of EDs still remain hegemonically hold by the clinic.

Within this position of power, the *American Psychiatric Association (APA)* is considered an international authority. It is the producer and publisher of the widely used *Diagnostic and Statistical Manual of Psychiatric Disorders (DSM)*[1], which sets the criteria needed to diagnose specific mental disorders. The DSM largely articulates what we know to be true about EDs and how clinicians and others may interpret behaviours from individuals with an eating disorder diagnosis. For example, from DSM description, non-compliance is understood as part of the individual's pathology, instead of being read as a disconnection between patients' needs and the care received (Malson et al., 2004 as cited in LaMarre, 2014, p.6).

The DSM clinical truths are far from being static realities, and they are also partly socially constructed - for example, in the last published edition, categories were re-shuffled to correspond more closely to the incidence of behaviours in clinical populations (LaMarre, 2014). Therefore, even within the scientifically objective limits of this diagnostic technology, the contours of the experiences falling under the category of eating disorders have proven to be mutable. In other words, EDs have shown to be a volatile reality, as their aetiology, symptoms and categories are still subjected to an ongoing process of revision and modification.

Critical positions have argued how DSM's medical diagnostic technology wagers on biologist approaches and forgets about patient's subjectivity by focusing on their pathological symptoms (Gil, 2005). That is, DSM's approach subtracts the body from its symbolic and social meaning and separates the mental disorder from the social framework producing it. Given the authority held by the DSM, this is the view that ends up imposing itself and shaping the limits and scope of the discussion on eating disorders.

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[1] Currently defined by its own creators as "an authoritative volume that defines and classifies mental disorders in order to improve diagnoses, treatment and research" (American Psychiatric Association web, 2020)

Therefore, DSM's articulation of eating disorders can be approached as discursive practices. Following Karen Barad (2003), discursive practices are not what is said; but rather what constrains and enables what can be said (p.819). This understanding entails assuming that in shaping EDs, DSM's discursive practices do not merely describe but rather *produce* them. Hence, scientific knowledge of EDs cannot be said to have ever been a neutral depiction of reality; rather, EDs definition is always socio-historically bounded. Good evidence of this is the historical medical evolution of the experiences that fall under the category of eating disorders.

The historical clinical evolution of eating disorders

Anorexia, the most popular and first to be studied type of EDs, acquired its clinical status by the end of the XIX century. In 1874, British physician William Withey Gull described a condition of "moral or mental aberration rooted in the nervous system but exacerbated by the patient's age, her mode of life, or both" (Brumberg, 1988, p.11) and gave it the name of *anorexia nervosa*. Even though Gull included mental distress as the core of the condition, the cure was still to be found in the sufferers' body (Brumberg, 1988). For that matter, he prescribed caloric diet, physical care, rest under guardianship and "parentectomy", isolation from family members and loved ones as its treatment.

By the beginning of the new century, new explanatory theories arose. The psychological approach began to be shaped, while biologistic understandings were fueled by the emergence of endocrinology, a discipline that attributed anorexia to a hormonal deficit (Gil, 2005). In the mid-nineteenth century, anorexia began to be considered a disease in its own right instead of a common symptom for various illnesses such as female hysteria (Brumberg, 1988, p.92). During the same period, the *American Psychiatric Associatio*n initiates a nosotaxical process whereby it starts to develop a mental illness classification. By 1952 we assist to the born of the DSM with the publication of its very first edition. Nevertheless, it will not be until the 1980s when eating disorders specificity was first addressed in its third edition (DSM-III, 1980).

To be classified as a disorder is to be recognized as a syndrome. According to the DSM-V (2013), a syndrome can be understood as a cognitive disturbance in the individual, an imbalance in behaviour or in emotional regulation that can stem from a psychological, biological or developmental dysfunction of the mental functioning (p.20). Therefore, the disorder is located within the individual body's limits, which individualizes the distress while concealing its socio-cultural dimension. According to the manual, there is a clear distinction between what counts as a mental disorder and an "expectable or culturally approved response to common stressors or loss" (p.20). This clear differentiation shapes an individual's normative behaviours, defining what can cause distress in someone's life and how reality is to be renegotiated by subjects. For example, in the specific case of eating disorders, the manual effectively draws a line that demarcates "normal" eating from "pathological" eating. In other words, the DSM produces normativity through the definition of its constitutive (defective) other: pathology.

This inherently dichotomous logic has been criticized by both crip studies scholars and the survivors movement, as it fails to situate the diversity of human experience within a wider continuous spectrum. Instead, mental disorder constructs create discrete, self-evident and mutually exclusive categories - illness/health, disordered/sane - that have marginalizing effects on those who are found outside of the norm. Confronting this dualistic conceptualization, crip theorists have worked to "explore the creation of such categories and the moments in which they fail to hold" (Schalk, 2013, p.9). Likewise, the survivors movement have campaigned against this medical model of distress, arguing for the need to stop tackling their experiences through "analysis, eradication, and mechanical and chemical constraint" and move to tinker with them with "understanding, empathy, support and a holistic approach to the body and self" (Beresford, Wallcraft, 1997).

With EDs' inclusion within the DSM came a significant growth in the clinical production addressing the issue at hand. The circulation of this new diagnostic technology boosted clinical researches' and epidemiologists interest, whose investigations were always focused on the same variables: weight, eating conduct and disturbed thoughts, the three aspects considered to be at the core of eds (DSM-V). If the disorder is to be defined in terms of deviant body weight and disturbed eating behaviours, diagnosis can be determined through measurable traits, both physical (Body Mass Index[2]) and behavioural (the extent to which eating habits deviate from the norm). However, not only diagnosis but also recovery has tended to be defined in terms of weight gain and eating habits reeducation. This conceptualization, widely accepted by the clinic, is more commonly held by the biomedical model, and it is later expanded by the emergence of the psychosocial approach.

In the Spanish context, the specific geopolitical location where this thesis' fieldwork takes place, the biomedical model was the prevalent framework from which eating disorders were clinically managed during the first half of the nineties. Gil's research work about Spanish discursive accounts on eating disorders unveils how clinic's primary focus on weight overlooked emotional healing as a necessary dimension of its treatment. Within this model, only one environmental factor was taken into account: family. At that time, the Spanish clinical literature regarded the family as the institution responsible for sufferers' eating habits. Dysfunctional family dynamics were seen as favouring stressors. Thus, isolation - for the sake of re-establishing familiar control and organization - was prescribed in treatment (Gil, 2005). Nevertheless, the most common form of

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[2] Body Mass Index (BMI) is a weight-to-height ratio used by a wide range of professionals - from health care providers, insurance companies, physical trainers, dietitians and scientifics - to measure body fat. It categorizes a person's weight as underweight, normal weight, overweight or obese. The formula was first developed by Belgian mathematician Adolphe Quetelet in 1832 using a sample predominantly western European - French and Scottish - entirely composed of men. It was firstly designed to measure populations, but in 1972 it was reintroduced by physiologist Ancel Keys as a measure of individual health. It has been criticized as a tool to assess health, as it assumes weight directly correlates health. It also does not take into account body composition - fat, muscle - which makes it flawed as a reliable tool. But more importantly, it is a tool based on findings derived from an homogenous population pretended to be fit for universal use.

treatment performed in the Spanish context was operant conditioning techniques, or behavioural therapy focused on nutritional recovery and improving eating conducts (Gil, 2005, p.164).

While the biomedical model mainly focuses on body weight and eating-related behaviours, the psychosocial is known for widening its analysis scope. Thus, the problem is not only to be found in the body, and its cure is no longer to be achieved through medical solutions, rather EDs are psychological malaises, and its healing needs to be pursued through psychotherapy. According to the psychosocial model, eating disorders' aetiology is multifactorial. Amongst its most popular causes, one can find: (again) dysfunctional family dynamics, but also dieting, weight loss fixation, stress and anxiety. However, when environmental causes are included, they seldom get to be analyzed as socio-historically conditioned but somewhat linked to sufferers' personality traits. Consequently, anorexics are deemed perfectionist and always in need of external approval. In contrast, bulimics are judged as inherently anxious, in a constant struggle for control (Bordo, 1993). These character traits are turned into disordered psychology that then again invisibilize the context where they take shape. The constant struggle for control is no longer socially driven but part of a pathological psychological profile. Therefore, these personality traits end up intrinsically tied up to eating disorders aetiology.

This psychological profile has changed and evolved with the times. For example, in the Spanish clinical literature published on eating disorders at the beginning of the nineties, authors described eating disordered patients as whimsical, strong-willed, exhibitionist, demanding young women who needed endless attention (Gil, 2005). I would argue that this psychological evaluation rather stems from clinic's patriarchal views than from a sensible and scientific observation. In spite of that, however biased these psychological profiles were, they partly inform the standards on which diagnosis is based. That is to say, diagnosis is shaped by some standards that stem from a very specific subset of the population - from its appearance as a medical entity, eating disorders have been argued to be a malaise targeting white, young, heterosexual and abled cis-woman. Moreover, these already biased standards resulted from the pathologization of ways of coping and moving through the world that are dislocated from the context were they take place and assumed to be inherent characteristics of its clinical population.

On the other hand, these psychological profiles are more than often contradictory. For example, the clinical literature published in Spain during the first half of the nineties alternately deemed eating disordered subjects as strong-willed and dispossessed of will. While the former referred to patients' reluctancy to engage with treatment - the non-compliance I have mentioned before - the later was used to argue how the apparent power women were exercising over their bodies actually turned against them under the pressure of cultural ideas of thinness (Gil, 2005). At this same time, from the clinic's influential position, it is argued that we are facing an epidemic as more young women are diagnosed with eating disorders types. As Gil argues, to associate the concept of the epidemic with a disorder has essential connotations in the field of public health (Gil, 2005). It entails designing preventive interventions and defining what is valued as a healthy behaviour, which is always already a normative and corrective process.

Last EDs' clinical official definition comes from the DSM-V, where they are argued to be "characterized by a persistent disturbance of eating or eating-related behaviour that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning" (DSM-V, 2013, p.339). In this last edition, the classification system for EDs was rearranged and new types were included[3], which created new realities and clinical truths. (LaMarre Blog, 2019). The modifications made in this last edition culminate a double process of looseness affecting diagnosis criteria - which makes it easier for clinicians to diagnose an eating disorder - and specification concerning new eating disorders subtypes - where multiple experiences get to receive its pathological name. The consequence is a growth in the population vulnerable to be affected by eating disorders. However, this growth contrasts with the obstacles preventing individuals who do not fit eating disorders stereotypes from accessing treatment, due to the

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[3] Currently, Feeding and Eating Disorders encompasses pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, binge-eating disorder and Other Specified/Unspecified Feeding or Eating Disorders.

assiduousness with which eating disorders go missed or miss-diagnosed in those bodies who do not fit the standards on which diagnoses are based (i.e those who are marginalized on the basis of ethnicity, socioeconomic status, gender and body size) (LaMarre Blog, 2019).

Parallel to the clinical evolution of eating disorders, its care also evolved through the times. From its early treatment as an endocrine disorder, for at least the first half of 1900s, or the prescription of "parentectomy" which was also deemed a suitable treatment well into the 20th century (Bishop, 2018), eating disorders care has been shaped around clinic's definitions on the distress. While the APA has issued some recommendations for assessing and treating psychiatric disorders, the problem is always the same: predictors of recovery still remain poorly defined (Yager et al., 2014, p.3). In the absence of a more accurate idea, success in recovery is widely measured through weight gain and corrected eating behaviour from the clinic's perspective.

Feminist accounts on eating disorders

Eating disorders have been extensively theorized from feminist perspectives for over forty years now. Susie Orbach's (1979) *Fat Is a Feminist Issue*, firstly published in 1979, is commonly accounted as one of the seminal publications on the matter, which led to a myriad of efforts that have sought to contest the hegemony of medical models and situate eating disorders experience in relation to the social contexts where it arises. Diverse in their approaches and even critical amongst their different conceptualizations, feminist accounts on eating disorders gather together around the quintessential feminist purpose, to make the personal political. By challenging the dominance of clinical perspectives whereby eating disorders are portrayed as individual (psycho)pathologies originating in the interior, feminist theorizations have deemed them to be a case of gender oppression (Wolf, 1990, Chernin, 1983), an unconscious political protest (Orbach, 1979) a specific crystallization of culture (Bordo, 1993) an embodied renegotiation of historically located discourses (Probyn, 1987), and a biochemical materialization of the body (Wilson, 2004).

The genealogy of these accounts follows a logic of contestation; critical theories and conceptualizations are developed as a response to problematics posed by those already existent. That is to say, feminist writings on the matter do not only challenge clinical pathologizing accounts of eating disorders - even though this could be seen as the shared bottom line of all writings - but they also call into question previous readings argued from critical perspectives. In other words, there is a dynamic of self-actualization and revision as new tools of analysis are generated in the conversation with cutting edge theoretical frameworks. And as a result, it is made explicit how feminist accounts of eating disorders have not been free of dangers, lacunas and biases. In the following sections I will illustrate structuralist, post-structuralist and new materialist feminist accounts on eating disorders.

Feminist Structuralist views on eating disorders

In 1980, as the American Psychiatric Association (APA) firstly registers anorexia under the denomination of syndrome in the *DSM*, other voices argued for a different reading of what is perceived as a feminist issue. For example, Kim Chermin (1983) portrayed anorexic subjects in *Womansize: The Tyranny of Slenderness* as keeping a battle in their bodies to erase the visible marks of their sex. According to the author, to desire tighter breast or a shred tummy might express women's unease in front of their being women in western societies. That is, with how their gendered identity is loaded in their cultures. Moreover, Chermin points out how the obsession with controlling their hunger and shrinking their appetite might be a reflection of a culture that has taught them to keep under control and carefully monitor their needs and passions.

In *Hunger Strike: Starving Amidst Plenty* (1986), Susan Orbach's, sees anorexia as a kind of language of the body through which women attempt to be part of, and at the same time disappear from, the culture that subjugates them. In this sense, Orbach draws a parallelism between the contemporary anorexic and the British suffragettes' figure, approaching anorexic symptoms as a kind of protest, a hunger strike. Therefore, following Orbach's lines, the anorexic body has to be seen as a political move conceptualized through a physical struggle. There is a kind of agency in what the anorexic does.

The overarching thesis of this first period approaches contended that EDs could only be understood in the oppressive and hierarchical gender ideologies operating in western/ized patriarchal cultures (Malson & Burns, 2009). Which, on the other side, perpetuates the image of the white skinny girl who has gone too far on her diet. Media and fashion industries and the familial unit are found to be the principal culprits for the anorexia nervosa and bulimia epidemics. Interestingly, feminists reconceptualization of eating disorders and clinic research on EDs of that time shared similar aetiological interpretations.

The culturally conditioned pursuit of thinness signalled by feminists works is also addressed within psychiatric work on social aetiology (Bruch, 1974). Both psychiatric and feminist literature (Chernin, 1983, Orbach, 1978) find media images promoting a thin standard of bodily attractiveness that is all-pervasive and harmful for some, almost always assumed to be female. The implications of this framework have been extensively contested. Even though it provides a cultural and social backdrop where to situate these experiences, it also reinforces women's subjection. The argumentation goes as follows: if in a mediatized society, everyone is exposed to bodily pressures, but just some are affected by them, it is entailed that those who self-starve or binge eat as a response to images of thinness are more susceptible than others.

This critique is echoed by feminist scholar Elspeth Probyn, who in *The anorexic body* (1987) suggests that if anorexia has to be depicted as an outcome of too much representation, it will equate to say that women are "the only ones suffering from living in the late twentieth century mediascape" (p.203). In other words, this explanatory model portrays eating disordered subjects as passive recipients being persuaded by any cultural imaginary. Furthermore, according to critical psychology studies scholar Andrea LaMarre, those interpretations have proven to be flawed as efforts to promote media literacy have not translated into a concordant fall of eating disorders numbers or lesser levels of bodily distortion. If anything, LaMarre suggests, "they have simply driven bodily discontent underground or portrayed under a guise of health (LaMarre, 2018, p.220).

Other problematics intrinsic to the organizing logic behind these first accounts on EDs is how they rewrote cartesian dualism into feminist argumentations. That is, that they were implicitly reifying hierarchies of domination that ultimately positioned women as inferior/subjugated. According to the Cartesian mind-body split, the rational reflexive mind is rendered the site of human experience; therefore, the corporeal aspects are left out. As the body is deprived of mind or ideas, it is reduced to its physical materiality and equated to the ungoverned natural realm. Therefore, bodily sensations, activities and processes are considered of lower order. Despite all human existence being processed and mediated through the body, some humans are rendered as more bound to it, more naturally governed. In short, more like objects instead of subjects. Historically, these have been gendered, racialized groups. Women, by definition, are the other, the corporeal, what cannot achieve transcendence because its condition is the very opposite: immanence. Thus, women's destiny has always been linked to their biology: the reproductive function, which has been used as the means for their subjection.

As women's existence was tied to their bodies, feminists took eating disorders as a paradigmatic case for speaking about female subjugation. Here, the body continues to be the place of oppression, an inscriptive surface where patriarchal culture (both shaping women's images of themselves, and life expectations, in other words, the women ideal) is written upon. Thus, eating disorders are seen as either patriarchal oppression unconsciously enacted by women themselves or an embodied response against patriarchal expectations on women. This feminist interpretation of eating disorders as self-objectification practices - sickly performing patriarchal gender norms - or self-erasing - running away from them -, has proven to be a flawed framework, as it fails to capture and account for many other experiences. For example, if desirability and internalized patriarchal ideals are seen as contributing factors in the development of eating disorders, those who are assumed to be already outside of the norm (large, disabled, trans, poor bodies) may be presumed to be immune to them. (LaMarre, 2018, p.33).

Furthermore, self-objectifying and self-erasing explanations follow a cartesian logic as they reinscribe a mind-body split: the disordered eating subject is one defined by its rational capability to exert power over the malleable materiality of their body. When EDs are read as an illness forced by patriarchal representation, they are seen as an unconscious decision of a sick mind. And when EDs are understood as an embodied protest against the patriarchal order, they are depicted as an emancipatory/damaging political move made by an agential subject. Both descriptions paint eating disorders as a case of mind control over an always feminine body. This idea also extends over recovery, as it is also commonly approached as the master of the mind over the body, which concurrently reproduces the idea around bodily control and surveillance that might have participated in the development of the eating disorder in the first place.

For this reason, while structuralist accounts did well in situating the disordered eating subject in relation to the broader social expectations surrounding western femininity (Holmes, Drake, Odgers, 2017, p.2), they also reinscribed a cartesian subject. In short, their approaches to the disordered eating subject perpetuated hierarchies of domination and a disembodied understanding of human existence.

Postmodernist feminist accounts on eating disorders

The second wave of feminist works accounting for eating disordered practices and subjectivities is built within post-modern and post-structuralist frameworks. Whereas modernist perspectives tended to assume socialization processes as unitary normalizing, all-pervasive and totalizing (Eckerman, 2009, p.16), postmodernist and post-structuralist accounts of the processes of subjectification assumed the self to be multiply constituted. Where the first generation of feminist writing about eating disorders foregrounded how bodies are subjugated by patriarchal culture, later approaches went a step further, widening the scope of forces intervening in the subject's formation processes and recognizing its agency.

From these post-structuralist perspectives eating disorders are theorized as "(multiply) constituted within and by the always-gendered discursive context in which we live: (individual) disorder is re-theorized as part and parcel of the (culturally normative) order of things" (Malson, Bruns, 2009, p.1). In other words, dichotomous rationales are discarded. Spectrums and contradictory overlappings replace explanations of over-compliance or resistance, making room for the changing and varying meanings embedded in eating disordered practices, experiences and bodies. The division between the normal and the pathological is rendered illusory, and diagnostic labels are considered to be discursive categories that reify what counts as normal or abnormal conduct around food and body.

We can observe this move in *Unbearable Weight,* where scholar Susan Bordo (1993), proposes to move beyond dichotomous approaches of eating disorders, either read as cases of oppression or strategies of resistance against dominant interpellations for women in western societies[4]. To that aim, Bordo draws on Foucauldian concept "technologies of the self" in conceptualizing anorexia and bulimia, which can be defined as a set of practices and strategies carried out by individuals in order to present themselves as subjects. These practices should be analyzed as a double-edged sword. On the one hand, they are experienced in terms of power and control. On the other, they install a self-regulation logic that serves a power now working from within. It is through this concept that we can understand power as productive, disciplinary and normalizing.

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[4] The author is critical with the rewritings arguing for an embodied protest reading of the disorders. According to her, this interpretation made from feminist academic positions seems to gloss over the dangers of these practices and the isolation that come with these practices. On the other hand, such analysis have been used by those who refute perspectives that situate eating disorders in its context to argue that to present Eds as a feminist issue is to portray them as deliberate choices. According to LaMarre, what this allegation misses is 1) that feminist accounts on the matter are varied and divergent 2) that such readings are not meant to be read onto any one's experience but rather to account for the social issues that might be informing subjective experiences of the distress (LaMarre, 2018, p.34).

Bordo departs from such concept and reads the practices that subjects engage with when living through eating disorders (dieting, binge-eating, purging, over-exercising, etc.) as both experienced in terms of subjectivity formation but also training the cultural body in docility and obedience to cultural demands (Bordo, 1993, p.xxiv). Following Bordo, these practices arise from and reproduce normative ideals of femininity, which contest the pathological status of the experience. In Bordo's words, "eating disorders, far from being bizarre and anomalous are utterly continuous with a dominant element of the experience of being female in this culture (Bordo, 1993, p.56). Therefore, eating disordered pathology should be rather read as a specific historical "crystallization of culture" (Bordo, 1993, p.139).

However, post-structuralist approaches' highlight of the discursive has been deemed to threaten the political cause and subject, as the unitary is relieved by the multiply constitutive and the verticality of domination by a horizontal, productive net. From this perspective, the struggle as well as the subject seem to dissolve. In the case of eating disorders, feminist post-structuralist readings might seem to threaten their very same existence as they call into question their inherent reality - for example, querying diagnostic labels. Even though these interpretations might benefit those diagnosed, as it works towards its de-pathologization, it also has its pitfalls. Doubting the clinical reality of eating disorders might get on the way to recovery, as having a clinical pathology diagnosed is the means to access treatment.

On the other hand, post-structuralist accounts of eating disorders expand their scope to theorize other experiences apart from those of the anorexic subject. The overly accounted anorexia is now slightly displaced from the front line while other practices and subjectivities come to be subjects of interest. However, the historical prominence of cultural analysis on anorexia, or the lack of literature surrounding, for example, bulimic experience, is not innocent. According to Squire, the absence of written literature on bulimic experiences - in contrast with the literature produced around the anorexic subject - is due to the bulimic's nature whose excess, fleshiness and messiness cannot be “easily contained by a language that is positioned above the realm of the flesh coded as feminine” (Squire, 2002, p.61). Again, this hierarchy follows a cartesian logic: while anorexia seems to enact the privilege given to rationality, bulimia is an experience that cannot be contained and overflows the typically clear and fleshless style of writing used in academic writing (Squire, 2002).

Other reason why bulimia has gone untheorized is because of its invisibility. While the visible consequences of anorexia - an emaciated body - are perceived as deviant, bulimia remains unseen because of its seeming lack of visual consequences (Squire, 2002). Deviance in the bulimic experience has to be found in the practices the subject engages in. However, bulimia might not only be invisible, but it is usually judged to be less severe and to receive much less recognition than anorexia (LaMarre, 2018). Rendering bulimia as less hazardous to health exposes a contempt over the “loss of control over bodily appetites” that this diagnosis has come to represent (Eckermann, 2009).

Moreover, in feminist post-structuralist approaches, the archetypical eating disordered (anorexic) subject is also contested. As described by Bordo (2009), the hegemonic mainstream image of eating disordered subject shapes a white, heterosexual, economically secure female (p.46). From the definition of this profile, numerous ideas about eating disorders followed. As I have addressed before, these ideas deeply informed understandings around eating disorders to the point that, in order to be diagnosed, one have to reproduce those same standards. Thus, ethnocentrism is embedded in eating disorders diagnosis (Bordo, 2009), making this diagnostic technology blind to those who come from different cultural backgrounds and whose eating disorder may present differently.

Nasser and Malson (2009) make a case for a non-ethnocentric understanding of eating disorders, a new approach able to account for cultural differences. As stated by the authors, even though the prevalence of EDs diagnostics in non-western societies is increasingly growing, the causality is still very much described in ethnocentric terms. According to them, the arguments used to make sense of eating disorders are the culture clash and the acculturation/globalization process. The former contends that eating disorders cases in non-western subjects living in western contexts appear in the tension between live expectations shaped by the minority culture and the difficulty to simultaneously perform western ideas about women (p.78). The second explains eating disorders growth amongst women of cultural minority groups in terms of exposure to dominant western values (p.79). As Nasser and Malson pointed out, these explanations are still very much dependent on white western mainstream culture (p.82). Instead, they propose to weave discourses about eating disorders able to account for other geopolitical positions' cultural, political and historical specificities. Moreover, they also foreground the need to research how eating disorders may simply present in different ways amongst those who come from different cultural backgrounds.

The material turn. Weaving back the body

As shown in the literature review so far, in feminist theorizations of eating disorders, the body has historically occupied a subordinated position. Moreover, its role in the experience of living through and healing from EDs has been completely overlooked. This absence goes hand in hand with the devalued place the body has occupied within feminist theory. For example, we can observe this influence in Chermin's account of anorexia, where the sexed body is portrayed as a battlefield where to erase the marks that hold her to immanence. Such a position aligns with what Grosz (1987) defines as a cautionary feminist position against the idea of the body. According to the author, one of the first theoretical emancipatory moves made by first-wave feminists was to reject one's body (p.1), which tied women to the natural realm and granted their subordination.

However, this first period of distrust concerning women's materiality ended when the body started to be understood as a socially produced object, no longer bound to a fixed essence but dependent on socio-historical relations. Since then, this theoretical tradition has deeply informed feminist accounts on eating disorders which have set themselves up to contest biomedical models by means of emphasizing culture over biology. In this effort of moving away from the biologic determinism, individualization and pathologization risks posed by the biomedical model, the body is, once again, left behind. In other words, the question about what does the body do when living through and recovering from eating disorders is one that has been left unanswered.

Far from being exiled, the body, the materiality where we exist and also that surrounding us, has been weaved back into cultural analysis in yet another interpretative turn, what has been called the material turn. From new materialist perspectives, body's materiality is recognized. It is argued that while "culture, society, language and discourse all have an impact on the material (in this case, the body), [they] do not wholly constitute that matter" (LaMarre, 2018, p.20). Put it otherwise, the body is not merely acted on, it interacts and has agency of its own. Within this framework, biology and society should be understood as inseparable domains that interplay to create reality.

Assuming a unitary understanding of mind and body, recent feminist theoretical efforts writing from new materialists perspectives have aimed to weave the material dimension of the disordered eating experience back to the equation. In other words, they have meant to move from interpretations that conceive the body as the place to escape from and/or fall under patriarchal oppression, and instead, shape the body as an active actor participating in eating disorders experience. According to Cetll (2011) this is not entirely new, as both feminist works and the clinic have already called attention to the biochemical components of EDs. In the latest version of the DSM the APA mentions how "observations of behaviours associated with other forms of starvation suggest that obsessions and compulsions related to food may be caused and exacerbated by undernutrition." (APA, 2013, p.341). Again, such diagnosis seems to bring to the fore a specific agency of the body that thus calls into question the assumed autonomy of the brain in starving bodies. In a similar vein, Susan Bordo notes that the empowering sensation in anorexia is also to be found in the workings of the body. That is, anorexia as an intoxicating, habit-forming experience also needs to be accounted as a physical addiction (Cetll, 2011).

Attending to the biochemical dimension of the disorder unveils how eating disordered practices (in this specific case I have been only talking about fasting) shape the body, but also how the (undernourished, emaciated) body shapes the subject's continued engagement in those same practices. Therefore, acknowledging the role of biochemistry in eating disorders contests the cartesian rational subject as it challenges the mind's autonomy. Moreover, it also cast doubts on some first-wave feminists approaches to eating disordered subjects, which provided them with an autonomy that is to be found in the head.

In a similar vein, Elisabeth Wilson workings (2004, 2014) further explore the biological dimension of eating disorders, specifically through her concept of the "brain in the gut" (Wilson, 2004). I have already exposed how both clinical and feminist accounts of eating disorders locate the distress (either if its pathological or cultural) in the mind. That is, eating misconducts are both understood as a way to cope with or renegotiate reality (argued from feminist perspectives) or as somatization of psychological distress located in the brain (contended from clinic optics). Either way, the gut is displaced, as the bigger problem is always found in the mind. In order to move beyond a mind governed approach to psychological distress, Wilson's text seeks to make a case for the psychological dimension of the gut. That is, she weaves a theory where she tries to explain how the gut is regulated by and regulates psychological events.

In her texts, the author contends that relations with others and the outside world do not only take place in ideational terms, that is, in the mind, but also in the rest of the body, or in this case, in the gut. In Wilson's own words, "the internalization of good relations to others and the damaging effects of traumatizing or destructive relations to others are events that both take place in the head and in the rest of the body" (p.45). Here, the gut is a privileged place where to observe these encounters, as it is where the outside world passes through the self (p.44). In other words, it works as a boundary between the self and the outside world.

She exemplifies this approaching the experience of depression and correlated functional gastrointestinal disorders. As the author points, there is no identifiable biological basis for such gut disorders (amongst its symptoms, we can find altered food intake) (p.39). Thus, they are judged to present a psychological causality, that is to say, they are considered manifestations of emotional or traumatic stress.

According to the author, functional gastrointestinal disorders (such as loss of appetite) accompanying experiences of depression are not to be understood as an affliction that is all in the head and expressed in the guts (Wilson, 2004). Wilson wants to contest the unidirectionality implied in this presumed transmission (from the brain to the gut). Instead, she proposes that the distress of the gut, that is, problems in either ingestion and digestion, are perhaps proving how the gut itself is failing to remain connected to others. In Wilson's words, "the failure to eat does not *represent* a breakdown of connection to others (depression), but is seen as a direct interruption to the process of remaining connected to others" (p.45). The workings of the gut are thought as "*actual* mechanisms for relating to others" (p.45).

We do not find a loss of appetite in all disordered eating experiences. However, in almost all of them mediates a particular way of ingestion, digestion. That is, the world/others travel through the gut in a specific way: fast and abundant, scarcely and controlled. These ways of travelling could also be analyzed as a way to relate to the world. To stop eating can be telling of an incapacity to take in the outside world as it is. Thus, fasting can be thought of as the constitutive process of a self no longer able to assimilate or ingest the world. This reading might displace the idea of the mentally ill subject and move towards the idea of an outside that cannot be digested.

On the other hand, if the gut is an internal place where connections to the world are established, we can also think of the gut as a place where to rework those relations. Regarding such gut potential, Wilson exposes the case of a man living through depression whose functional gastrointestinal disorder - he is unable to ingest food by himself - improves as he starts to have dinner with his father. His father walks all the process with him - mincing the food, moving it close to his mouth, keeping him company - and he does so with kindness and patience. In these conditions, he can ingest the food and therefore take in a part of the world, one that presents itself wrapped in kindness and care-fullness.

I want to propose this scene as potentially useful to think about how to re-establish connections with the world in cases of eating disorders. As it points towards how to weave new and more sustainable relations to oneself, others, and the world can be done through eating.
In the following section, I will address how even if nutritional rehabilitation is the primary treatment when talking about EDs - to the point that psychological interventions are only considered helpful "once malnutrition has been corrected and weight gain has begun" (Yager et al., 2014, p.4) -, the process is done in such a way that it is not felt attentive, careful or acknowledging. Sometimes it does not even involve the person who is being fed - as in the case of nasogastric feeding. Moreover, it also tends to silence the person taking in the food as any food-related opinions are judged as "eating disorders talking" (Lavis, 2016). Here, I want to propose that following Wilson's speculation, we can think of the workings of the oesophagus as a specific way of relating to the world. This poses many questions about the world and the available ways of connecting and relating to it. It also targets food as a way through which to work new, more attentive, careful and sustainable ways of relating to that very same world.

To approach eating disorders from a feminist position that considers what happens to the body while living through and healing from the distress allows us to understand recovery as an embodied and ongoing process. It brings to the fore the need to think about how the body is involved in the healing process and how to attend to its necessities. Moreover, it displaces the idea that to overcome eating disorders, we only have to engage in "brain work". It foregrounds subjects' corporeality while making them attune to sensations and those other ways of knowing that are very much felt. Furthermore, it is an alternative framework from which to contest the prejudice shared by the clinic and popular narratives alike that eating disordered subjects are untrustworthy. It does so, complicating the idea that not eating is a choice and instead presenting it as a) the consequence of the biochemical alterations of an emaciated body and/or b) the difficulty of remaining connected to the world. This could significantly impact the way we think about eating disorders care as it could translate into more carefulness when refeeding eating disordered bodies.

Problematizing recovery and care

Counter-cultural recoveries and recovery assemblages

While much has been researched and written on the genesis and maintenance of eating disorders (Strober & Johnson, 2012 as cite in LaMarre, 2018), there is still a lack of consensus over what constitutes recovery. From a clinic perspective, despite a general acknowledgement that recovery should attend to physical, behavioural and psychological elements, recovery is still measured through weight gain and corrected eating behaviour (Yager et al., 2014). Therefore, symptom remission and nutritional rehabilitation are often used as markers of health. According to LaMarre (2018), for the last twenty years, research on recovery has focused on the "isolating factors involved in reaching recovery", that is, identifying variables that foster or stand in the way of attaining recovery. With this research focus, the *what* of eating disorders recovery has been neglected - how eating disorders recovery is experienced, how it looks and feels like -, which has contributed shaping a narrow narrative around recovery that fails to acknowledge the variety of experiences held under the term.

The concept of autonomy is specifically mobilized when talking about recovery from EDs: to get well is to become an unproblematic autonomous self. Saukko (2009) brings attention to the fact that autonomy is always seen as something good and desirable, an ideal end-state. Implicit to an approach that situates a more authentic genuine healthy self in the future is the existence of a sick, inauthentic self in the current present, what has been called a false consciousness (p.70). According to Saukko, this approach to eating disorders is based on a time-based metaphor and builds a narrative of linear progression between two dichotomous ends. In other words, it draws a pretty simplistic linear transition from a pathological self to a recovered one (p.67).

Anna Lavis' ethnographic work carried in an Eating Disorders Unit evinces how this mode of thinking contrast with patient's views, for whom selfhood manifests within and through the illness (Lavis, 2016, p.98). According to Lavis', care-full attempts to heal eating disorders by removing them from the self without considering how they are intrinsically linked with patients' subjectivity might be experienced rather care-less. For example, focusing on the specifics of foodwork in anorexic treatment, Lavis (2016) argues that, to the extent that not eating "is felt [by patients] to be a modality of self-care that mediates how they live and move through the present moment" (p.98), clinic's food-as-medicine paradigm does not rematerialize the lost self but goes against this very same sense of self. Lavi's analysis contends that not eating works as "a form of care' craft[ing] more bearable ways of living with, or in, reality" (Mol, 2008 p.53 as cited in Lavis, 2016, p.99). For that matter, when in the context of treatment, health care providers dismiss patients vocalizations of distress at eating as "anorexia's talking", it conceals and precludes manifestations of care that difficult the experience of healing. In other words, understanding the healing process as a linear path from a pathological - not trusted self - towards a recovered one - capable of taking care of him/herself -, oversimplifies the experience of living and recovering from eating disorders and fails to acknowledge patients agency in their healing process.

To move away from this linear and dichotomous understanding of distress and recovery, Saukko (2009) proposes a shift from a time-based metaphor to a space-based one. This new mould opens up space to fit multiple contradictory discourses simultaneously coming into play in eating disordered experiences. Acknowledging, for example, how seeking other's approval or perfectionism can be read both as enabling and disabling dynamics shaping the disordered eating self. Moreover, it also contests autonomy as an indisputable end goal, bringing to the fore its different connotations and expanding its meaning beyond individual free will. To recover, after all, might not mean rescuing a normality lurking inside the individual. Instead, as proposed by the recovery movement, we might approach recovery as a journey toward finding personal meaning in life (LaMarre, 2018).

Following LaMarre (2018), theoretic accounts on recovery present two main issues. The first one is the subtle way the path towards recovery is portrayed as an individual's responsibility. The second is the failure to account for how health prescriptions issued for those recovering from eating disorders collide with health directives addressed to the broader population. In that sense, LaMarre and Rice's work judges the process of recovery, counter-cultural, as it defies normative instructions about bodily management, health, and food. The authors draw on Wright and Harwood notion of biopedagogy[5] to name "the normalizing and often moralizing prescriptions for healthy living that underpin the term recovery" (LaMarre, Rice, 2016, p.137) and examine the tensions that arise when navigating recovery biopedagogies along with the more general prescriptions for health. Recognizing these limits, difficulties, and paradoxes allows to "situate the embodied experience of eating disorders recovery within a sociocultural context rife with moralizing imperatives around food, health and bodies" (LaMarre, Rice, 2016, p.137). Moreover, while biopedagogies are grounded in "health-enhancing" and "live-saving techniques and technologies of cure" (LaMarre, Rice, 2016, p.147), they can also feel constraining, as they might hold individuals in recovery to different standards - sometimes higher standards - than others in their lives. According to LaMarre and Rice's perspective, acknowledging the working of such biopedagogies could benefit more supportive relationships and a deeper understanding of those who are in their journeys towards recovery.

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[5] The term biopedagogy, coined by Wright ad Hardwood (2009), takes up Foucault's concept of biopower to recount a set of messages that operate around bodies issued to normalize them into productive citizenry. In Harwood words, "biopedagogies are loose collections of information, instructions and directives about how to live, how to be embodied, what "health" is and what to do in order to be healthy and happy (Harwood, 2010, 16). They travel through both formal and informal educational sites, for example, in schools, doctors' office, public health campaigns, media and everyday interactions amongst others. It was firstly use to address the moralizing messages that operate around "obesed" bodies.

Similarly, understanding recovery as an individual work, suggesting that recovery resides within the individual and its capacity and will to put the effort and make the right choices, does not only gloss over the context where this process takes place, but it also overlooks its contingency. This approach does not take into consideration how recovery is something that happens in relation to other people, and how it depends on structural conditions. Moving beyond this idea of recovery as an individual process, LaMarre and Rice (2020) approach eating disorder recovery as an assemblage, "a provisional arrangement made up of people and material things (treatment providers, food, supports, etc.) but also immaterial aspects […] relational, entangled, affective, and dynamic behaviours and ways of being – on the part of people in recovery, but also their supporters and others in their social worlds" (LaMarre & Rice, 2020, p.2). Bringing this lens to recovery allows us to consider the multiplicity of forces involved in the recovery process, better understanding what generates possibilities and impossibilities for recovery (LaMarre & Rice, 2020, 4). Moreover, from this perspective, recovery might no longer appear as a static phenomena, but as a continually unfolding one, as relationships, food

Alternative approaches to eating disorders care: The logic of care vs The logic of choice

Access to treatment can be a fundamental aspect of the healing process. However, paths toward recovery depend on the systemic supports available in a specific geographical area, which can vary substantially since there is still a lack of consensus on the best or most evidence-based treatment for eating disorders (Strober, Johnson, 2012 as cited in LaMarre, 2018). In the specific geographical area where I conducted this thesis fieldwork, Spain, eating disorders public health care is organized in three different levels of intervention. First, there is the outpatient treatment where patients are visited by different specialists - psychiatrist, psychologist -, ideally, once every other week. The second level is the patient's referral to a day hospital or his/her partial hospitalization. In this inpatient setting, patients are more closely monitored, and their attendance varies substantially (ranging from a couple of days a week, some hours a day, to all working hours from Monday to

Friday). Lastly, the third level is total hospitalization, where patients spend 24 hours a day in eating disorders units, where they not only receive treatment but also live.

I have previously argued how access to EDs treatment depends on meeting diagnosis criteria informed by narrow ethnocentric standards. Here, we can see how access to treatment is also conditioned by the patients' ability to put their time on hold and abandon their environments to pursue recovery (Eli, 2014). In the Spanish public healthcare system, this characteristic reinforces a focus on child and adolescent populations at the expense of adult patients who cannot leave their responsibilities unattended to fully engage in these programs. Moreover, adult patients are not only abandoned in terms of suitable treatment options but also financially. According to Miriam Sanchez (Custo, 2020), due to the Spanish public health system's incapacity to take care of the dramatic increase of cases experienced in the last decade, most patients are referred to private treatment centres. And while treatment expenses are covered by a period of two years by the scholar insurance, those who are not currently studying have to face prohibitive prices. Moreover, as LaMarre (2018) signalled, even in cases where treatment is accessed, patients might not find their needs met. This is partly due to the limited resources available but also because of the lack of choice eating disorders patients encounter in treatments.

The option of choice within the mental health field was fought by the consumer-survivors movement. While different amongst each other, both worked to grant patients the possibility to take over their therapeutic fates and embrace an active role in their health care trajectories (Tomes, 2006). However, while the logic of choice has permeated the health care system of many Western countries where "patient laws" oblige to provide patients with information in order for them to decide their fitted treatment (Mol, 2008, p.30), such logic has not done as well in the mental health care system. Especially in eating disorders care, as eating disordered people are commonly deemed untrustworthy. It is worth noting that while part of the reticence choice found came from the part of professionals within mental health systems (Samele, 2007), patients themselves are also found to prefer shared decision making over fully autonomous choice (Laugharne, Priebe, 2006). Whatever minor impact such logic has in eating disorders care, here I would like to briefly discuss choice as a means to investigate the alternative care models available.

According to philosopher Annamarie Mol (2008), choice is celebrated as it raises patients to citizens' status and/or consumers in the consulting room. It is understood that choice foregrounds patients individual autonomy and emancipates them from a medical authority. At first, Mol would argue, this may seem fine, as autonomy is an ideal widely celebrated in Western societies. However, on close examination, we might discover that this comparison does not quite do the job for the patient. While, by definition, citizens are expected to control, tame and transcend their bodies, patients are troubled by them (Mol, 2008). Therefore, from Mol's perspective, the logic of choice does not accord very well with life with a disease. Instead, she proposes investigating a different logic, one that already exists in the consulting room but has not been properly theorized. The logic of care, as she names it, is not worried for the patients will or what they may opt for, but focus on what they (and others) do.

These two logics incorporate different normatives - goods and bads - and specific ways of doing. While the 'good' relevant in the logic of choice is autonomy and equality, and 'bad' is oppression, in the logic of care, attentiveness and specificity are good, and neglect is bad (p.74). The logic of choice provides no answer to which treatment is best suited in any specific case as individuals (patients) are asked to exercise their judgement. What autonomy, the good in the logic of choice, does in practice is compelling patients to make normative judgements. Therefore, the process here is linear: facts, values, decision and ultimately action. In order to choose, patients have to be provided with all the relevant facts - the different treatment options available, their effectiveness, etc -, this is possible because "within the logic of choice scientific knowledge is taken to be a growing collection of facts that gradually increases in certainty" (p.42). Professionals should know these facts, and it is their responsibility to pass them on to people. Having all the information, a decision is a matter of balancing values. And since the treatment chosen will mostly impact the patient's life, his or her values are the ones that are taken into consideration.

On the contrary, in the logic of care, good is not decided before engaging in practical activities. Instead, it is established along the way. In other words, the moral activity is not to find good through value judgements because in the logic of care, defining good, worse or better does not precede practice. Instead, it is part of it. According to Mol, there is no specific moment in the logic of care when all relevant facts and values are available because when the original problems are tackled, new ones will probably arise (p.54). Therefore, "a 'sensible course of action' and the 'normative facts' relevant to it, co-constitute each other" (p.45). While choice is individual and delimited, "care is an interactive, open-ended process that may be shaped and reshaped depending on its results" (p.20). In this sense, Mol argues that the logic of care is better geared to "attend to the unpredictabilities of bodies with a disease" (p.12).

There are two central concepts to the logic of care. The first one is *patientism*. When in the logic of choice, patients are raised to the category of citizens, they are expected to control their bodies. On the contrary, *patientism* seeks to establish disease as our common condition. The relation that it builds with the body is not one of control but one that is kind, attentive, nourishing and attuned to our mortal bodies. In other words, *patientism* aligns with other theoretical positions that do not marginalize but think of the disease as part of life.

The second concept refers to the methodology of the logic of care. According to Mol, engaging with care within the logic of care is a matter of doctoring. Doctoring does not only involve doctors but is something that the entire care team does, including the patient. In other words, care activities move between patients, doctors, nurses, drugs, machines and others (p.28). The author describes doctoring as "the creative calibrating of elements that make up a situation, until they somehow fit - and work" (Mol, 2006, p.411). Doctoring "depends on being knowledgeable, accurate and skilful" but also on "being attentive, inventive, persistent and forgiving" (Mol, 2008, p.55). Doctoring is a democratized work. It is not about following someone's orders - either doctor's or patient's orders - but rather about whether all the activities involved are attuned to one another (p.56).

Because good does not precede action, "there is no such thing as an (argumentative) ethics that can be disentangled from (practical) doctoring" (p.79). In the logic of care, you tinker around and watch for problems that might unfold in the course of the disease. In that sense, this logic does not provide security. No more than the one offered by life. Doubt does not preclude action because, in the logic of care, the attitude is experimental: "you interact with the world, while seeking what brings improvement and what does not" (p.93). However, following Mol, in the logic of care, there is one consolation. Contrary to the logic of choice, when things go wrong, you as a patient are not to blame yourself. Having a choice might translate into one being responsible for what follows. Reversely, in the logic of care, frictions and problems are attended with an openness to wonder what could possibly have gone wrong. The attitude is different. While facing what went wrong is a wise first step, feeling guilty leads nowhere. Instead, the logic of care calls for tenacity, "for a sticky combination of adaptability and perseverance (p.79).

While the logic of choice is far from being implemented in eating disorders care systems and, fairly, its introduction would question many harmful assumptions about eating disorder patients, such model could also threaten other valuable approaches. For example, it could prevent us from thinking of eating disorders recovery as a collective effort. It is in that sense that I include Mol's work in this literature review, as a means to conduct an analysis that is watchful of the pitfalls of those more obvious alternative care models.

Chapter 2: Methodology

To approach women's experiences of care and recovery during and after treatment, I employed a qualitative methodology informed by a critical feminist framework.

Recruitment Criteria

Inclusion criteria were kept purposively broad. As I aimed to research the experiences of care and recovery during and after treatment, the main criterion for inclusion was for patients to have undergone an institutionalized process of recovery. Here I assumed that ideas of recovery and ways to manage feelings of distress around food and the body - that is, care - can vary substantially depending on whether one has had access to treatment or not. However, the pervasiveness of the clinic approach in dominant cultural narratives has evidently impacted far beyond the 'what' of the distress, and it also vastly shapes 'how' recovery gets to be defined on a cultural level. The extent to which non-treated eating disorder experiences might approximate the ones here examined surpasses the scope of this research. And unfortunately, these voices are not only left out in this text, but they also appear to be systemically missing in the academic literature. Their absence, however, is slowly diminishing, as more recent works on recovery from an eating disorder have started to take into consideration how those who could never recover - because they were not diagnosed in the first place - experience and understand recovery (see LaMarre 2014, LaMarre, 2018).

Having attained medical discharge was not used as an inclusion criterion. As I have already addressed elsewhere in this text, despite decades of research, there is still a lack of consensus amongst clinicians and researchers over what constitutes recovery. In other's words, eating disorder recovery remains an elusive construct (LaMarre, Rice, 2016). In this research, I was not so interested in how recovery was understood in the specific clinical setting where participants got to be treated. Therefore, having attained clinical recognition at the end of their treatment was not a prerequisite. However, participant's thoughts and feelings about how their treatment finalized came up as a relevant aspect across the data. The same happened concerning the possible consequences - pitfalls and potentialities - of recovery's lack of definition in the day hospital. I will delve into these topics later in this dissertation.

Even though I aimed to explore participant's orientations towards the concept of 'recovery', I did not want to presuppose one. Therefore, the term 'recovered' was not one that I used when approaching potential participants, as I intended to make room for other experiences that might be ascribed to different names. Also, the idea of recovery is not the only one investigated here. How treatment's care assisted them during their healing process is also a central inquiry of this investigation. And in order to reflect on this transition, one does not necessarily to be considered recovered.

In this research, I employed a mixed purposive/convenience sampling strategy. This is to say, participants were chosen following the only criterion mentioned above while also trying to build a representative sample (regarding educational levels, socioeconomic status, age, gender, sexual orientation, ethnicity, etc.). However, the recruitment process, which profoundly influenced the resulting sample, was chosen out of convenience. In other words, limitations on the selection were due to primary recruitment location. All participants were recruited using my network, which resulted in a homogenous sample of former patients from the same day hospital treatment. This sample's peculiarity should be accounted for since the kind of care and how it is deployed might differ depending on the setting where treatment took place (inpatient, outpatient, day hospital).

The recruitment process was chosen over other options for two main reasons. First, it was a time-efficient decision that allowed me to easily gather a substantial sample of ten participants within the time constraints of this thesis. Second, and most importantly, it was a safe way to reach my participants through a trusted network since I wanted to create a comfortable atmosphere and build a horizontal relation that allowed them to share their experiences in a relaxed and safe manner.

For this same reason, the election of the scenario where the interviews were to take place was left up to them, with the only instruction of choosing a place where they could be at ease opening up about their eating disorder's experience. However, due to the COVID-19 pandemic and the measures approved by the Spanish government at the moment the interviews took place, possibilities were limited. Bars and restaurants were closed, and keeping social distance of 1.5 meters and wearing a mask was mandatory outside the main household. In a follow-up message and in line with the new measures approved, I offered the participants two alternative interview possibilities, either arranging a video call or meeting in person in an open-air place. Finally, nine interviews were conducted in the open air (parks or patios) while keeping social distance and wearing a mask. The remaining one took place via video-call.

I want to note that it came to me as a surprise that almost all the sample preferred to be interviewed in person, even if that meant to meet in a public park. In this sense, their preference made me reflect on the assumptions I, as a researcher, was making before setting foot in the fieldwork. On the one hand, I was taking for granted the idea that the topic of discussion would feel rather delicate or vulnerable to discuss in a public setting. In a way, I was assuming that the stigma often associated with mental health issues was indeed experienced by the participants recruited. But as I will later bring up concerning anonymity, that might nit apply to all participants.

On the other hand, whereas video-call can bring the interview to the privacy of one's home, the home might not necessarily be a safer space where to open up about eating disorder related experiences. In some cases, it seemed to be an indirectly proportional relation between intimacy and willingness to open about the topic, suggesting the tensions underlying supportive relations. I will delve into this point later in the Results section.

Participant Demographics

The sample number was based on time constraints. A total of 10 self-identified women participated in the interviews. Participants ranged in age from 24 to 33. Eight were university educated, one had finished secondary school, and the last was primary school educated. Among those who pursued higher education, one was in the process of completing an undergraduate degree, seven had completed undergraduate degrees, one of them was in the process of finishing a Master degree, and three had already completed it. Six were currently working, two were unemployed, and two more were currently finishing their studies. Nine identified as heterosexual, one as lesbian. Two were moms. All identified as white/Spanish. Four participants had been diagnosed with anorexia nervosa, four had been diagnosed with bulimia nervosa, and the other three with EDNOS (Eating Disorder Not Otherwise Specified) (not mutually exclusive, one participant received different diagnosis in different treatment settings). Three of them received a discharge certificate, one a voluntary certificate of discharge, and seven left (or were abandoned by) treatment before being officially discharged.

Participant demographics were collected to make explicit the nature of the sample. The final homogeneity present across it warns us about the potential limitations of the research. However, and despite the richness that a more diverse sample could have brought to the research, the existing variety of experiences within a considered homogenous group also makes a point about the perils of packing an apparently uniform sample into one singular story.

Ethics

The main ethical issue that I took into consideration while conducting the fieldwork was confidentiality. Before the interview, all participants were asked whether they wanted to be anonymized or to keep their real names[6]. Three chose to remain anonymous, while the rest

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[6] Participants who decided to keep their real names are Laia, Silvia, Maria, Nica, Ari, Clara and Gemma

preferred to have their name displayed in the text. Pseudonyms were assigned to each participant who wanted to be anonymized. Those who rejected that option appear under their real name. This decision did not go unnoticed. Confidentiality is widely considered in eating disorders research, as participants might not want to disclose this experience to family members, friends, and colleagues (Ison, Kent, 2010, as cited in LaMarre 2014). Again, no question was asked about the reasoning behind their decision; therefore, their motives are unknown. However, some possible reasons that I found plausible are worth noting. One of the reasons could have been the previous relation that existed between me, as the researcher, and them as participants. Knowing each other in a rather intimate way - an intimacy developed during treatment - could have acted as a trust builder.

The fact that we all shared an experience with eating disorders could have made them believe that I would not do anything with the information that they would not do. On the other hand, as I already observed in relation to the public setting where almost all the interviews took place, deciding to appear under their real name might be read as an openness about the experience that is usually not assumed. The lesson I learned here is that stories that involve pain, mental distress or even carry the label of mental health stigma can be more than often reclaimed and reappropriated.

Data Collection Method: Interviews

Interviews were conducted with ten participants beginning in October 2020. They ranged in length from 31 to 138 minutes, averaging 63 minutes in length.

Interviews were conducted using a semistructured interview guide (see Appendix 1) but followed participants as they shared their stories. I decided to lean towards a semistructured format as my goal in this research was not to make inference about specific population experiences based on the present sample, but rather record as many embodied experiences about care and recovery as possible. Key questions asked participants to reflect on their experiences of care during treatment: how it felt and how it was experienced, how later guided them- or failed to do so - when they moved through their lives after being discharged, but also about recovery: how it was understood during treatment, and how it is later experienced when "outside".

I chose the interview as the primary data collection method for its adequacy to the principals of a feminist methodology and epistemology. That is not to say that the interview and the rest of the qualitative methods are intrinsically feminist. Neither to affirm that quantitative methods cannot be of great service for feminist research, even though qualitative methods are said to exceed quantitative ones in humanities and social science-based feminist research (Lykee, 2010, p.160). Interviews - especially semistructured, unstructured, open-ended question interviews - were a preferred method in seminal feminist researches - specifically used in inquiries about women's experiences - as they enabled access to women's ideas, memories and thoughts in their own words instead of those of the researcher (Shilamit, 1992). In other words, the interview was considered to be "the principal means by which feminist […] sought to achieve the active involvement of their respondents in the construction of data about their lives" (Shulamit, 1992, p.18).

Data Analysis

Interview analysis followed Clarke & Braun (2006) thematic analysis method. "Thematic analysis is a method for indentifying, analysing and reporting patterns (themes) within the data" (Braun, Clarke, 2006, p.6). A theme is understood to capture something relevant across the data corpus concerning the research question. It might encapsulate a patterned response or a relevant idea, even if not widely shared, amongst the data. It is considered a method rather than a methodology as it is essentially independent of theory, meaning it "can be applied across a range of theoretical and epistemological approaches" (p.5). Therefore, the theoretical position and values in thematic analysis cannot be taken for granted and must be stated.

I began the data analysis by transcribing each interview attending both to verbal and non-verbal communications. Sometimes what cannot be clearly articulated may be expressed in ways such as laughter (Shulamit, 1992). Therefore, I was attentive to pauses, tones and bursts of emotions. I later included those in the analysis as meaningful assets. After transcribing, I rewrote each interview into a synthesised short version to better understand participants' individual stories (see Appendix 2). Once I had all the content transferred and re-read all the data corpus, I proceed with coding. After that, I started the recursive process of examining all the codes and collating them under broader patterns of meaning (themes). In this stage, I followed Patton's dual criteria for building categories; "data within themes should cohere together meaningfully, while there should be clear and identifiable distinctions between themes", in other words, internal homogeneity and external heterogeneity (Patton, 1990, as cited in Braun & Clarke, 2006, p.20).

The themes were identified both inductively and deductively. That is to say, I was actively coding for a quite specific research question while also being attentive to more data-driven themes that appeared to me also relevant.

Theoretical framework

In writing and designing the methodology of this thesis, I took a critical feminist theoretical approach. Specifically, I aligned myself with postmodern and post-constructionist approaches (Lykee, 2012).

Postmodern's take on epistemology urges researchers to radically problematize and criticize normativities (Lykee, 2012) throughout a discursive-linguistic understanding of the researched subject. In other words, feminist postmodern perspectives challenge essentialism focusing on how discourse materializes social and cultural practices, subjects and power relations. Following postmodern guidelines, I favoured open categories over predetermined ones. For example, by not subscribing to any specific definition about recovery, I aimed "to look for excess meanings, undecidable in-between spaces between fixed categories [...] that do not fit in with binary models" (Lykee, 2012, p.148): eating disordered/recovered. With a similar spirit, I partly approached institutionalized care from a Foucauldian stance, as an operation of power that is “being performed as a decentralized, localized, discursively and institutionally normalizing process, and which also productively generates various and multiple local forms of resistance” (p.149).

Even though the postmodern theoretical and methodological approach was my departing point, in the process of writing the thesis, I found myself and the stories here being told outgrowing the postmodern framework towards a postconstructionist perspective (Lykee, 2012). Nina Lykee coined the term postconstructionism to name the last strand - following feminist empiricism, feminist standpoint and postmodern feminist epistemology identified by feminist philosopher Sandra Harding (1986) - in feminist reflections on the questions of epistemology. She added postconstructionist feminist epistemology as an umbrella term that gathers together various epistemological stances that move beyond postmodern and poststructuralist traditions “(…) in search of alternative understandings of objectivity and epistemological implications of embodiment” (Lykee, 2012, p.142). To name a few, situated knowledges (Haraway, 1991), posthuman embodiments (Braidotti) and onto-epistemology (Barad) all fall under the postconstructionist strand.

As stated by various authors, properly accounted partial knowledge is more reliable than that presented with universalist pretensions (Haraway, 1991; Harding, 1986). This epistemological framework’s core idea is that scientific and scholarly knowledge is not value-neutral but rather contextually produced. That is, it “is to be understood as embedded in its context of production, which include the researcher subject’s location in time, space, body, historical and societal power relations and so on, as well as the research technologies” (Lykee, 2012, p.211). This epistemological standpoint has two key methodological implications: a demand for “siting” (site), in other words, an acknowledgement of researcher’s situatedness, and a call for “sighting” (sight), that is, the need to be transparent about the research technologies, the optics through which the research object is constructed (Lykee, 2012, p.211). Which in this present thesis, I aim to have covered in this methodological chapter.

Aligning myself with postconstructionist epistemological stances allowed me to bring the body back to the research - mine and that of those who participated in the making of this thesis. In that sense, I aimed to incorporate an embodiment-focused approach to analyzing care and recovery experiences in eating disorders. That meant being attentive to how participant's bodies were agentic entities during their process of recovery. Rather than seeing bodies as the place where care is enacted upon, where discourses are inscribed and acted on, a postconstructionist perspective allowed me to flip the script to make room for body's agency. Therefore, during the analysis, I tried to attune myself with the body's voice to discern how it was actively involved (facilitating or constraining) the process of recovery.

My positionality

The motivation behind this thesis stems from my personal experience. Thus, my positionality (both my socio-historically situatedness and my relationship with the topic here researched) played a central role in conceptualising this dissertation. As I subscribe to Haraway's situated knowledges epistemology, here I aim to weave a brief commentary on how I am entangled in my data, its production and ultimately its analysis.

I first started contemplating eating disorders as a potential research topic during my first year of GEMMA, roughly three years after I ended my eating disorder's treatment. I was never officially discharged from treatment - a pattern that appeared quite consistently across participants' stories-, instead, my treatment ended with the absence of follow-ups. Some years into my recovery and having gained some perspective over my time in treatment, I started thinking about some unresolved issues that were never addressed during my time in the day hospital - sometimes because they were not allowed to be discussed. Also, I started to be more attuned to the tensions that I felt in the transition from thinking myself and my health within the treatment's schema to following society's neoliberal healthcare prescriptions. I began to wonder about how care is shaped and delivered during treatment and what prescriptions of health underpinned therapy. Even though the support I received was crucial to my recovery, I felt like I needed to undo some rigidities that were inscribed in my doings during my treatment experience.

My eating disorders' story and recovery mostly fit dominant narratives about eating disorders - as I am white, middle-class, heterosexual passing, cis-gender, educated, with an abled body and with quite normative natural body size. Therefore, if I only had to analyse my personal story, this research would not only lack representation, but it would also reify a normativity that systemically excludes other experiences from treatment. As it has already been noted, stereotypical representations of eating disorders "pervade treatment models and current perspectives in recovery" (LaMarre, 2018, p.56). Therefore, such ideas systemically preclude possibilities of recovery for those who do not match the expected mould of eating disordered person in terms of class, race, gender, sexual orientation and ableism, amongst others.

However, the truth is that my personal experience has deeply informed this research project. I lean to think that this has positively contributed to the final product since it has been a helpful guiding light throughout the research process. However, it has also posed some challenges. Due to my personal implication with the topic, I had trouble finding an academic approach to what always had been a personal matter. I struggled thinking about treatment experiences and recovery from a different perspective, using a new vocabulary. Especially when building the more theoretical sections, I felt a tense relationship between my academic voice and my embodied lived experience, a tension that proved challenging to work through. The way I was thinking and writing as a researcher seemed to be putting aside my other way of talking about the experience of care and recovery from eating disorders. In a way, I was suspending my previous way of knowing to privilege ideas or words that seemed to know better. For that matter, and in order to reconcile this tension, I resolved to include myself as a part of the sample, so at least I would have a space of my own to speak freely, where no academic arguments would quickly jump to persuade me of making a thoroughly elaborate statement.

Participants did not only contribute to this thesis's meaning-making process bringing their personal perspectives, but they also affected the thesis by challenging me in many ways. For example, even though I did not want to subscribe to any specific definition of recovery, I inevitably carried my own personal understanding of recovery to the interviews. This idea made itself evident to me when I found myself feeling challenged by other's takes on recovery that did not necessarily align with my personal views. Here is where including myself as part of the sample came in handy.

Later reading my interview and acquiring awareness of my perspectives on recovery helped me disentangle my own version of recovery. It allowed me to recognise my assumptions and deconstruct my own views to favour a more complex and rich account. Moreover, it is precisely this diversity amongst participants' experiences that ultimately made clear how we only experience recovery through our specifically situated bodies. Therefore, it reminded me about how perspectives on recovery, including those presented here, will be ever-partial.

After some interviews, different participants asked me about other's answers. They wanted to know if their experience and thoughts about how recovery looks were shared amongst the others. I interpreted this curiosity as a way to obtain validation over an experience of recovery that did not necessarily fit clinic or cultural representations. This preoccupation speaks about the need to broaden and problematise dominant definitions of recovery. This is what I aim to address in the following two chapters.

Chapter 3: Embodied cartographies of care and recovery

In this section, I present three themes distilled from participants' stories about their experiences living through eating disorders treatment and its recovery. Despite being treated in the same day hospital, no two participants' experience was identical. Nonetheless, some commonalities and other remarkable differences from their testimonies are weaved together to form a polyphonic account on the relationship between care and cure in eating disorders. To that aim, I will present three general themes, each underscored by a number of different sub-themes. 1) "Negotiating biomedical and neoliberal discourses" is comprised of two sub-themes: "Choice" and "Not a matter of weight", where dominant definitions about eating disorders and its recovery shape participants' experiences which either voice or refute them. A second thematic area 2) "Unravelling care" consist of four sub-themes: "Being cared for and being watched", "Not being trusted", "Unaddressed topics: body and food", and "Life after: undoing and redoing care practices". Here, participants' address what constitutes and how care feels during eating disorders treatment to untangle the conditions of good-transformative care. The last general theme 3) "Figuring out recovery" includes three sub-themes: "Finding their way", "Unattainable recoveries: Love your body as it is" and finally "Recovery as a daily habit". In this last section, I gathered participants' experiences renegotiating idealistic recovery representations and finding their own ways of inhabiting a stage that appears to be always in the making.

3.1. Negotiating biomedical and neoliberal discourses

3.1.1 Choice

Participants often framed eating disorders and its recovery as a matter of choice. However, this position is nuanced by other accounts where participants appear to be unaware or unsure of how and when their distress started and where to situate their turning point in the recovery process.

Narratives of choice are also present in the approach taken by the health care providers who treated them. Following the quote below, participant's health care providers conceptualised recovery as an individual decision the patient had to make for herself.

> *I decided to commit to recovery on multiple occasions during treatment. And I don't think it comes down to one, but I mostly remember this one time. I recall I was doing individual therapy and the psychologist told me: "no one is going to help you, Silvia, I'm sorry, but your parents don't know what you need, so if you don't do something about it, you'll end up hurting yourself, and it's going to impact both your health and your wellbeing, and they'll hospitalise you, and the only one who will end up losing it's going to be you. You can go on with this, or you can do something about it". And probably I had already heard this like 30.000 times, but I remember telling myself "I swear I'm not going to purge again". And I kept that promise for some time. It was the first time I kept it so consciously and probably for the longest since I first started therapy. (Silvia)*

In stressing Silvia's role in her own recovery and rendering it as the only mean by which she would be able to attain it, the psychologist foregrounds participant's agency while also making her responsible for her healing. That is to say, here recovery appears to be a process made available to patients by choice, which might also fail to recognise the relationality of recovery. According to LaMarre and Rice (2020), this approach may foreclose a more nuanced understanding of recovery, one that portrays it as a complex process, deeply entangled with life. From their perspective, recovery, far from being an individual achievement, it mobilizes multiple forces, human (people, systems of care, etc) but also non human (affect, discourses, etc). Put simply, recoveries are multiple and co-constitute. Therefore, having Silvia commit to her recovery might not be enough. In fact, not recognizing how other forces come into play generating possibilities or impossibilities for recovery could complicate the process itself.

It is also worth noting how the focus on recovery as a choice[7] within therapeutic spaces highly reassembles the neoliberal outlook on health, a framework in which the individual is made responsible for their wellbeing. Therefore, from the neoliberal optic, recovery is a direct outcome of the choices patients are expected to make every day. This perspective can be quite unforgiving if we have to come to terms with the idea that recovery cannot be thought in a clear, direct, linear manner but rather as an entangled unfolding. Therefore, recovery as choice is an approach that might easily translate into frustration or guilt as it does not offer enough space for trial and error, ups and downs and stuckness during recovery.

This idea of choice evidences how, despite feminist efforts to contextualize the distress and its interconnectedness with sociocultural discourses, eating disorders and their recovery are still clinically judged to be an issue of individual concern. However, Silvia's voice in this very same quote offers a more complex and nuanced account of choice. Even though she is also keen to think of recovery as a matter of choice, she accounts how the decision itself, even if made repeatedly, does not necessarily deliver the desired results. Therefore, recovery can easily be missed if it is solely approached as a matter of will and predisposition.

Moreover, not only recovery but also eating disorders appear to be framed as a matter of choice. This approach, which perfectly reflects those seminal definitions about eating disordered sufferers being willful, superficial and vain, potentially difficult supportive relationships during the distress. Framing eating disorders and their recovery as a choice harms both those who are suffering and those who, engaged in the process of recovery, fail to live every day up to recovery standards. In the following quote, Ari explains how the relationship with her father suffered because she failed to cut off her symptoms overnight after he offered his help.

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[7] Not to mistake with the logic of choice. Here choice is use to talk about patients compliance with eating disorders treatment. Not about patients' ability to make free informed choices regarding the direction of their treatments.

> *During the lockdown, I started purging four times a day. So I called my dad and asked him to come and stay with me because I feared for my health. He came, but he thought I could change that overnight. He came with the idea that I would stop purging immediately. And now he is angry at me because the other day I told him that during that month he stayed with me, I went from purging three times a day to three times a week. I told him I didn't manage to stop it for good, but that the change was huge. But that meant nothing to him, all he could think of was "you kept on doing it, my help was worthless". (Ari)*

Ari's father's frustration is due to his misguided understanding of symptom remission as merely a matter of choice. Therefore, the continuation of her daughter's purging, even if significantly less regular, was directly read as a failure. By expecting her to abandon overnight all eating disorder's symptoms she was previously engaging with, her father assumes that willingness is the only thing that takes to recover, failing to acknowledge all the forces involved in a more intricate process. As Ari's story shows, by framing both eating disorders and its recovery as a choice, the person is deprived of support and from having her efforts and progress recognised. Moreover, if supportive relationships are part of the recovery assemblages, the idea that willingness is the only thing that takes to recover might be directly preventing it from happening.

However, this idea of choice is also contested by other participants' views, where eating disorders are portrayed as an alternative made available to them to deal with their lives.

> *For a long time, I obsessed over what triggered my eating disorder. Some girls at the day hospital had a super clear idea about what triggered them, but I didn't have that. I had a good relationship with my family, school was fine, everything was fine, nothing traumatic ever happened to me. So the question I repeatedly asked myself was: what happened to me? But in the end, I learned that maybe it wasn't something specific, that nothing happened to me and that my eating disorder was a poor way I found to manage my life.(Gemma)*

Gemma understands her eating disorder as a coping mechanism she developed during her teenage years. However, this coping mechanism was not meant to manage distress caused by any specific traumatic experience she lived through - what was the case for other fellow patients - but rather to cope with her everyday life. Here, one could easily argue how choosing to engage in eating disorderd behaviours as a coping mechanism cannot be understood as a choice. In this sense, the idea of choice is challenged by the subsequent feeling of engaging in such a way of managing life. When asked about how their eating disorders felt, all participants rendered them as stories of pain and suffering. The two quotes below encapsulate the general feeling shared amongst all participants proving how EDs, while being "profoundly dangerous and distressing" experiences, still "may offer a painful and precarious way of coping with day-to-day life and distress" (Lavis, 2011, ?)

> *First hopelessness, loads of hopelessness, not knowing what to do. I also felt empty and a deep pain inside me—also anxiety and anguish. I felt broken, inside. (Clara)*
>
> *Emptiness, sadness, hopelessness, frustration, unhappiness, apathy. (Bel)*

In direct contradiction to the idea of choice, participants also described eating disorders as a severe medical illness. This is a common position that has also been taken in public advocacy campaigns when seeking to grant eating disorders recognition as a severe mental health issue, while also trying to boost compassion towards those who suffer them. In taking this position, participants complicated the idea of choice in eating disorders recovery, first, explaining why one cannot simply choose to stop having them, while also acknowledging the importance of making treatment available to everyone. In this regard, some participants draw parallelisms with the experience of addiction to explain how being aware of the disorder did not mean knowing how to control it. As an example, in the following quote, Ari's identifies the development of an addicted brain as the turning point of her eating disorder, which later explains why she decided to focus on her brain's workings to gain more insight into how she could go in her recovery process.

> *I've always wanted to know what is going on in my brain, why it developed this addiction. You know, you start this illness with a goal, either seeing yourself better, thinner, being able*

> *to eat whatever you want without putting on weight… but eventually you realise that it might be giving you what you sought, but it is also taking away more than you could ever imagine. And when I reached that point of realising "fuck, I'm losing everything" I decided that I didn't want this in my life anymore. The problem is that at that point, it is tough to fix it because it has become an addiction. So it's no longer a choice, something has changed in your brain. (Ari)*

Ari understands her eating disorder as a direct consequence of a diet she started following in her teenage years, which again reproduces the idea of eating disorders as a matter of choice. However, from her perspective, the practices in which she started engaging with - such as restriction - quickly unleashed others - such as binging and purging. In other words, to Ari, her eating disorder and, more importantly, its later maintenance, is not to be understood as a matter of choice, but instead as the biological consequence of engaging in such practices for a continuous period of time.

The addiction her brain developed is the central question she considers needs to be tackled to attain recovery. In that sense, Ari's take on both eating disorders and its recovery is very much focused on the working of the body. She further expanded her stance defining eating disorders as a state of undernutrition.

> *Some experts describe eating disorders as a malnourished state. You can weigh more or less, I am not talking about weight, I am talking about nutrition, I am talking about the fact that your body asks for vitamins, proteins, fats, something that you are not giving to it. So as a response, your body binges. A binge is a response from a healthy brain to let you know "hey, you are not feeding me right, I need more". If you get your brain used to eating every three hours, your brain won't ask you to eat more after lunchtime, because it knows you'll be feeding it again in three hours. I have driven my body crazy, so I can have breakfast, lunch, or dinner that it will ask me for more because it doesn't know when I'm going to withdraw food again. (Ari)*

From Ari’s point of view, it is not the person who has to be held responsible for the eating disorders behaviours but rather the body itself. On the one hand, this idea aligns with clinic’s focus on nutritional rehabilitation as the necessary first step towards recovery. On the other, it also resonates with feminist new materialists works on eating disorders, who have interpreted biochemical imbalances affecting eating behaviour, in this case, triggering binges, as a way to speak about body's agency. In relocating in the body the origin of the distress, Ari’s perspective dismisses the idea that choice plays any relevant role in eating disorders development. That is to say, understanding eating disorders as a state of malnourishment calls into question the primacy of the mind over the body, or rather the separation of the mind from the rest of the body.

However, this conceptual move comes with its own risks. If malnourishment is to be seen as feeding eating disorders, it can be used to make eating disordered subjects into unreliable advocates for themselves, unfitted to make good choices. It runs the risk of reinforcing the idea that they are untrustworthy.

3.1.2 Not a matter of weight

Participants expressed skepticism about weight being a reliable indicator of health both when they were in distress and also in recovery. They agreed upon the idea that the primary focus on weight in clinical settings and dominant discourses about eating disorders fails to recognise one’s distress. Moreover, they also argued how attending solely to biometrics, such as BMI or weight, can lead to misguided diagnoses. In this sense, Bel is very adamant about how biological metrics, such as weight, should not be considered diagnostic criteria for an eating disorder.

> *An eating disorder does not come predetermined by the person’s weight, or by the BMI. This appears in the DSM, and many people are diagnosed with anorexia because they are depressed and stop eating. To me this is not a case of anorexia because the weight loss is due to the depression.(Ada)*

By expressing how in cases of depression a low BMI can be mistakenly read as a sign of disordered eating behaviour, Ada questions weight centred diagnoses' reliability, pointing out how weight loss can be a com-morbid effect to many other mental health issues. However, as I have tackled in previous chapters, the likelihood of someone being diagnosed with an eating disorder when showing symptoms of depression paired with a lower BMI depends on the person's identity. Variables such as gender, age, sexual orientation, race, ableism can deeply influence the outcome of the diagnosis as stereotypes around the disordered eating subject deeply inform diagnosis criteria (Malson & Burns, 2009). Similarly, Nica notes how weight centred portrayals of the distress, often leave differently embodied eating disorders unacknowledged.

> *We always associate anorexia and bulimia with this image of a severely emaciated body. But for example, many people have bulimia and don't purge, so there is not always this extreme thinness. And I find that people in this society have a hard time understanding this. In my case, I've never been severely emaciated, so I sometimes felt that because I was not thin enough they didn't see what was happening to me. Part of my family never really understood me nor supported me because they attributed my body change to puberty or hormones because it was nothing like a drastic change. (Nica)*

Because her weight was never read like something out of the ordinary, Nica's loved ones never acknowledged her eating disorder. In Nica's experience we can observe how not matching the stereotypical image often seen in media representations of eating disorders, calls into question the authenticity of one's experience, which directly impacts the support one will receive. Biometrics such as weight or BMI are not only deemed to be misleading or detrimental in acknowledging one's distress, but they are also considered to be misfitted for accounting progress during recovery time. For example, when asked about what she would like health care providers knew about the recovery process, Ari expressed the need to approach nutritional rehabilitation from a non-weight-centric perspective.

> *I believe there is no need for weighting. There are other ways to measure nutritional progress. A number doesn't say anything, never. And a dietitian cannot base their work in a formula (BMI), a formula doesn't say anything about the person's health. So I think recovery shouldn't focus on weight but instead in developing healthier relations with food. (Ari)*

In the interview, Ari expressed how she felt her health was regularly judged based on her weight. She complained about how others would make comments about her body being thinner than a couple of years before, assuming she was healthier when she weighed more. This assumption annoyed her as it failed to recognise how far she had come in her struggle with eating disorders. She also reflected on how this tendency of equalling health with weight allowed her distress to go unnoticed in the past.

> *I could be binging and purging every day that, because I looked fatter at that moment, they would assume I was better (Ari).*

Later in the interviews, she explained how that hurtful dynamic with food changed for her when she decided to turn towards nutrition. Learning more about it allowed her to take better care of her body, ensuring she was feeding it with all the necessary nutrients while building a healthier relationship with food. However, the fact that she still weighed less than before would automatically call into question her wellbeing. In other words, Ari's health, as well as her efforts, were disregarded by a weight centred definition of recovery.

Further expanding on how eating disorders tend to be dismissed on the base of weight, Maria's testimony shows how, in larger bodies, the distress seems to go unnoticed at greater lengths. In that sense, when talking about her relapse experience, she shared how her family did not acknowledge her pain because a) she was not engaging in restricting or purging behaviours and just binge-eating, and b) she gained weight instead of losing it.

> *They think that because my weight has changed, I am better now. And they don't realise that sometimes I feel as I felt when I had just entered treatment. I try to talk about it with my mom, but she only sees that I eat normally and thinks that I am fine now because I no longer restrict meals. She is like "well, before you were not eating and now you do eat", and it's like yes, now I eat my plate but I also eat yours, but it doesn't matter because I do eat, so… that's the thing. (Maria)*

Maria described her mental state as distressed and her current body-type as obese. In contemporary western societies, fatness gets to be equated with unhealthiness caused by a lack of restraint and morals (LeBesco, 2011). Fatness might be seen as an illness, but not of an eating disordered kind. In other words, when talking about food/body related problems experienced by a fat embodiment, the person suffering from them is the one held responsible for their condition. While in other contexts weight gain is quickly pointed out and addressed as something in need of change[8], that might be a delicate matter when it involves someone who has a history with eating disorders. This clearly exemplifies the different messages operating in dominant biopedagogical instructions issued to the broader population and the biopedagogies of recovery those who were ever diagnosed are expected to follow. Therefore, to Maria's family members, putting on more weight was never read as an indicator of risk because to them, thinness and not fatness meant illness. In that sense, Maria felt unseen, and her distress went unrecognised as her eating disorder - binge eating - was judged to be a matter of personal preference or taste.

> *I think there is this belief that I have a sweet tooth and that is why I eat more. It feels like eating in excess without vomiting after is somewhat normalised, they [family]are not aware of the problem, so I don't feel they support me because they can't see what is happening to me. So I would tell them that an eating disorder is not only about restriction and purging, you know? Binging without purging is also an eating disorder. (Maria)*

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[8] In contemporary western societies, fatness gets to be equated with laziness, unhealthiness and ugliness and is constructed through a global health crisis discourse known as "obesity epidemic", which produce fat bodies/subjects as "diseased on an individual level, and as parasitic on a social level, monopolising healthcare resources while failing their responsibility as good neoliberal citizens to enact proper self-management through weight loss" (Pausé, Wykes, Murray, 2016, p.2)

In this quote, Maria accounts for a hierarchy in eating disorders types, presided by those types that restrict food intake. This idea was shared amongst many other participants who highlighted the need to recognise the vast spectre of symptoms eating disorders can manifest through. In other words, they accounted for the need to acknowledge other eating-related behaviours apart from drastic food intake restriction - anorexia. I have already argued how this hierarchy is not innocent. While symptoms based on exerting control over the body reproduce a valued cartesian logic, there is a kind of disdain over the "loss of control over bodily appetites" that bulimia and other non-restricting and non-purging eating disorders types come to represent.

Moreover, Maria experience might show how disordered eating behaviours embodied in fat corporalities tend to be judged as a matter of personal choice or preference - her having a sweet tooth - rather than as the manifestation of mental distress. The idea that a fat body might be suffering from an eating disorder does not match the pathology’s normative image. Similarly, some feminists interpretations might also fail to account for such experiences. For example, from a feminist interpretation of eating disorders as practices of self-objectification it might be presumed that fat bodies are immune to the distress, as they already overflow what counts as desirable.

3.2. Unravelling care

Participants felt treatment as a safe and supportive space - both in the physical and ideological sense and as a highly surveilled one. Interestingly, these same two conditions both enabled and limited participants in their paths towards recovery.

3.2.1 Being cared for and being watched

One of the characteristics of the day hospital where all participants received treatment was its group therapy format. Together with other approaches - such as individual and occupational therapy - the group was the main place where treatment was conducted. And not only treatment, but also the rest of daily activities - such as having breakfast or lunch, study sessions, and spare time - that would make a regular day at the day hospital. In that sense, for the vast majority of participants, the group became the primary support in their recovery. For example, Laia described the group as a place where she got to have her whole story understood.

> *I struggled opening up to them [the group], but when I finally did it, they became my main support system. I could tell them anything I couldn't share with others. I also felt safe in sharing other traumatic episodes of my life. Everyone had her story, and some could get me more than others because they experienced similar things in life, but however different our stories were, we all understood and showed empathy for one another. Or at least that is how I felt. (Laia)*

To Laia, the group was a place safe of judgement, a place where she could share the complete version of her story expecting to receive nothing but empathy at the other end. Similarly to Laia's experience, the group was seen by many other participants as a place where they felt unconditionally supported and understood. For some, that meant seeing themselves in the lives, thoughts, and feelings of others companions, while for others it meant feeling comforted by the dynamics of care and love that they found within the group. The group was sometimes perceived as a "*micro world"* where they got to be someone, which contrasted with their general feeling of finding themselves lost in a world that felt momentarily too big for them. In that sense, treatment was perceived as a safe, supportive space, where participants developed caring relationships that nourished, helped and accompanied them throughout both treatment and life.

In some lucky cases, that support extended way beyond the physical limits of the day hospital and it was also found in other spheres of life such as in family members, partners and friends relationships. In that sense, some participants recounted how treatment got involved some of the core actors in their lives, making allies out of them. Outside-supporters often worked as mediators between treatment and the outside world. For example, in the following extract, Laia remembers how her friends helped her get where treatment rules did not allow her to go.

> *My friend Ana was always there, supporting me in anything. For example, when I was being treated, I was not allowed to cook, and one day I had this dinner with friends at my place, and Ana came to my house to cook dinner for them and me. I mean, not everyone would've done that. (Laia)*

Laia was lucky enough to count with her loved ones during her recovery process, but not all participants found support in their most intimate circles and were often left alone in their journeys. However, the reality was that half the participants expressed trouble finding support. The reasons why were varied. In some cases their families, partners or friends failed to acknowledge their distress, judging it a matter of personal choice. In others, participants felt that even if their outside-supporters followed all the rules treatment taught them - for example, keeping them company, covering their mirrors, not letting them cook or eat alone, etc. - they did not manage to fill their supportive roles accordingly to their personal needs. In other words, participants felt surveilled - not being able to do things by themselves and not being left alone - but not taken care of - feeling seen, or listened -. Even in the most favourable scenarios, supporters involvement was not categorically perceived as helpful. Sometimes the most well-intentioned care was experienced as limiting. For example, when asked about what she would have liked her supporters to know about the process towards recovery, Bel pointed out how their care can sometimes feel restrictive.

> *I would tell them that they have to accept the process of the person they are supporting with no holds barred. They can't change that process, and sometimes, they try to do so. They try to force it, even if they have good intentions and do so from a place of love. To support someone in their recovery process is a difficult thing to do, and it involves working on personal things. Like not projecting your expectations and wishes on the other. Taking care of someone means fully accepting them and their pace and journey. (Bel)*

Care, even good, loving, well-intended care can sometimes feel hurtful, specifically when it remains blind and deft to the specificities of the person taken care of. On the contrary, as Bel suggests, care-full care is one that is attuned with the person's needs, free of judgement and above anything else, accepting and patient. This approach resonates with the logic of care described by Mol, in which care is a practice that both demands being knowledgable, accurate and skilfull but also attentive and forgiving. While following treatment directions on how to take care of someone in recovery can be crucial in their trajectories toward wellness it is no less so to do it attentively. However, as the quote below exemplifies, being attentive to the person's needs might be a more difficult task than it initially appears. In this extract, Ona talks about the care dynamics within the group, and she brings up a situation that allows reflecting on the complexities of care in the context of eating disorders treatment.

> *For example, if the girl who was having trouble eating was sharing a table with you, you would've stayed with her, to make her company. The thing is that, even if you had good intentions and you wanted to help and support her, I think the person felt more pressured because of you. And probably you are doing it with the very best intention, you just want to help her to eat because if she doesn't manage to do so, she'll have to face the consequences and you don't want that. But, yeah, imagine how the other person feels in this situation, you are there, kind of insisting, staying there "because of her" when you should be at a therapy session. I think that probably made her feel even worse in some way. (Ona)*

This scene reveals how in eating disorders treatment, there is not always the possibility of being attentive to people's needs, especially when those needs are interpreted to be eating disordered. In the scene described by Ona, the struggle to eat is not listened to, but instead dismissed. The company that the peer offers is not intended to make room for the struggle but rather fix it. To make her eat seems to be the only possible course of action care can take in this situation, because if she does not manage to do it, "she'll have to face the consequences". Therefore, help here is put in motion to avoid greater harm; the possible consequences of not eating. And according to Ona, those were not minor.

> *When someone would not eat, they would bring up the possibility of referring you to a hospital, where they would be able to feed you through tubes if you kept on refusing. And on many occasions, they would bring that up at lunchtime, when someone didn't want to finish their plate. And if the day went by and the person still hadn't managed to eat her meal, the chances were that the ambulance would come to pick them up. It felt almost like a punishment, "if you don't finish your plate, the ambulance will come for you". Even if they said it was in the best interest of the person. (Ona)*

What I see lacking in these two previous scenarios is precisely the care described by Bel. A support that is accepting and free of prejudice, mindful of people's pace and journey and attuned with their personal needs. In any of those situations, no space is made for the person's trouble. The problem - not feeling/wanting/being able to eat - is not tackled with care, but rather it is attempted to be solved through the threat of its consequences. What the unwillingness to listen and make room for the patient's struggle implies, is the idea that eating disordered patients are no to be trusted. As addressed in the first chapter, clinically, their motives are distrust as they are often seen as vessels of their disorders' voices. Consequently, while in other circumstances not eating during lunch time would have been approached differently, asking questions such as what is wrong? how does it feel? or where does it hurt?, in eating disorders treatment the refusal is interpreted as non-compliance. And as exposed before, non-compliance is conceptualized by the DSM as part of the individual's pathology. Therefore, whatever reason they might have not to eat, none will excuse them from doing it.

On the other hand, the reasoning behind this way of handling the situation is the idea that by refusing to finish her plate, the patient is positioning herself against her own health. By not eating - or what is the same, by failing to choose recovery as it gets to be defined in treatment spaces - the patient is understood as both unfit to look after herself - as her eating disorder has taken over - and willfully unwilling to get better. In any case, the patient is perceived as a threat for herself, what later justifies referring her to a hospital where her will can be momentarily suspended. Participants evinced how the idea that eating disordered patients are against their own best interest pervaded treatment spaces. This untrustworthiness is further exemplified in the quote below.

> *At the beginning, it was torture. When I started, I was having breakfast there and every day I had the same, toast with jam or a sandwich. And I have never liked jam. I hated it. But when a patient expressed…and I get it, if we would've started sharing what we don't like…but to me, eating jam almost every single day was a nightmare. Just the smell of it brought on my retching. I didn't stand jam then and I still can't have it now. But they never gave me another option, when I would have taken anything instead of that. I was not even allowed to say that I didn't like it. And I can assure you it had nothing to do with my eating disorder. (Nica)*

Nica experience exemplifies how in eating disorders treatment, patients are not thought to be trusted, especially when it comes to food. In this sense, Nica's dislike for jam was always dismissed because her discomfort was understood as her eating disorder talking. In other words, her personal preference was subjected to be pathologized as Nica’s persona was interpreted to be a false consciousness (Saukko, 2009, p.70), whose voice has been co-opt by the eating disorder. Within this frame of thinking, opinions around food are not only not to be trusted but counterproductive in the task of bringing back the lost self (Lavis, 2016). If, as the DSM suggests, obsessions and compulsions related to food are caused and exacerbated by undernutrition (APA, 2013, p.341), food might be needed to free the self. However, as exposed in the quote above, to understand re-feeding as a way to bring back or move forward to an authentic self might mean to overlook or be unaware of patient’s current needs.

This mistrust was not unique to food or eating-related situations or topics, but rather it affected patients as a whole. In the following quote, Vera explains how she felt her preferred physical/gender presentation was problematized as a body issue.

> *They made an issue out of things that I don't believe they were a problem at all. For example, the way I dressed was a hot topic there. They were really annoying about it. And I still dress the same way I used to dress then, you know? I mean, I've never been a fashion girl or anything of sorts, and I've always preferred loose clothes. Never say never, but I'm pretty sure you won't catch me wearing tight tops or things like that. And I think they pressured me to wear things I didn't feel comfortable wearing. I don't believe it was because of my body issues. Because nowadays I feel good about it, but I'd still feel uncomfortable wearing that kind of clothes. But at that time, this was problematic. (Vera)*

In the quote above we can see how dress code is used to tackle body issues in a way that is not attuned to personal or gender expression, which shows how broader societal idealization of proper femininity are enacted within treatment (Eli, 2014). Again, patients preference is not believed. Similarly, in her interview, Vera reported how she felt her personality type scrutinized and some traits valued as problematic. From her perspective, treatment missed some flexibility and more tailor-made approaches to each patient. However, I would add, such concessions cannot be made departing from a place of untrustiness. I will expand more in the topic in the following section.

3.2.2 Not being trusted

As exposed in the previous subtheme, the idea that people with eating disorders are untrustworthy deeply informed treatment. In that sense, participants described how being framed as untrustworthy fenced in their freedom and made them feel childlike and dependent.

> *In my case, it [the surveillance] was disproportionated. My parents never left me alone, not even when I had to shower or use the bathroom. I really struggled with it. Yeah, I mean, eventually I got used to it, but still, I had a tough time because I've always been independent in that sense, I've always felt a little bit advanced for my age and wanted to do things by my own, so being watched all the time really annoyed me. It made me feel like a child. (Nica)*

Apart from Nica, other participants intensely disliked the surveillance under which they were put down. Some expressed how they felt they did not have a say in their lives anymore. Vera remarked the shame and humiliation she felt when other people noticed how her supporters watched her closely. On the other hand, Clara talked about how the surveillance enacted by her parents infuriated her to the point she felt angry at them all the time. According to LaMarre and Rice (2020) "surveillance in recovery may be intended to create safety but yet generate resistance and self-doubt". To them, this does not mean that rules or watching do not play a role in supporting recoveries, but rather that they might be variously helpful depending on the way and the specific moment in recovery they are enacted. For example, other participants reflected how their supporters' surveillance practices made them feel looked after and cared for.

> *They were always keeping an eye on me, and I really liked all that attention, it made me feel safe and deeply cared, so I liked that. But… and I think that is truly important, you know, feeling looked after, but I also think it had its downside. Because what I learned over my treatment is that my eating disorder was a way I found to look for love and care and empathy, so, in a way, the fact that, for example, my mum was constantly keeping an eye on me, I think it also worked as a maintaining factor. I kind of associated being ill with being cared for. (Bel)*

While for Bel surveillance meant love, for Nica, it meant losing her freedom. The contrast between these two experiences shows the mutable nature of care and how it cannot be assumed to serve everyone the same. It speaks about the need to be attentive to how specific articulations of care might mean different things to different people and different things to the same person in different moments within their journeys. Drawing on Mol's work, here the logic of care offers a suitable guide to how we might approach care practices. According to the author, care is a matter of doctoring. And as I have previously exposed, doctoring requires you to be knowledgeable and skilful no more than attentive, inventive and collaborative. When solutions do not suit problems, in this case, when supportive relationships based on being watchful become an obstacle to recovery, the attitude should be experimental. Not only psychologists, but also the patient and their support system are expected to tinker with alternatives to find an appropriate solution for the time being.

But Bel was not the only one questioning the effectiveness of surveillance approaches regarding recovery. For example, in her interview, Ari was adamant about how the surveillance practices shaping her treatment experience lead to a false recovery.

> *I mean yeah, I stopped having symptoms when I was in therapy because they left me with no other choice. Even if I don't believe it to be a good method nowadays, the truth is that being watched continuously kept me from purging. So in my opinion, being watched can help depending on how old you are, and your living situation, if you are still living with your parents or have someone who can do that job. But there are many people who suffer from eating disorders that don't have that support. So yeah, it helped me, I stopped doing it, but later when I left, I relapsed, and I started doing it all over again. That's why I don't believe this conventional method works because they can make you stop purging or restricting or whatever, but they are not really treating you. They aren't teaching you that you are independent and have to want it, and you have to do it for yourself. I mean, yeah okay, if they lock me inside my house for a month, obviously I'm not going to buy things to binge, but what is going to happen after that month passes by? For example, my sister was admitted to a rehab centre for some time, did she recover? Okay, well, yes in the sense that she had no drugs in her organism when she left. But was she healed? No, because she relapsed short after that.(Ari)*

In her interview, Ari talked about how she had two very different recoveries. According to her, the first one - the false one - was a direct consequence of the highly surveilled situation she was put under during treatment, which led to momentary symptom remission. However, Ari does not believe that recovery was complete and successful as it was not her own choice but rather an external imposition. In that sense, Ari’s experience challenges clinic’s predictors of recovery: in her case, weight restoration and corrected eating behaviour lead to a false recovery. That brings us to her second recovery process, where she finds herself currently struggling. In her interview, Ari mentioned how much she has been trying to find alternative ways to tackle eating disorders that do not align with "the conventional method" she received during her stay at the day hospital. To that aim, she has dismissed searching help in programs that will impose her what to do and instead she has been participating in different workshops, following and consulting with different professionals to find suitable strategies that will help her get over her eating disorder.

Moreover, she also stressed the need to put herself at centre in the process, as she currently lacks a solid outside-support system to take over her responsibilities. Again, Ari's experience in that sense was not unique, and other participants expressed how treatment stopped working for them as they grew older. For example, Silvia mentioned how she dismissed reaching back to the psychologist who treated her in the day hospital as she knew treatment rules were incompatible with being a first-time mother. All in all, what these experiences unveil is how eating disorders care is designed with a specific patient in mind. One that does not only have a strong support system but that is also able to suspend their time and abandon their environment in order to pursue recovery.

However, it is worth mentioning how some participants disagreed with Ari's point of view and thought that treatment restrictions played a relevant role in their recovery processes, allowing them to distance themselves from their symptoms. This permitted them to achieve a mental space from where to focus on other relevant aspects to their recoveries. For example, in Nica's case, even if treatment surveillance and restrictions made her feel childish, she also recognised how it helped her control her bingeing anxiety.

> *I didn't like it at that moment, but I believe being watched 24 hours a day was key in my recovery. I mean, I obviously hated it, but knowing that the kitchen and the bathroom were closed was a relief because it meant I could stop worrying about binging. (Nica)*

Even if Nica struggled with being watched and tracked, she also recounted how the restrictions imposed on her freed up some mental space that allowed her to access more calmness. However, while these restrictions worked for some participants during their initial treatment period, they became problematic in the long run.

3.2.3 Unaddressed topics: the body and food

Participants deemed treatment’s job at healing their relationships with body and food insufficient. For example, Clara shared how being forbidden to talk about the body or food left her unprepared to deal with such topics whenever she encountered them in her outside life.

> *In the beginning, it [treatment] worked well for me… but it came to a point where I felt like…in a bubble. For example…every time I bumped into a mirror or a weight-loss ad popped up in the TV was like "fuck, I was not supposed to see that". But it's not like you can escape from it you know? So I would've liked it not to be so taboo in some aspects. Because in treatment, there were many things you were not supposed to talk about. But you go outside and it is what it is. So maybe it would've been better not to be so overprotected. I mean, in the end, it is quite likely that some friend tells you about a diet she's been following because she recently has put on some weight. And every time someone talked to me about kilos or diets…it was too much for me. (Clara)*

Similar to Clara’s definition of treatment as a bubble, treatment has been conceptualized as a liminal space momentarily abstracted from the world (Lester, 2007), at once within and without society (Eli, 2018). In this sense, treatment space has been judged to work as a coping mechanism or a live-saving technique (LaMarre, 2018). However what Clara's quote brings to the fore is the tension participants experienced both inhabiting treatment liminal spaces and the outside world. In other words, how playing by the former's rules might have been challenged by the later. Participants were expected to follow treatment directives - in this case, do not talk about their bodies and food - no matter where they were at. However, as accounted by Clara's testimony that might have never been a plausible option given the assiduousness food and body are discussed in contexts permeated by neoliberal approaches to health. Not being able to talk about such topics outside therapy made them feel more taboo and secretive, consequently affecting participants' capacity to deal with them. In that sense, Clara felt overprotected, which later also impacted her transitioning experience after being discharged. Together with Clara, other participants expressed discomfort about the lack of a guided transition from total restriction to being once again in charge of themselves. For example, Gemma shared how she felt unprepared having to face food on her own after a long period of being forbidden to cook or talk about it.

> *It came to a point where you had to start doing things on your own, and when that moment came for me, I remember not being able to choose between a banana and an apple, like, everything was puzzling because I didn't know how to choose or what to eat. Also, I didn't know how much food I was supposed to eat. Nowadays, I've kind of learned how to do it, but for example, if you ask me to serve you your plate I wouldn't know how much a regular person that is not me eats. I still struggle with that. (Gemma)*

As argued by LaMarre (2018), choice deprivation characteristic of eating disorders treatment can later affect participant's choice capacity once recovered. Here, for example, we can see how Gemma struggled - and still does - with her food decisions. In that sense, almost all participants shared the opinion that while food and body issues were the apparent reason why they were there, they never fully got the chance to address those topics during their stay in order to rebuild their relationships with them. For example, expressed how while food and eating appeared to be treatment's priority - as the day was organised around food intake and weighting routine - she felt denied her need to talk about how she felt when eating. Similarly, Ona recounted how any attempt to discuss feelings, thoughts or sensations concerning her body quickly strayed from the conversation she meant to have and the topic was redirected towards "the problem behind it all".

> *I don't remember dealing with it in any way. I recall we were forbidden to talk about our bodies and food except when we were in therapy. Also, there was this idea that your body is not in any way, shape or form the issue but something more profound. So the relation I built with my body was similar to the one I developed with food, non-existent. All contact with it was restricted, you were not supposed to look at it, touch it or exercise it, at least at in the beginning. Even some bodily gestures were frowned upon, like pulling your shirt down whenever you felt uncomfortable with your belly. This was read like: something is going on you are channeling it through your body…But what if you were just feeling uncomfortable*

> *with your belly? What if it's just that? It almost felt like they expected us to disconnect from our bodily sensations. (Ona)*

Ona complained about not being allowed to address the sensorial experience of embodying her body in a time of stress was a shared view amongst some participants. Even though they highly valued the introspective work developed in therapy, they also felt not heard or believed enough when it came to their bodies. They accounted how every time they would bring up the topic it was quickly dismissed as a cover or manifestation of something deeper, ultimately overseeing the material and sensorial aspect of living in a body that does not feel right. Instead, the caretakers' response to any kind of vocalization of discomfort by the patients in regard to their bodies was: "Love your body as it is". This motto had a double meaning attached to it. First, on a superficial level, it spoke for the need to accept oneself as one is, both in a physical sense but also in a personal one. But more importantly, it was intended to stress the idea that participants' distress had nothing to do with their bodies, shape or weight, but rather the real problem or problems were to be found beneath the surface, in a deeper psychological level. In other words, body distress was understood to be a channel through which deeper harm was expressed. "*I think that the eating disorder is the last of your problems, what you have to fix is buried beneath" (Gemma)*. Thus, it was understood that focusing on it would keep patients from tackling the root causing the distress.

Paradoxically, body love was not taught or addressed during treatment, and no guidance was offered in developing a healthier relationship with it or looking at it through newer, more loving lenses. Instead, patients were instructed to completely detach from it to not lose sight from what mattered. To that aim, participants were required to follow a set of rules such as covering up mirrors and avoid any reflections, not measuring or weighing the body, avoiding touching it, for example, using a sponge in the shower, avoiding looking at sizes when shopping or not shopping clothes at all, amongst others. Moreover, issues concerning one's body were only allowed to be addressed during therapy time.

A similar view was shared regarding food. When asked about what they would have liked treatment did differently, participants complained about not receiving any nutritional reeducation. Thus, they missed being taught about how to feed and nourish themselves and others properly. Moreover, they also complained about how they experienced their nutritional rehabilitation. For example, Bel pointed out the importance of taking the pleasurable dimension of eating into consideration during treatment.

> *I will say the food there was shitty, it didn't help in any way. I think that if you want to win back someone who has fallen out of love with food, you shouldn't give her that shit, try to win her back with good food. Food that nourishes, good appetising food. To me, that was their first mistake. I didn't enjoy my feeding experience there. (Bel)*

Within Mol's logic of care, food and drink are not only instruments that serve the greater goal but are also relevant to caring practices (Mol, 2002).This idea is echoed by Bel in the quote above where she approaches food beyond its nutritional value. What she argues here is that food and drinks should not be treated as mere means to nutritional rehabilitation, but also as media for care. Similarly, Wilson's work argues how processes of ingestion and digestion could be understood as ways of relating to the world. Therefore, if eating can be approached as a place through which to rework more sustainable relations to oneself and others, more emphasis should be put on the process itself. From these perspectives qualities such as taste, consistency and temperature come to matter - as they might generate longing or aversion -. Moreover, other ingredients that shape daily dealings with food, both social and material should be attended to (p.217). For example, the space where these activities take place, how the tables are arranged, the people that gather around them and share the meal together and the words of encouragement or distraction that might come to sooth you when needed. They all might contribute to make of refeeding a more pleasant experience.

While some participants recounted enjoying the ritual of sharing their daily meals with the rest of the group and how they felt cared after with the occasional words of encouragement they received from health care providers and peers alike, treatment’s approach to food was not always careful. For example, Nica shared how treatment's use of food as punishment made her food reconciliation even more challenging.

> *I remember the chocolate squares vividly. They used to give us those as a punishment. I mean, what do you want me to learn from it? That chocolate is bad, it's a punishment, and that you are giving it to me because gaining weight is a bad thing. I used to have a chocolate square a day, for whatever reason. I mean, what are they teaching you with that? If you want me to normalise food, don't punish me with it. And that's what they were doing. (Nica)*

Food therefore, was not only non-negotiable, as I have already exposed before, but also used to punish. This is a conflicting idea that Nica had to work through when she tried to rebuild a healthier relationship with food. By being forced to eat a square of chocolate every time Nica did something wrong (according to treatment standards), food was used as a threat. Moreover, this was not done with just any type of food, but specifically chocolate. This also has many implications and ascribed meanings in terms of which food is deemed inadequate. Especially for a patient as Nica, for whom 'inadequate' was directly related to 'fat' at that time. Therefore, she did not only understand food to be something awful, but her fear of putting more weight was reaffirmed by the professionals treating her. This example shows how treatment is not a neutral space, but rather it also reproduces broader societal messages that could have been feeding eating disorders in the first place.

3.2.4 Life after: undoing and redoing caring practices

Practices of surveillance and restriction continued shaping participants' lives well into their recoveries. Either because they consciously chose to rebel against them or because they struggled to move on from them. For some, treatment rules or directives became established ways of moving through the world. Sometimes these ways of taking care of themselves were perceived as useful; other times, participants experienced them as limiting frameworks that did not enable them to move forward. For example, Ona recounted how she still feels limited to freely talk about her body after some years into her recovery, which does not allow her to move on in her healing journey.

> *I'd like to be able to talk about it [her body] more openly, in my day to day, without feeling guilty. I'd like to share whatever thoughts I have about my body in a more normalised way. Just as my friends can say "I don't like this or that", I'd like to share it without feeling like, "what am I doing? I can't talk about that". (Ona)*

What Ona misses is the opportunity to share her thoughts and feelings about her body, hoping to see her dislike in a non-pathological light. In her interview, Ona expressed how her frustration concerning the limitations posed by treatment's inherited ways of doing was a current issue for her. In that sense, she feels trapped in a moral conundrum about how to choose what is right for her. The conundrum here described by Ona can also be theorized as the struggle to navigate the biopedagogies of recovery described by LaMarre and Rice (2016). In the authors' opinion, while biopedagogies of recovery are grounded in "live-saving techniques and technologies of cure" (LaMarre & Rice, 2016, p.137) they can also feel limiting as they might hold individuals in recovery to different standards than others in their lives. In this case, while avoiding to discuss one's body worked for Ona in her path towards recovery, at the moment, such strategy prevents her from vocalizing an inconformity that is only denied to her in her most immediate surroundings. In other words, what this example shows is how continuing to live by treatment's generic rules complicates and limits one's capacity to move forward once treatment is over. In top of this limiting feeling, Ona also recounted feeling deeply guilty every time she thought of transgressing treatments prescriptions, suggesting the moralizing effects of such discourses. In the following quote, she further addresses how this guilt prevents her from making choices that could make her feel more comfortable in her own body.

> *What are you supposed to do if after treatment you still dislike your body? What happens then? And what if you want to do something about it? How do you deal with…I mean, I don't politically agree with diets but at the same time is like, what if that helps me? What if I feel happier by losing a little bit of weight…or I don't know, what if I like myself more when I look in the mirror and my tummy looks different? What if that helps me stop having all these thoughts about being uncomfortable in my body? But I can't even give it a try, because what I've learned in therapy is that wanting to change your body is bad, is pathological and sick. So whenever I think about it I feel this guilt, like I'm doing a bad thing. (Ona)*

When asked about what she would have liked to be done differently during treatment, Ona brought up the need for undoing. She specifically talked about the need for undoing the rigidity with which intentioned body changes are perceived during treatment. The question that here arises is if recovered individuals should keep engaging in biopedagogies of recovery or if on the contrary, they are expected to follow dominant biopedagogical instructions for the every person once they are discharged (LaMarre, 2018, p.105). What this dichotomy brings up again is the discussion about what being recovered is really about, at which point it occurs and wether it does, or people remain "in recovery" forever (LaMarre, 2018, p.247).

As we will see in the next section, some participants argued that recovery is never a final stage but an ongoing process and a constant struggle that extends well beyond after being discharged. Thus, it would seem reasonable to assume that diets or should be avoided as they can trigger obsessive thoughts about food and restrictive practices that can lead to feelings of anxiety. However, in her interview Ona also argued that the continued presence of these preventive ways of taking care of oneself can also make you feel “sick” and doubtful if the motives guiding your decisions are, ultimately, pathological. Indeed, doubting your decisions - especially when they are body related - is a logical outcome of the untrustworthiness patients are treated with and end up perceiving themselves in.

These doubts about whether one “is doing the right thing” when engaging in care approaches that oppose the biopedagogies of recovery, appeared recurrently in participants accounts. For example, Silvia, who recently decided to follow a diet to try to repair her long-lasting contempt with her body, also recounted these very same doubts.

> *Before I got pregnant again I was on a diet. When I started it I began to feel better because I had this specific goal, and I didn’t want to do it wrong, I didn’t want to become too fixated with it, I wanted to be happy, I wanted to feel good. So I did it gradually, not being hungry so I would not have anxiety, I wanted to do it the right way. I really didn’t loose much weight but in the process I started to perceive myself differently. I would look in the mirror and like myself better, even though it wasn't something noticeable, the process itself made me see my body differently. But I’m also not sure if this is a bad, you know? At the moment I thought it was cool, but because they instilled in us that wanting to change anything about our bodies was wrong…So what I am supposed to do then? I can’t do anything to feel better with my body? I’m superficial if I decide to do something about it? Or am I hiding a trauma with my father because I want to lose some weight? (Silvia)*

Silvia decided to follow a diet to lose the weight gained during her first pregnancy. After years avoiding to interfere in any way with the physical state of her body, she decided to try a “controversial” approach to heal this relationship consulting with a dietitian. Even though she still doubted whether she was doing something wrong, Silvia also recounted how she felt better with her body by just engaging in the process. What Silvia's doubts unveil again is the contradictory messages that participants have to face when both navigating biopedagogies of recovery and dominant biopedagogical instructions issued for the broader population. While in the former, pursuing a diet can be read as a pathological symptom, even a sign of relapse, in the later, sticking to a diet - especially after putting on some weight - is perceived as a responsible (expected) decision that shows self-control and discipline. In other words, in this quote Silvia contest the idea that eating disorders are individual illnesses that take place in a vacuum, caused by the individual's past lived experiences and exacerbated by their (superficial) personality traits. Instead she highlights how eating disordered symptoms, far from being pathological practices vulnerable individuals engage with, are simultaneously issued as health prescriptions to the broader population.

However the experience of following a diet for Silvia is somehow different. She is not merely abiding by the rules but she is also breaking them. In a way, this relates to how within the logic of care, care is an open-ended process that requires us to constantly make adjustments in order to serve its purpose. At some point, for Silvia that meant to overthrown old caring mechanisms - such as not weighing or measuring herself, not curating her food beyond the vague "eat a bit of everything five times a day" with which treatment defined normal eating, and not pursuing body transformation - to take care of herself and her relationship with her body. Thus, she routinely steps on the scale once a week, at the beginning following directions from her dietician, but later out of free will. This routine reassured her and reminded her how body weight fluctuates but it is also mainly stable. And that knowledge helped her to gain peace of mind concerning her body.

There were many other participants who in their processes of coming out from treatment and finding their own ways to stay recovered resorted towards new directions that diverged more or less from treatment approaches to recovery and care. For example, concerning the food one is expected to eat in recovery, some participants engaged with specific diets - such as vegetarianism and realfooding[9] - that would move away from treatment's food-related directives as they avoid food types - such as animal meat or processed food - and are also popularly understood to be substitutes of former eating disorders. However, according to participant experiences, this allowed them to develop a richer relationship not only with the process of feeding themselves and taking

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[9] Realfooding is a kind of diet that consists of on consuming only fresh non-processed foods.

care of their bodies, but also it allowed them to better align with and live by their values. For example, when asked about how she would describe her current relationship with food, Bel described it as a source of knowledge.

> *I enjoy learning about nutrition and how it plays with the hormonal processes in our bodies, I really like educating myself on how we can better nourish ourselves, and I believe nutrition plays a big role. I'm also vegetarian, so my diet is also a criticism on society or a way I found to be in line with what I think and how I feel and see the world. So it is also a way I express myself. But mainly I see it as a way to nourish myself and as a source of pleasure. (Bel)*

Following Wilson's work, eating is a way of relating to the world. Therefore, opening the space to talk about how you want to relate with it might allow patients to develop a way of eating that truly feels theirs. For Bel, being vegetarian - which was not allowed in the day hospital - and diverting from treatment approaches to food, opened a path to self-expression, exploration and care. In other words, it became a pre-requisite for her being in the world that could not have been achieved within treatment's framework.

However, as mentioned before, others recounted how self-surveillance devices continued presence made them feel safe and were important in their daily recovery enactment. For example, with regard to food and meals, many found it easier to keep on following a detailed meal plan to make sure they were not missing anything in their diets. Some found that by sticking to those, they would feel less anxious around food. For them, treatment "normal eating" directives - such as "eat a bit of everything 5 times a day" - were to loose and relied too much on their instincts, which were not accounted to be reliable sources of information. Therefore, for them, keeping treatment's rigidity in eating - having all their meals as it has been strictly planned - became a way to keep their recoveries going.

To sum up, participants' accounts on how they choose to live their recoveries were varied and colorful, proving there is not one ideal way to be recovered. It also came to my attention how, if I were to conform to a classical definition of recovery as understood in popular discourses, their choices could be easily misrepresented as not recovered enough. Either because they still aim to lose weight, because they decide to follow diets that are restrictive in some ways or because of their need to stick to a strict meal plan. This implies that there is objectively a way recovered people should be eating to prove their recovery, which, according to LaMarre, would "reimpose the very surveillance that some with eating disorders have found so problematic and contributory to their disorders" (LaMarre, 2018, p.273). Moreover, it is worth noting how all these personal decisions enabled participants to stay in their recoveries and move safely and coherently through their lives. What brings me to conclude that there is no specific, nor a correct way of being recovered.

3.3. Figuring out recovery

3.3.1 Finding their way

When asked about how recovery was portrayed within treatment space, participants expressed doubts of ever having had the topic addressed in a meaningful way.

> *The truth is that no one ever told me how my life would look like after finishing treatment, I could imagine it myself, but no one ever came to me to explain me "well, when you'll be done here you will feel this, this and this, and this, this and this will probably happen to you". We all knew that we could expect some kind of reconciliation with food, or at least this is what I thought one of the therapy goals should be: having a healthy relationship with food without feeling guilty. Also feeling better with your body and improving other things like relationships with family and friends. But no one ever told me…in fact the words "this is how a recovery would look like", never…(Laia)*

Following LaMarre, "participants do not recover into a void in which they know nothing about what eating disorder recovery is and how to get there" (LaMarre, 2018, p.285). Instead, their experiences and expectations stand in relation to multiple discourses and representations around what being recovered means (LaMarre, 2018). Therefore, even if the topic was not directly addressed, internalised recovery ideals were still embedded in participants' discourses. Here, Laia mentions two fundamental recovery ideals present in all ten participants' testimonies: reconciliation with one's body and food. Even though these standards informed the way they thought about and judged their recovery processes, participants were unsure about what their personal horizon of recovery looked like when they were in treatment.

> *There was this thing… the stages, there were five of them, the last one being the official discharge. Everyone passed stages in different personal moments. Like they meant different things for different people, and everyone passed to the next one in different points of their recoveries, so they were pretty contextual. I think that because of this, we never understood what recovery meant. It was something that was in the hands of the psychologist. We were just waiting for them to see something changed in us. (Ona)*

One the one hand, I would argue that not having a specific definition about how recovery looks like and what constitutes progress is the horizon we should be walking towards in eating disorders care. Attempting to grasp recovery in a singular story is a challenging task and a discriminatory one. Any definition of recovery forecloses possibilities. Instead, leaving the concept open and accessible to interpretation and renegotiation allows it to fit in a diversity of experiences otherwise left unacknowledged. On the other, if no definition about recovery is made available during treatment, it can leave the patient uncertain about how to attain progress and ultimately recovery. In that sense, some participants longed for a realistic image of what recovery would look like to them so they could have known before when they were ready to leave treatment.

> *I would've liked to know that (recovery) is more like coexisting. I remember having this conversation with the girls and saying something like "there is a cure to this, I totally see that". Right now, I don't see it that way. It is not like one day you have a cold and the other you don't have it. I would've liked to know that because, maybe, I would have known that I*

> *was recovered way before I did. At that moment I remember thinking "how do they have to discharge me if I feel like it is still here?" Knowing that recovery is more like coexisting, I would have asked for my discharge sooner. (Silvia)*

On the one hand, Silvia's experience highlights the importance of having access to a wide variety of realistic recovery stories to properly evaluate one's progress and finish line. On the other, it sheds light to the pitfalls of not involving the patient in the process of determining what constitutes recovery in each case. After several years of therapy, Silvia checked herself out of the day hospital when she got pregnant. According to her, she had been feeling ready to go for quite some time by then. In that sense, she regrets not having had closure - receiving treatment's official discharge - but she also recounted how the endless waiting for authority's approval made her feel chronically ill.

> *Treatment went on forever. They didn't let us go. [...] And maybe that is what made me not want to go back there when I relapsed, because going back meant being chronically sick again (Silvia).*

Silvia's experience demonstrates how the lack of an orientational definition of what recovery might look like in each case might translate into indefinite treatment timelines that can cause feelings of despair or unacomplishment. Other participants shared Silvia's opinion on the treatment's length. The general feeling about it was "not being able to see the end of it". In fact, after being treated an average of four years, some participants never got discharged and eventually decided to leave therapy because of other personal circumstances - for example, having a child, not being able to keep up with the expenses or moving to another country -. In that sense, many missed having some sort of closure that recognised their progress and personal investment over the years.

3.3.2 Unattainable recoveries: "Love your body as it is"

Besides experiencing recovery as an ongoing process rather than as a fixed, stable place, a recurrent reason why some participants were hesitant whether they successfully had attained recovery, was the feeling of an unresolved animosity towards their bodies. In participants' testimonies, the relationship with their bodies ranged from "discontent" to "totally detached", the general feeling being one of resignation. However, body dissatisfaction, despite being a better scenario, still felt at odds with treatment's mantra "love your body as it is", which made participants doubt their recoveries.

In this respect, I will argue that treatment's efforts to guide patients towards a healthy and loving relationship with their bodies was incomplete. This is made explicit in Maria's testimony:

> *The truth is that since I started following treatment's rules, I never stop doing it. For example, I never hang back the mirrors in my house. This has been my way of taking care of myself, detaching from my body. But this is also counterproductive. This detachment has worked well for me for some time, but as of today is more a way I have to avoid things. In fact, when someone takes a photo of me at a birthday celebration or… I don't recognize myself, I think, "uau, is that one me?". In these moments, I realize that because I no longer look at myself I don't SEE myself, I don't recognize myself. So I think I need to work on becoming a whole again. Right now my body goes one direction and I go the other. (Maria)*

As made clear in Maria's experience, there is a fundamental tension between the mantra "love your body" and its restrictive implementation through treatment's rules. Far from not serving any purpose, Maria reflects on how these rules once worked as a caring mechanism. However, they stopped working that way when they were not replaced by something of a more constructive nature, a guided process that granted body reconciliation. This tension surfaced quite recurrently in participants' stories, who reflected on how some practices of care deployed in treatment were experienced in different ways depending on the recovery stage they found themselves at. Therefore, while some care practices may have saved their lives once, these very same practices became a hurdle as recovery progressed. This unveils an important matter in relationship with the research enquiry that resonates with Mol's logic of care, as it evinces how it is impossible to judge articulations of care solely as helpful or hurtful. If care in eating disorders treatment has to be analyzed, one has to pay close attention to its fluid and variable nature, as it serves multiple purposes throughout recovery's timeline.

In Maria's story, we can observe how abiding by the rules, the distressful relationship with her body was replaced by a non-existing one. Learning to avoid any reflection that could return an image of her, Maria grew increasingly detached from her body and from a sense of self. In other words, what started as a practice of care developed into an evasive strategy. In this sense, Maria talks about a much-needed reconciliation that moves beyond avoiding and restrictive practices, a healing process that Bel thinks could have been pursued through a social and historical education in matters of the body.

> *It would have been helpful, and I don't remember they ever did anything similar, that they would have educated us in relation with our body, how our body is perceived in this society, how it has been read in the past, how it changes, what this depends on, what interests are behind. Instead of, "don't look at it, look at it, the option that you have chosen is not the best, because you are losing too many things with it". I think that would have been really helpful for all of us. (Bel)*

To Bel, a potential tool to heal the fractured relationship with the body could have been learning about the social significations of it, as well as about the regular changes it undergoes through one's lifespan. What Bel brings up regarding body reconciliation, is the need to address how collective memory is embodied in participants' feelings and relationships with their bodies. In other words, how participants' bodies are woven into being both by historically and politically discourses. Thinking along these lines would entail understanding healing from eating disorders not only as an individual process but also as a historico-political one. Whilst participants' testimonies accounted for the social forces and the environmental factors that participated in the development and maintenance of the distress and their recoveries, theirs were testimonies that mainly focus on the individual. In that sense, recognizing and accounting for the historico-political dimensions of the matter could open up an opportunity to bring the critical feminist eating disorder literature to treatment spaces. While feminist approaches have much to offer in terms of the cultural and socio-historical situatedness of eating concerns, their analyses have not been adopted in clinical frameworks. However, as Bel suggested, these perspectives might procure new lenses through which to understand and face distress around body weight, shape and food.

While almost all participants expressed the need for more information or a better reeducation concerning how to build a healthy relationship with the body, others were reluctant to accept their bodies as they were in the present moment. For example, Clara expressed irritation towards the ideal "loving your body as it is", making clear how, even if she eventually had to come to terms with her current body, she refuses to accept and go along with it.

> *There are things that I don't want to…* (makes a gesture asking for permission to speak freely) *there are things I don't want to accept because no matter how much I'm told, I don't like them and I don't want to accept certain things of my body. The obligation of* "*accepting yourself whatever your weight is…" I have a hard time with it. Obviously, your weight changes, and this is something I have been struggling with, my weight now. I mean, I have come to terms with it because there is no other choice, but I am still not comfortable with it. (Clara)*

In a similar way, as I have gathered elswhere in this section, Silvia also needed to justify her recent decision of following a diet, fully aware of how her choice would have been welcomed in the day hospital where she was treated. Both Silvia and Clara needed to wait until well past sometime after their discharge to express disagreement with some treatment ideas, which again speaks about the moralizing effects of the biopedagogies of recovery. However, it would not come as a surprise that Clara's longing for body changes and Silvia's decision to pursue a diet were to be read as eating disorder's voice talking. This way of reading body discontent in those who have had eating disorders during their lives can also be found in participants themselves.

> *I still think I want to change my body, you know? I would like it to be different, not super different, but I would like certain parts to be different. And I don't know if I think like this because I would be happier and more at ease with my body if the parts I don't like would change, or if these thoughts are remains of the disorder. (Ona)*

To Ona, the continued longing for a different body well into her recovery called into question the persistence of an eating disorder voice. Similarly, other participants also expressed doubts about their capacity to judge their body accurately. However, I would argue that doubting whether one correctly perceives one's body is a perfectly understandable consequence of having been repeatedly told that they cannot trustfully assess their bodies.

Moreover, demanding those who have suffered from eating disorders to love their bodies no matter how they look might be setting unrealistic expectations considering the socio-cultural context. In other words, it might seem that people in recovery are held to higher standards than those who are not. In this sense, the following quote from Nica's interview touches on the difficulty of loving your body as it is when society encourages the opposite.

> *I can't say I am healed or wholly recovered, and I'm not sure this moment will ever come. I also think that society has a lot of influence. Currently, there are just a few people who know that I've had anorexia, and I'm not ashamed to share it. On the contrary, I feel proud to have come out of there, but it's also something that I don't share with everyone. And society has a lot to do with it because people link thinness or losing weight as something positive, and perhaps to us that is a problem. For example, you haven't commented on my body or said anything like "oh, you look thinner now". And I wouldn't have dared to say anything about your body, because I know it could have affected you. But people don't know that, and they comment "oh Nica, you are losing weight, you look great" not knowing that it might hurt me. (Nica)*

Nica’s reflection touches on an important matter, the overlapping and most often contradictory signification attached to body weight. While weight is used as a marker of health in treatment spaces, weight also works as a marker of value and worth. In this sense, the neoliberal rhetoric of health values being fit and healthy as individuals are thought to be responsible for their well-being. And these two ideals are not easily disentangled from being thin. Not seeing how the multiple significations of weight - weight as health and weight as worth - potentially contradicts or collude with one another fails to recognize the difficulty of navigating both biopedagogies of recovery and more general health directives issued to the broader population.

Finishing this theme in a lighter note, when asked about when and where they have felt more at ease with their bodies participants orientated their answers towards situations rather than body states. In other words, the moments when participants cherished and felt love towards their bodies had nothing to do with how it looked like, its shape or weight, but they were instead connected with specific embodied experiences such as pregnancy and dancing.

> *I’ve never felt happy with how my body looked, I’ve never liked my belly or my love handles, but I remember that when I started dancing, I began to appreciate my body not for how it looked like but for what it was doing and how it was moving. And to me that was a cathartic moment. It didn’t mean that all of the sudden I was like “okay, now I feel perfectly fine with my body”, but it meant that I had found a field, a moment or an activity in which I could appreciate my body, or in which I could feel it in a healing way but also in a creative way. It was a healing experience that allowed me to grow and do and learn new things.(Ona)*

This perspective might be helpful when thinking about how to address body love in a more embodied way during recovery.

3.3.3 Recovery as a daily habit

Some participants were keen to think of themselves as recovered, while others did not resonate with the term and when asked, preferred to refer to their experience as a coexistence.

Regardless of their preferred terminology, in some participants' accounts, there was this underpinning idea that recovering from an eating disorder could not be equated to recover from another illness. At various levels, participants described their eating disorder as an experience that marked their lives and continued to do so even when they no longer struggled with the distress. This ever-present influence was both seen in a positive and in a limiting light. For example, Silvia reflected how her struggle with eating disorders worked as a foundational experience in her journey to become the person she currently is.

> *Of course a mental disorder is never a good thing, but seen in perspective, it helped me to get to know me a great deal more, also to create quality relationships and to see things differently. It allowed me to get to know myself in a way that maybe without the disorder would have been more superficial. (Silvia)*

On a different note, having had an eating disorder was also experienced as a constraining presence in participants' lives. To some, that meant shaping one's life around the task of maintaining their eating disorder under control. For example, Nica compared recovery from eating disorders to the process of living a sober life after overcoming alcoholism.

> *My weak spot is always going to be my body and food. Right now I don't have thoughts about restricting or whatever, and as of today, I'd stake my life that I am not going to do it again, but my way to stop that from happening is…I compare it to alcoholism, if you are an alcoholic once, there is a big chance you are not going to drink again. So for me is something similar. I don't see myself able to do some things that normal people can do. For example, dieting. To me 'diet' is a forbidden word. (Nica)*

To Nica and other participants, attaining recovery did not mean rejoining life as it used to be before entering treatment. Underpinning Nica's account of life after struggling with mental health issues, is the idea that you are always in danger or vulnerable to relapse if you are not actively engaging with biopedagogies of recovery. Here, recovery is understood as a daily commitment. This idea is also illustrated by Ona, who sees recovery as a work of repetition.

> *It's a constant struggle, so to speak. But in the same way taking care of oneself is a constant work for everyone. The word itself says it, the re of recovery indicates repetition, a continuous effort you have to do every day. Every day you have to pick yourself up, you have to be constantly involved in your well-being and health. (Ona)*

To Ona recovery is not a fixed state but an ongoing process. An effort one has to engage in, which is not so different from the daily routines a person has to perform to take care of itself.
In other words, recovery mimics life in the sense that it is sustained by repetition. In drawing this comparison, Ona moves away from the belief that not attaining a fixed, never-changing state of recovery equates to the illness's chronification, an idea present in some participants' discourses. Instead, she understands the need to engage with recovery on a daily basis not as a characteristic of its fragile or circumstantial nature, but as the normal condition of staying healthy. I would argue that from Ona perspective, we can only make sense of recovery if we approach it as an assemblage, a provisional arrangements of material and immaterial things that are mobilized in our day to day in order to keep us recovered. This perspective allows to acknowledge other stories about recovery that might be otherwise dismissed. Stories that are not about being healed but rather about the struggles of staying healthy.

However, not everyone felt their history with eating disorders to be so prominent in their life, and their experience with the distress only surfaced when things went wrong. In that sense, the eating disorder was experienced as something latent or asleep that would potentially come up whenever life felt challenging.

> *I think that even if you are recovered, food and body are recurring topics in your life. It's like your Achilles heel. Maybe, when others are having a difficult time in their lives, they experience more headaches or tummy aches. In my case, I struggle with my body and food. When you've struggled with something for a long time, it's tough to make it disappear, there*

> *is a part of you that learns to associate things going wrong with obsessing over food or seeing yourself ugly, so if you have a bad day the best you can do is avoid looking yourself in the mirror, because that is going to go bad for you. (Clara)*

Clara implemented precautions such as avoiding to stand in front of a mirror whenever something went wrong. She also understood recovery as an ongoing process that could be destabilized whenever life hit a bump. Nevertheless, far from thinking of this lingering presence as an unhinging threat, she talks about it as a somewhat regular thing, something that happens differently in everyone else's lives. In fact, knowing in advance the risk of it happening works as a caring mechanism for her. Similarly, Silvia understands this coexistence with the distress as something that works to her favour.

> *Recovery to me feels like a coexistence rather than a cure. A coexistence that can be pretty healthy, but this voice never goes away for good. People sometimes have a bad day or a bad streak, anxieties and other things, and it seems like they don't know what is happening, why they are feeling like that. They come to therapy asking "what is wrong with me, why I'm feeling so bad" and you have to dig deep, and dig deep before finding it. And in a way, this voice that I am living with works as an alarm, whenever it goes off is like "you! Wake up, we are not okay" and whenever I hear that voice it's like "okay, something is wrong" it makes me tune with myself immediately, and it helps me anticipate whatever is happening. A person who does not coexist with that voice doesn't have this help. So they usually have a harder time realizing that they are not fine. (Silvia)*

Interestingly, whenever the distress surfaces in Silvia's life, she decides to pay attention rather than dismissing it altogether. The experience of having certain thoughts or feelings around food or one's body is not automatically judged as a sign of an ever-present struggle, but rather as a useful tool to be attuned with one's mental health. To Silvia, this 'alarm' as she calls it, activates self-awareness that works as an ally to procure emotional well-being. Aptitude she sees lacking in the patients she treats at the psychological unit where she works.

Common to all quotes gathered above, is the idea that recovery is experienced as the ability to take care of oneself. Therefore, recovery gets to be defined as a tool kit you acquire or develop during treatment that ideally later equips you to face other life challenges that might come your way. Said otherwise, recovery might not mean having an always perfect relationship with the food you eat or not eat, or with the body carrying you around, but rather it means learning to read the signals and knowing how to proceed when the frequency you are attuned with goes out of tune. Being recovered is equated to acquiring management skills that would not prevent you from ever struggling again, but rather help you take care of yourself.

Entwined with the idea of recovery as a tool kit is some participants' reluctance to consider themselves recovered. Their experience of recovery as an ongoing process did not match with the unrealistic standards they compared their experience to. In that sense, some participants complained about not being warned about how life would look like after treatment. For example, Nica expressed irritation when she shared her disappointment after realizing what recovery looked like for her.

> *I thought this would be something temporary that would go away and that everything would be fine eventually. But this is not true, I don't know how it was for you, but my experience is that you are never completely fine. So I wish someone would have told me "look, it's going to go away, at least the worst part of it, and we will give you the tools so you can manage it, but you will have to fight with yourself, I don't know if for the rest of your life, but for a long time at least". That would have helped me today. (Nica)*

Knowing in advance what recovery entails would have helped Nica better prepare for what came next for her. yh4hw5However, these representations should not be only made available to patients, but also to their supporters. When asked about what they would have liked their supporters to know about recovery some participants referred to the lack of support after finishing treatment.

Once recovered participants felt they could not have a bad day in their supporters' presence or share thoughts and feelings eating disorder related because, to them, that meant going back to square one.

> *To my parents, even the tiniest little thing is alarming, I can't afford to feel bad with this topic because I have already overcome it. I am supposed to be recovered now. They struggled enough at the beginning to accept that it might happen to me again. (Silvia)*

When Silvia relapsed, she decided to keep that information from her mom, knowing she would not understand. To Silvia's parents, as well as other participants' supporters, recovery is a final stage. Therefore, the surfacing of feelings, thoughts or even of an occasional symptom is perceived as a catastrophic scenario where their loved ones are as bad as they were on day one. In this sense, they understand recovery as a) linear and always moving forward and b) white and black, ill or healed. Having a more nuanced picture of what the process towards recovery might look like and how it feels to be recovered, might allow them to offer better support. In other words, if supporters were to understand the untidiness of the process, it might allow sufferers to navigate the messiness of it all better.

As I have unpacked in this section, recovery means different things for all participants. For some, recovery is a daily commitment, and ongoing process one has to stick to everyday. For others, recovery is a journey toward self-discovery, an introspective exercise where you are faced with your (food, weight, shape and live) fears. For still others, recovery is a coexistance with a distress that you learn to make work at your favor. For some participants, recovery might not mean liking their body or even making peace with it, but it might mean reframing it as less important to who they are. All in all, the diversity amongst these accounts calls for a definition of recovery that is not foreclosed, but welcoming of divergence and difference.

Conclusions

In this thesis, I have sought to address two different questions with regard to eating disorders. The first has to do with its care and the later with its cure. Funnily enough, while I departed from a position that thought of them as two different experiences, in the process of writing this thesis, they have meshed into one inseparable thing. Contrary to what I first believed, care is not merely the means to recovery, but specific articulations of care might be the space where recovery takes place. In this section, I aim to address this connection and others to bring back the research questions from which I first departed.

Regarding care, I wanted to analyze how eating disorders treatment assists patients in their recoveries, how and when it opens or forecloses possibilities of recovery, and how it feels. The answer to these questions substantially varied between respondents, which already makes an important point about eating disorders care. That is, it should not be presumed that all people living through eating disorders require the same approach in order to recover. In other words, in our treatment systems, the identities of those recovering from eating disorders should not be swallowed up by the eating disorder itself. Instead, the care administrated should be aware of how eating disorders might show up differently in patients lives. Unfortunately, that was not the case for most participants.

Participants described recurrent scenarios where treatment systematically failed to hear their voices. Care in the day hospital was highly structured and formalized. There were rules and obligations that could not be broken, which reveals how in eating disorders care, following a specific course of action prevails over a willingness to attune to participants' individual needs. This partly explains why, when Nica expressed her dislike of jam, no other options were offered to her, as everyone was expected to finish what is on their plate without comment. One of the consequences of this approach is that care, in the day hospital, could sometimes feel rather careless.

In this text, I have proposed that an alternative approach to care would have been Mol's work on the *Logic of Care*. Within this perspective, care is an open-ended process; it is flexible enough to accommodate different patients and their changing needs over time. For that matter, Mol's highlights how care depends on being attentive but also inventive, persistent and forgiving. When something does not work or stops working the attitude should be patient and experimental. New problems are likely to pop up over the course of the recovery process. Therefore, care requires us to continually make adjustments in order to serve its purpose.

One key aspect that prevents the logic of care from being emulated in eating disorders treatment systems is the fact that patients are clinically conceptualized as untrustworthy. Their needs and reasons are distrusted, as they are believed to be co-opted by the disorder. This explains why in eating disorders care, support and surveillance are two different sides of the same coin. In the context of treatment, supportive relations are always vigilant ones, as the eating disordered subject is understood to be unfit to look after themselves. However, this belief is called into question by the story of those participants who, while not having help from others and not being watched outside treatment's physical limits, still managed to recover.

Advocating for increased agency and voice in treatment does not mean to give in to the patients' desires. In fact, participants themselves were aware of how surveillance helped them in specific moments of their recoveries to detach from practices that were not in their best interest. However, I would argue that there is a difference between granting patients safety through imposition and doing so collaboratively, honouring their preferences and voices by discussing how to better attune care to their specific needs.

Regardless of how participants felt with surveillance, they all agreed on its little effectiveness in promoting real recovery. While in a highly surveilled situation, nutritional rehabilitation and corrected eating behaviour can be easily ensured, participants did not approach recovery in those terms, which already contests clinic's views on the subject. For them, biometrics are misleading devices for assessing progress that can also have hurtful consequences, as more than often, subjects who do not show an altered weight pattern are disavowed compared to those who show signs of starvation. Furthermore, one participant believed that pursuing these two goals through imposition often leads to false recoveries. The logic behind this reasoning sustains that recovery should be an active process that the subject has to undertake, not an external imposition. This can hardly be achieved when patients are deprived of the possibility of taking over their healing journeys the moment they enter treatment.

In this regard, patients also expressed how having choice removed during treatment made them feel more troubled whenever they had to face it once they got that privilege back. In other words, surveillance generated self-doubt. In this sense, participants missed a guided transition from total restriction to being once again in charge of themselves. This mainly had to do with food, what to eat, and their bodies and how to love them. During treatment, patients were forbidden to address food or body issues outside therapy. They could not watch themselves in the mirror nor touch their bodies, choose any food or make any comment about it. Thus, the experience of being in the body while healing from an eating disorder was utterly neglected.

Funnily enough, this happened at the same time their bodies were intensely targeted from the first minute they accessed therapy. Nutritional rehabilitation is the primary treatment in eating disorders care, where food is approached as medicine, as the means to rescue the true self from the clutches of the eating disorder. This has partly to do with the biochemical dimension of the distress, suggesting how, in eating disorders, the body has its own agency and plays an active role in its maintenance. This idea complicates the alleged autonomy of the brain in eating disorders, which already refutes perspectives that portray the distress as a choice, and understand its recovery as merely a matter of will. However, the later idea pervaded treatment and was held by participants, supporters and health care providers alike. Its effects were damaging. In many ways, they foreclosed possibilities of recovery; it deprived participants from support, created unrealistic ideas around recovery trajectories, and a deceptive image of the forces that have to come into play to recover.

If recovery is not solely something that happens in the brain but also in the body, re-feeding must be foregrounded as a necessary first step towards recovery. However, participants' stories recounted how food is not merely relevant for its nutritional value, but also as a media for care. In this thesis, I have further expanded this idea drawing on Wilson's work, where processes of ingestion and digestion are understood as ways of relating to the world. Thus, the gut should not only be approached as an organ where nutrients are absorbed, but also a place from where to rework patients' broken relations with the world and others.

From this perspective, we might call into question different aspects involved in the nutritional rehabilitation process. For example, we might be sceptic about the benefits of using food as punishment. We might also pay more attention to food itself, which food do we bring to the table or where does it come from. We might also attend to how it feels in the mouth; its texture, consistency and taste. But also in the body; how does this meal feel? Does it feel warm, heavy, comforting or overwhelming? What thoughts does it trigger? Does it hurt somewhere? How does your body feel when you move from barely eating to eating a three-course meal? Or How does it feel to stop binging? The experience of being a body is a necessary next step in theorizing eating disorders. It is also a relevant dimension that must be considered to better assist patients' trajectories towards recovery.

Regarding this thesis's second topic of discussion, recovery, I wanted to examine how those who were once diagnosed with eating disorders experience and understand it. Even if only a few participants considered to be fully recovered, most of them noted how their lives no longer revolved around food or weight. Despite that, the term 'recovery' did not resonate with them. From their perspectives, the idea of recovery was imbued with a sense of invulnerability that felt far away from their realities. Their understanding of recovery did not fit in with binary models: eating disordered/

recovered. Instead, in many cases, recovery was understood as an in-between space where a healthy, transformed self somehow coexisted with the distress's shadow.

Therefore, recovery was not understood as a return to a state prior to the distress, a step back to normal, rather it was described as a process that changes you in some minor or major way. Similarly, recovery was not approached in terms of destination, a place where you arrive, but rather as a process you continuously engage with, each and every day, with a little bit more ease. In this sense, the borders between eating disordered and recovered appeared to be blurred in participants accounts. Recovery was not something that happened to them one day, rather they perceived it as something they need to engage with every day. Then, we might affirm that recovery is an ongoing process, something that is constantly in the making, that needs to be held over time to keep it going.

Thinking of recovery as a process situates it in the sphere of those daily commitments that usually have to be maintained in people's lives in order to take care of themselves. In this sense, some participants described recovery as a toolbox they developed throughout treatment that they can use to thrive through every day. However, owning this toolbox did not necessarily secure recovery in participants' lives. Some of them recalled episodes of their lives where they struggled even relapsed for a period of time. In these moments, the emergence of the eating disorder was not understood as a failure, rather as an alarm, an unmistakable sign that they needed to re-attune with their mental and emotional health. This shows how while the process of recovery might not always be sustained, it can always be re-engaged.

Recovery proved to be highly personal; it meant different things for different people, which already contrasts with the narrow, idealized recovery narrative participants compared their experience to. In this sense, many doubted whether they were really recovered, as their experience did not match unrealistic expectations around recovery. For example, some shared how recovery did not necessarily mean liking or making peace with their bodies. In fact, they found such expectation to be utterly unfair as it holds them to different - higher - standards than others in their lives.

Similarly, participants complained about how treatments' mantra *love your body as it is* seems to remain blind to how, in the sociocultural context where their recoveries took place, weight is seen as a marker of value.

Participants often felt confused and troubled over how to live through their recoveries as they were faced with conflicting messages about how to live and what to do to stay healthy. In this thesis, I have approached this incongruence and uncertainty drawing on LaMarre and Rice's work on biopedagogies of recovery. This idea allows us to account how recovery is underpinned by prescriptions for healthy living that are sometimes in direct contradiction to dominant biopedagogies issued to the broader population. In this sense, participants were unsure over which set of instructions they were supposed to follow. For some, sticking to the health directives learned during treatment made more sense as it helped them feel safe and supported in their every day. While others felt a sense of normalcy engaging in dominant biopedagogies as did everyone else in their lives. Moreover, some thought that leaving behind recovery biopedagogies was necessary to keep growing in their healing journeys.

Participants experiences show how there is not a specific nor correct way of being recovered. This necessarily points toward the need to render visible and acknowledge realistic stories of what recovery can look like for different individuals. In this sense, I believe that research on recovery could use less energy trying to collapse the concept into a singular definition over which experts could agree on. Instead, I think it would be more beneficial to expand its possible meanings, widening it enough to fit many different experiences. This shift would not merely challenge singular narratives that already foreclose possibilities of recovery for many, but it would also work as a more sensible framework to account for how recoveries are highly contingent experiences.

Far from being an issue of individual concern, participants portrayed eating disorders recovery as a dynamic and relational process situated in time and space. Therefore, recovery is not merely a matter of will, though it requires the subject to be actively engaged, but something that happens entwined with others, within specific contexts, in dialogue with multiple and contradictory discourses and facilitated or repressed by different affects. In this sense, I have approached recovery as an assemblage; a provisional arrangement of people, material - food, treatment centres, health care providers, supporters - and immaterial things - supportive relations, discourses, affects, behaviours on the part of the patient but also from their supporters and social worlds - in which recovery advances or retreats. From this perspective, I would argue that individuals do not fail to recover, rather assemblages do.

Care and recovery are, then, one and the same thing. Specific articulations of care - the encounters and disencounters between patients' toolboxes, caring supporters, trustful relationships, enabling discourses, supportive affects - stage the space where recovery might take place. In other words, recovery is hardly advanced by sudden moments of progress, rather it is progressively arranged, made and remade, in the daily scenographies where all these multiple actors and forces come to interact. In this sense, recovery may not always look the same - not for different individuals, neither for oneself -. Moreover, as everything comes into place in different ways, it might even be the case that recovery does not materialize or fails to make an appearance in its expected form. Thus, we might come to embrace how, as the very nature of care, recovery is the always incomplete task of maintaining, continuing and repairing ourselves and our worlds, a process that emerges, now, as a dynamic, complex and relational life-sustaining web.

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Appendix 1: Interview guide

Demographics

- Age
- Gender
- Sexual orientation
- Ethnicity
- Highest level of education
- Current paid work (how many jobs? unemployed?)
- Current unpaid work

Warm up questions

- How are you feeling?
- Why did you want to be interviewed
- What is important to you about it

Background questions to situate their story

- Please tell me a little bit about what an eating disorder means to you? How did it feel and what did that look like for you?

- Can you tell me a bit about what that experience was like for you?
    - When did it begin?
    - Did you seek any kind of support - formal or informal - for the distress?
    - What diagnosis you received?

- When did you begin to consider the possibility of stopping the disordered eating? How did this feel?

- How would you describe your current relation with eating disorders

Questions around care

- Could you please describe those things that assisted you during your healing process? What did you find helpful and not so helpful from treatment and also from the outside world.

- Do you still engage with this things (practices of care) after treatment? How they have evolved? Which ones are no longer useful. What new ones have you incorporated.

- Where or when you felt less cared about, or constraint by the care you received when you were in acute distress?

- Where did you find help or felt cared during the treatment process (inside/outside treatment). Were there any people in your life who were particularly helpful during your distress? If so, who was/were these people?

- Where do you find this care/help now.

- If you could have had/could have any type of support/therapy you wanted what would it be?

- What were your interactions with healthcare providers like when you during treatment? (Did you feel heard, validated, understood, marginalized, etc.?) Was there anything they did that was particularly helpful? What were some challenges you faced with respect to this support?

- How was the relation with the rest of the group. Was there anything they did that was particularly helpful? What were some challenges you faced with respect to this support?

- What relation is built with the body during treatment. How this relation has evolve outside treatment.

- What relation is built with food during treatment. How this relation has later evolve outside treatment.

Questions around recovery

- What kind of messages have you received about what recovery is about during treatment? How do you feel about those messages?

- What does the word “recovery” mean to you? Is this a word that resonates with your experiences?

- What does “recovery” feel like?

- What are the top things you wish healthcare providers knew about eating disorder recovery?

- Is there anything you wish you knew while you were experiencing distress about life after eating disorders

- Is there anything you wish your supporters knew about recovery from an eating disorder?

- How are you feeling?

Appendix 2: Participants' background story

Participant 1. Laia

Profession: Psychologist + Administrative

Age: 33

A brief history with medicalisation: Laia was diagnosed with EDNOS when she was 27 years old. Soon after that, she decided to start her treatment at the day hospital IADA. After 3 to 4 years, the centre's management and part of the professional team changed. Her therapist left the day hospital, and she decided to continue her treatment with her doing outpatient visits. Her therapist decided she was recovered a year after that. Nowadays, she considers herself recovered, even if her approach to recovery challenges dominant discourses on the matter.

Relevant themes in her story: Laia stressed the importance of group therapy in her healing journey. She also put an emphasised how developing patients' autonomy should be much more encouraged during treatment.

Participant 2: Gemma

Profession: Speech therapist

Age: 25

A brief history with medicalisation: Gemma was diagnosed with anorexia nervosa when she was 17 years old. While she was in treatment, she finished high school and got a degree in speech therapy. She was officially discharged after 5 years in treatment. Gemma believes she is over her eating disorder, even though she thinks she will always have to watch out for food and body issues, as they are her Achilles heel.

Relevant themes: Gemma expressed on various occasions how she had almost forgotten her treatment experience. She also recounted how she needs to have some control over her body and the food she eats. If she loses this control, she sometimes finds herself fighting against mechanisms that she reads as eating disordered.

Participant 3: Maria

Profession: Psychologist

Age: 29

A brief history with medicalisation: She was diagnosed with anorexia when she was 18 years old. Maria was not aware she had an eating disorder, she thought she had depression. After receiving her eating disorder diagnostic, she started treatment on the same day hospital. Along with her treatment, she worked at different jobs and graduated from psychology. She never got officially discharged as her treatment ended with a lack of follow-ups. Currently, Maria thinks she has a binge eating disorder but has not sought help.

Relevant themes: Maria felt that treatment made her divorce herself from her body. She also approached how eating disorders tend to go unseen when embodied in larger bodies.

Participant 4. Silvia

Profession: Psychologist

Age: 29

A brief history with medicalisation: Silvia was diagnosed with bulimia when she was 22. She received treatment for over 5 years. During the first year, she was asked to commit full time to treatment (each day from 10 am to 6 pm). Along with treatment, she graduated from psychology. Her treatment ended when she decided to leave after she got pregnant. After having her first kid, she relapsed. Silvia did some outpatient visits with a psychologist and got back at her feet soon after. Nowadays, she considers herself recovered even though her take on recovery does not match dominant discourses shaping the concept.

Relevant themes: Silvia recounted how relapse is an expected stage in the course of eating disorders. Therefore, she stressed the need to educate on the possibility of relapse after recovering. She also approached recovery as a coexistence with a dormant distress.

Participant 5: Ari

Profession: Entrepreneur (unemployed)

Age: 26

A brief history with medicalisation: Ari was 18 when she was first diagnosed with bulimia. She went to different psychologists before being referred to the day hospital where she received treatment for her eating disorder. Aru stayed at the day hospital for over 4 years. Along with treatment, she pursued an education in hotel management. She left treatment when the centre's management changed. After one year, she relapsed, and since that moment, she has engaged in several different treatments. She has followed different workshops on how to overcome eating disorders. She has also looked for help from nutritionist and coaches. Recently, she booked a hypnosis session, hoping it would help her with her purging impulses. Currently, Ari does outpatient visits at an eating disorders unit from a public hospital.

Relevant themes: Ari was very adamant about how she felt regarding the "conventional method" used in eating disorders treatment. She stressed the importance of involving the patient in her healing journey. Ari also saw eating disorders mainly as a malnourishment problem. Therefore, she repeatedly foregrounded nutritional reeducation as a relevant aspect of the healing process.

Participant 6. Clara

Profession: Marketing student

Age: 25

A brief history with medicalisation: Clara was first diagnosed with depression and ADHD at a public hospital (Taulí, Sabadell). Soon after, she was diagnosed with EDNOS and was referred to the day hospital IADA where she received treatment for over 4 years. Along with treatment, she started a university degree in marketing, but she could not finalise it in the expected time as she was following a full-time schedule at the day hospital. When the centre's management changed and half of the professional team left, she felt abandoned as she lost her psychologist. Soon after that, the new professional team discharged her, even though she did not see herself ready to be on her own. She currently does outpatient visits with a psychiatrist at a public hospital (Taulí, Sabadell) while also visiting a private psychologist. Clara does not think of herself as recovered, even though her distress around food, weight and shape has dramatically decreased.

Relevant themes: Clara felt deeply abandoned when the professional team left the day hospital, and her treatment ended before she was ready to leave. She stressed the importance of working on how to better navigate this transitional period where you start being left on your own.

Participant 7: Nica

Profession: Hairstylist/Waitress (unemployed)

Age: 24

A brief history with medicalisation: Nica was 13 years old when she was diagnosed with anorexia nervosa. Before being referred to the day hospital IADA, she was being visited by a psychiatrist in a public hospital (Taulí, Sabadell). Nica was treated for over 5 years while she was in high school (what she eventually dropped as she fell back behind in her studies during treatment). After dropping high school, she lost her school insurance which covered all treatment expenses. Unable to continue her treatment for economic reasons, she asked to be officially discharged. However, the professional team did not consider she was ready just yet. This decision made her feel angry as she did not see recognised all the hard work she put and all the progress she made for over 5 years. Currently, Nica does not feel distressed around food, weight or shape but she does not see herself completely recovered. In fact, she does not believe in the possibility of full recovery.

Relevant themes: Nica thought that the way food was reintroduced in her life during treatment was sometimes harmful - using food as punishment -. She also stressed the importance of rendering visible realistic stories about recovery.

Participant 8. Bel (pseudonim)

Profession: Psychologist

Age: 24

A brief history with medicalisation: Bel was diagnosed with anorexia nervosa when she was 14 years old. She received treatment for 5 years at the day hospital IADA. During this time, she finished high school and started a university degree in psychology. Bel was officially discharged and currently thinks of herself as totally recovered.

Relevant themes: Bel thought some psychological interventions she witnessed during her treatment were potentially detrimental for some patients. She also stressed the importance of yoga in her healing journey and wished the discipline was part of every eating disorders treatment.

Participant 9. Vera - (pseudonim)

Profession: Journalist (unemployed)

Age: 25

A brief history with medicalisation: Vera was diagnosed with EDNOS when she was 18 years old. She was admitted to the day hospital IADA where she received treatment for 4 years. Along with treatment, she graduated from journalism. She requested to be voluntarily discharged once she felt she was good enough on her own. She currently thinks of herself as thoroughly recovered.

Relevant themes: To Vera, the surveillance that came along with treatment was a significant inconvenience. She thinks it did not contribute to her recovery process. Moreover, she complained about how the treatment she received was blind to her personal needs.

Participant 10: Ona (pseudonim)

Profession: Student + Journalist (unemployed)

Age: 26

A brief history with medicalisation: Ona was diagnosed with bulimia when she was 15 years old and was admitted to the same day hospital after her parents forced her to do so. She received treatment for over 6 years. Along with her treatment, she finished high school and started and finished a degree in journalism. Her treatment ended with the lack of follow-ups once management changed. Ona was never officially discharged. The term recovery does not particularly resonate with her, even though she no longer experiences distress feelings around food, exercise, weight and shape.

Relevant themes: Ona felt confused about navigating recovery in a context where treatment's health prescriptions are potentially seen as odd. She was unsure about how to have a good, loving relationship with her body and missed not having approached the issue during treatment.