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# Developing an emotion intervention for bulimic-type eating disorders: Lived Experience Perspectives of the FEEL-ED (Fostering Effective Emotional Life Skills for Eating Disorders) toolkit

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## Abstract

# Background

Binge Eating Disorder, Bulimia Nervosa, and related conditions are common, and vastly distressing and impairing to quality of life. Current treatments remain suboptimal for many individuals and often do not sufficiently target emotional processes, despite strong empirical evidence identifying emotional processes as central to the onset and maintenance of eating disorders. This paper outlines the rationale behind, and lived experience perspectives on, a novel brief emotion intervention for individuals with bulimic-type disorders: FEEL-ED (Fostering Effective Emotional Life Skills for Eating Disorders). FEEL-ED is a self-guided online mini-course comprising eight short videos targeting key aspects of emotion regulation, designed for individuals awaiting eating disorder treatment.

# Methods

Six public contributors with lived experience of an eating disorder provided feedback on FEEL-ED, including perceived benefits and potential risks. Data were analysed by a lived- experience researcher, using reflexive thematic analysis.

# Results

Three themes were generated: (1) emotion regulation as central to eating disorder pathology and recovery; (2) FEEL-ED as addressing a critical gap in care; and (3) the importance of responsible and ethical innovation in intervention design.

# Conclusions

Contributors positioned emotions as a key facet of their eating disorders and noted that emotions are often insufficiently addressed in therapy. Hence, FEEL-ED shows potential to address current gaps in care by explicitly addressing emotional processes, and providing timely support for people awaiting treatment. Contributors also highlighted the importance of clearly positioning FEEL-ED as an adjunct to, rather than a replacement for, clinician-delivered care, alongside ensuring the intervention is inclusive of diverse users and experiences.

## Plain English summary

Eating disorders such as binge eating disorder and bulimia nervosa are common and can have a strong negative impact on people's lives. Emotions play an important role in these disorders but are not always fully addressed in treatment. We developed FEEL-ED (Fostering Effective Emotional Life Skills for Eating Disorders), a short online mini-course with eight videos that teach practical skills for managing

emotions. It is designed to support people to better understand and manage their emotions, so they do not need to rely on eating disorder behaviours to help manage their distress. We asked six people with lived experience of eating disorders to share their views on the benefits and risks of the FEEL-ED mini-course. They felt that focusing on emotions was important and that the course could help fill a gap in support. They also highlighted that it should be used alongside professional care and designed in a way that feels inclusive and supportive.

## Background

Eating disorders (EDs) are associated with marked disruption to everyday functioning, elevated mortality, and significant societal cost, affecting an estimated 3.4 million people in the UK (BEAT, 2020; Van Hoeken & Hoek, 2020). Bulimic-type EDs involving patterns of binge eating are the most prevalent and include bulimia nervosa (BN), binge eating disorder (BED), and some presentations of otherwise specified feeding and eating disorder (OSFED) (Keski-Rahkonen, 2021). These disorders are defined by repeated binge-eating episodes (consuming an objectively large amount of food accompanied by a subjective sense of loss of control (Giel et al., 2022)), with or without compensatory behaviours. Binge eating is associated with marked impairment in quality of life, elevated psychiatric and medical comorbidity, and a chronic course, particularly in the absence of timely and appropriate support (Agh et al., 2015; Van Hoeken & Hoek, 2020). Current treatments remain suboptimal, with 50–60% of individuals with binge-eating presentations not achieving abstinence from core symptoms following treatment (Linardon & Wade, 2018; Linardon, 2018).

A substantial body of evidence suggests that one reason for these suboptimal outcomes may lie in the limited focus on underlying emotional processes. Difficulties in identifying, describing, experiencing, and regulating emotions have been consistently implicated in the onset and maintenance of EDs across diagnoses (Dingemans et al., 2017; Prefit et al., 2019; Salias et al., 2025; Walenda et al., 2021; Westwood et al., 2017). Individuals with binge-eating presentations often experience emotions with heightened intensity (Vuillier et al., 2025), and seem to hold unhelpful beliefs about emotions, such as viewing them as uncontrollable and harmful, which can lead to emotional non-acceptance and the development of secondary emotional responses (Vuillier et al., 2021; Vuillier & al., in preparation). Evidence also suggests that individuals with EDs rely more heavily on unhelpful strategies such as suppression and rumination, and less on strategies such as acceptance or cognitive reappraisal, which are often associated with more effective emotion regulation (Prefit et al., 2019; Salias et al., 2025; Vuillier et al., 2022; Vuillier et al., 2025). However, it remains unclear whether this reflects a limited repertoire of adaptive strategies, difficulties implementing helpful strategies effectively, or even difficulties identifying emotions in the first place (Vuillier et al. in preparation).

Qualitative and lived experience research further highlight the functional role of disordered eating in emotion regulation. For example, some individuals report that their eating disorder behaviours help them to regulate internal emotional states and suppress external emotional expression (Henderson et al., 2019). Lived experience-led literature has further described eating disorder behaviours as both

responses to and causes of difficult emotions (McColl et al., 2024; Downs, 2025), illustrating a cyclical relationship in which emotional distress and eating disorder behaviours mutually reinforce one another. Together, these findings position emotion regulation as a central and clinically relevant target for intervention in binge-eating presentations.

Treatment for bulimic-type eating disorders primarily takes the form of cognitive behavioural therapy (CBT), which targets disorder-specific thoughts and behaviours (NICE, 2017). In contrast, emerging emotion-focused approaches, such as dialectical behaviour therapy (DBT), emotion-focused therapy (EFT), and acceptance and commitment therapy (ACT), seek to address the emotional processes implicated in the development and maintenance of binge eating and related EDs. Despite growing evidence supporting these third-wave approaches (Ben-Porath et al., 2020; Di Sante et al., 2022; Linardon et al., 2019; Rozakou-Soumalia et al., 2021), emotion-focused therapies are not typically offered as first-line treatments within national guidelines (NICE, 2017), with their use often reserved for individuals with more complex presentations involving marked emotion dysregulation or comorbidity. Such approaches can also be resource-intensive, requiring clinicians with specialist training and structured service delivery, which may limit their scalability and wider implementation within routine care.

The limited availability of emotion-focused interventions also exists within a broader context of constrained ED service provision. Gaps and delays in access to timely and appropriate care are widely documented, with individuals with bulimic-type EDs particularly affected (Bray et al., 2022; Viljoen et al., 2024). Delays in treatment are associated with worsening symptoms, increased healthcare costs, reduced treatment uptake, poorer treatment response, and a greater likelihood of dropout (Austin et al., 2021; Carter et al., 2012). Patients facing long waits also report feeling disempowered, forgotten, and deprioritised (Blackburn et al., 2026; Downs, 2025). Together, these gaps between need and provision raise significant clinical and ethical concerns, given the ongoing distress, functional impairment, and risk of symptom escalation while individuals remain on waiting lists.

Online self-help interventions have been proposed as a means of providing interim support during gaps in care (Wade et al., 2024), with potential to enhance agency, support self-efficacy, and offer practical strategies that can be applied in everyday life. In ED services, waiting list help most commonly takes the form of CBT-informed guided self-help (NICE, 2017). However, for individuals who binge eat, such approaches may not sufficiently address emotional distress, shame, and maladaptive coping processes, highlighting the need for interventions that explicitly target emotional awareness, distress tolerance, self-compassion, and adaptive emotion regulation (Linardon et al., 2023; Wasil et al., 2021). The development of an emotion-focused, skills-based intervention for individuals awaiting treatment therefore represents a potential opportunity to address a well-established gap in care.

At the same time, waiting list interventions raise important ethical concerns. Without careful assessment of appropriateness, and clear communication regarding their purpose and limits, they may be experienced as invalidating or dismissive, or as shifting responsibility for managing distress onto individuals in the absence of adequate service provision (Downs et al., 2023; Downs, 2026). These

concerns highlight the importance of developing interventions that are not only theoretically and clinically grounded but also shaped by the perspectives of those who are intended to use them. The person-based approach (Yardley et al., 2015) emphasises grounding intervention design in the needs, contexts, and perspectives of the target population, and supports ongoing engagement with intended users to iteratively refine content and delivery to enhance accessibility, acceptability, and feasibility.

In line with guidance for the development and evaluation of complex interventions (Skivington et al., 2021) and informed by both empirical evidence and a person-based approach, we developed FEEL-ED (Fostering Effective Emotional Life Skills for Eating Disorders). FEEL-ED is a brief online psychoeducational toolkit targeting emotional processes implicated in binge eating, designed for individuals awaiting specialist ED treatment. The rationale for, and development processes underpinning the intervention are outlined below, followed by the aims of the current paper.

## Theory-informed and co-designed intervention development

The intervention draws on affect regulation models of binge eating (Leppanen et al., 2022), the extended process model of emotion regulation (Gross, 2015), the biosocial model underpinning DBT (Linehan, 2015), the psychological flexibility model central to ACT (Hayes et al., 2011), and emotion-focused models emphasising emotional awareness and validation (Greenberg, 2004). These models informed intervention components targeting emotional awareness, acceptance, alexithymia, distress tolerance, beliefs about emotions, behavioural activation, and adaptive regulation strategies, which were synthesised into a brief, self-guided skills-based toolkit. The intervention integrated shared emotion-related processes implicated in binge eating rather than combining discrete or manualised treatment approaches.

In addition to these theoretical foundations, intervention development was shaped through collaboration with people with lived experience of binge eating and other EDs. Lived experience contributors included individuals who volunteered via the VOICE platform (https://voice-global.org/; an online platform for public engagement and involvement in research), individuals who were recruited through social media, and members of the project's lived experience advisory group. Co-production was embedded throughout development and refinement of the online emotion-focused course, and informed both the content and framing of FEEL-ED to ensure that the intervention was relevant, emotionally safe and appropriate for delivery as a self-guided resource during waiting periods for specialist care. For example, people with lived experience contributed to reviewing and refining psychoeducational video content, with feedback focusing on tone, pacing, language, inclusivity (including explicit mentioning of culture and neurodiversity), and emotional impact. This input led to revisions that emphasised validation, and framed binge eating as an understandable response to emotional distress rather than a personal failure. Together, these contributions ensured that lived experience perspectives meaningfully shaped intervention development and informed the guiding principles and logic model.

# Guiding principles and logic model

FEEL-ED's guiding principles (outlined in Supplementary Table 1) were developed iteratively and informed all stages of intervention design, ensuring alignment between theoretical considerations, ethical issues, and practical constraints associated with delivery as a self-guided resource during waiting periods for specialist care. Examples include: (i) a lived experience expertise-led approach guiding the development and delivery of content; (ii) delivery of content in brief, bite-sized components to support engagement during periods of distress and minimise emotional overload; (iii) validation and normalisation of emotional experiences; (iv) targeting key emotional processes central to bulimic-type presentations; (v) use of non-judgemental language; (vi) inclusive content reflecting diverse experiences; (vii) support for self-paced access and the ability to revisit content and practise newly acquired skills; (viii) clear framing of the intervention as supportive and adjunctive rather than a replacement for care; and (ix) inclusion of practice exercises to reinforce and consolidate learning.

A preliminary logic model for FEEL-ED (presented in Supplementary Fig. 1) was developed to describe the intervention components, the emotional processes they target and the hypothesised mechanisms through which the intervention is proposed to work. The programme theory proposes that brief, self-guided emotion skills delivered during waiting periods may support coping with distress by enhancing emotional awareness and regulation, thereby reducing reliance on binge eating as an emotional-coping strategy.

## Description of FEEL-ED

FEEL-ED was developed to provide self-guided emotion-focused support while individuals are on waiting lists for specialist treatments for their BEDs, although the potential for this mini-course to be used adjunctively during or after routinely delivered interventions should be noted. FEEL-ED currently consists of eight brief animated videos, each targeting a specific aspect of emotional difficulties implicated in binge eating, including emotional awareness, emotion regulation, beliefs about emotions, and reflective exercises, organised across five modules (see Table 1). Each of these videos is around five minutes in duration. These are accompanied by a workbook designed to support reflection and practice of skills introduced in the videos, offering both knowledge consolidation and personalisation of the material to the specific circumstances of the individual. The intervention is self-guided and flexible, allowing individuals to engage with content at their own pace and revisit materials as needed. We suggest that individuals work through the course over three or four weeks, but this is not mandated within the course.

Table 1
Overview of video content of FEEL-ED

| Module | Description of videos |
|---|---|
| **Module 1: Introducing the toolkit and normalising emotions** | Video 1: Exploring the role of emotions, how they may be experienced and how eating disordered behaviours may be used to cope with difficult emotions. This video also highlights that culture, neurodiversity and trauma can affect how somebody responds to their emotions and to the course. |
| **Module 2: Targeting alexithymia** | Video 2: Helping how to separate, identify and label emotions by looking at the context and body cues etc. |
| **Module 3: Targeting beliefs about emotions and secondary emotions** | Video 3: Looking at how beliefs about emotions can lead to secondary emotions (e.g. shame about feeling angry) and how these beliefs can lead to binge-eating behaviours. |
| **Module 4: Targeting emotion regulation, coping and self-care** | Video 4, 5 and 6: Providing help with strategies to manage emotions instead of using binge-eating. Video 4 specifically looks at reappraisal and distraction. Video 5 covers acceptance, and Video 6 covers self-care activities to lower emotional intensity and reactivity, as well as behavioural activation and mindfulness. |
| **Module 5: Difficult emotions whilst going through recovery** | Video 7: Explains that (re)-establishing a regular pattern of eating through food monitoring & meal planning is part of the recovery journey and provides help on how to cope with guilt, shame and other strong emotions whilst going through this challenging step. Video 8 normalises setbacks and provide tools on how to cope with guilt and shame associated with setbacks, reminding users they now have a toolkit to use in challenging situations. |

Following initial development, FEEL-ED was evaluated in a published proof-of-concept pre-post study involving a self-identified eating disorder sample (N = 39) which provided preliminary signals of change and early evidence of acceptability (Vuillier et al., 2024). Qualitative feedback suggested that perceived improvements were associated with greater emotional literacy, exemplified by one participant's reflection : *"I'm responding to my emotions in a more patient manner as well as not engaging in unhealthy coping mechanisms [...] such as eating less or self-harming. I feel that I have found alternative ways to cope that actually feel just as effective and make far more sense."* Building on this work, the current study forms part of an ongoing programme of research examining acceptability and early feasibility of FEEL-ED as a waiting list intervention within NHS (UK health system) services. The present paper reports specifically on a qualitative component of this work, drawing on in-depth feedback from six participants with lived experience of eating disorders.

# Current study

Given the clinical and ethical complexity of offering self-guided support during treatment delays, it is essential to examine not only the theoretical rationale for such an intervention, but also how it is perceived by those it is intended to support. This paper therefore presents qualitative findings from

individuals with lived experience of eating disorders exploring the perceived needs, potential benefits, acceptability concerns, and risks associated with the FEEL-ED toolkit to inform further refinement prior to wider evaluation and implementation.

## Methods

# Study design

Qualitative research was used to explore the perceived benefits, unmet needs and potential risks associated with the FEEL-ED intervention as a waiting list support within NHS services. A small-scale qualitative design was chosen to allow in-depth exploration of participants' perspectives in an area where limited prior research exists.

# Participants and Procedures

Six participants with lived experience of binge eating or other EDs took part in the study. Demographic information was not collected due to the small sample size and to the need to protect participants' anonymity. Some participants had previously viewed earlier iterations of the FEEL-ED toolkit videos, and all participants were provided with links to the videos prior to taking part although not all chose to watch them. Consequently, some participants provided feedback based on direct experience of the videos, whereas others reflected more broadly on the intervention from the perspective of their lived experience of eating disorders and, where relevant, experiences of waiting for treatment.

Participants were recruited from the study's public advisory group. One co-author contributed to the dataset as a participant with lived experience but was not involved in the analysis, while another co-author, a member of the lived experience advisory group, led the analysis but hence did not contribute data. Individuals who expressed interest were provided with study information and invited to participate. All participants provided written informed consent prior to participation. Given the potentially sensitive nature of discussions relating to binge eating and waiting list experiences, participants were provided with information about sources of support and were reminded that they could skip questions or withdraw at any time.

## Data collection

Data were collected using an online or Microsoft Word form comprising open-ended questions with associated prompts (see appendix for a copy of the form). Questions explored perceived benefits, unmet needs, potential risks, safeguards, and the acceptability of using the intervention while awaiting specialist care. The decision to use an asynchronous written format was made following an initial face-to-face meeting involving members of the research team and a lived experience contributor (JD), who led this study. During this discussion, concerns were raised about the emotional demands and accessibility of synchronous or group-based formats, particularly given the sensitive nature of binge eating and waiting list experiences. An online form was therefore selected to support emotional safety, reduce

social pressure, and allow participants to reflect and respond at their own pace and in their own environment, ensuring everyone had the opportunity to have their voices heard.

# Data analysis

Responses were analysed using reflexive thematic analysis, following the six-step approach described by Braun and Clarke (2021). Analysis involved familiarisation with the dataset, initial coding and iterative development and refinement of themes through reflexive engagement with the dataset. Coding and theme development were led by JD, supplemented by reflexive team discussions to enhance analytic rigour and incorporate multiple perspectives, strengthening interpretative depth. Given the exploratory and reflexive nature of the analysis, formal member checking was not undertaken. Instead, rigour was supported through ongoing reflexive engagement with the data and consideration of how researchers' professional and personal backgrounds, including their lived experiences, may shape interpretation and determined which aspects of the dataset were most salient (Dodgson, 2019; Xiao et al., 2024). Reporting of the qualitative study was informed by the Consolidated Criteria for reporting qualitative research (COREQ; Tong et al., 2007).

## Results

Three themes were generated from the analysis: (1) the role of emotional experience in eating disorders and recovery; (2) bridging the gap in care; (3) innovating responsibly and ethically. Each theme comprised two subthemes, outlined below and summarised in Fig. 1. Illustrative quotes have been selected to exemplify the central meaning of each theme and subtheme, prioritising extracts that most clearly capture contributors' accounts while preserving the range and nuance of perspectives represented across the dataset.

**Theme one: Emotional regulation at the heart of eating disorders and their recovery**: *"I didn't always have an understanding of why my emotions would often be happening the way in which they did so I would want to run away or escape the struggle in any way I could" (C5)*

Contributors positioned emotional experience as central to both eating disorders and their recovery. Difficulties recognising, regulating or expressing feelings were described as fundamental to the disorder, with emotional life often experienced as confusing, overwhelming, inaccessible or unsafe. Contributors challenged weight- and appearance-based framings of eating disorders, emphasising the need for support that helps people understand and live with emotions more safely and skilfully.

### 1.A. Emotional experience: central but often overlooked

Contributors described struggling to recognise, understand and/or manage emotions. Eating disorder behaviours were frequently framed as ways of coping when emotions felt uncontained or unsafe to express. For example, one contributor described how different behaviours became available depending on their emotional and behavioural state:

*"Difficulties with my emotions have been central. I think for me, the channel for these emotion difficulties depends on whether or not I am in restrictive mode: if I am, then emotional overwhelm and difficult emotions that I cannot express … are dealt with through cutting or frenetic exercise … whereas if I am not in restricting mode, [through] binge-eating." (C1)*

This account illustrates how binge eating was not experienced as an isolated behavioural problem, but as part of a broader pattern of attempting to manage emotional overwhelm. Additionally, not only did individuals report difficulties with recognising and managing their own emotions, but these issues were also at times magnified or insufficiently addressed by ED services, leading to feelings of disconnection. Contributors felt that emotional experiences were often minimised in eating disorder care, with services prioritising weight, behaviour or body image over the distress driving symptoms.

*"Equipping people with more understanding of their emotions and empowering them with tools and techniques to regulate and accept different emotional states is, in my opinion, more important than 'other' aspects of treatment that are over-emphasised (such as body image and looking at weight graphs). I wish I had been given an intervention like this rather than told to not trust what I saw in the mirror (body image issues were never an aspect of my ED, though I think it would have suited the treatment team better if they were). I am autistic so whilst my experience of my ED may be different to neurotypicals, I know from speaking to many other autistic people that difficulties recognising and regulating emotions and how you're feeling, is far more common than the stereotyped 'body image issues." (C2).*

This was particularly marked for contributors whose distress was masked, expressed differently, or shaped by neurodivergence, disability, racism or cultural expectations. One contributor reflected:

*"I felt a lot of my emotions were invalidated because at times I looked 'fine' through masking as part of autism … people would assume I was fine so wouldn't check in with me and my emotions and just tell me I was doing well even if I was struggling." (C5)*

Another contributor described how diagnostic assumptions could lead to distress being misread:

*"Food restriction was dismissed as 'sensory issues' without follow-up. Emotional eating was framed as 'bad habits' or self-sabotage rather than linked to distress. Weight was used as the main indicator of severity, ignoring psychological and functional impact." (C6)*

These accounts suggested that emotional needs may be especially likely to be overlooked when people do not fit dominant eating disorder narratives.

**1.B. Emotional learning as recovery**

Contributors described learning to recognise, tolerate and regulate emotions as an important part of recovery. This included developing emotional language, identifying triggers, building coping strategies and finding safer ways to respond to distress. Contributors described emotional learning as central to moving away from eating disorder behaviours:

*“It was also about understanding why I was scared to make change … and learning how to unmask scary, difficult or sad emotions and be able to feel it to heal it without having to turn to an eating disorder to numb it or feel a sense of safety and in control.” (C5)*

*“Part of my ‘recovery’ involved me developing coping strategies for the feelings that would previously have led me to binge (and the FEEL-ED toolkit would definitely have helped)” (C3)*

Emotional work was therefore understood not as an optional adjunct to treatment, but as part of what makes recovery possible.

**Theme 2: Bridging the gap in care**: *“it will allow for an individual whilst waiting for the right eating disorder treatment to build resilience and positive coping strategies.” (C5)*

Contributors described waiting for treatment as an emotionally precarious period marked by uncertainty, isolation and loss of hope. FEEL-ED was valued for its potential to offer structure, contact and continuity while people awaited specialist support. It was not viewed as a replacement for treatment, but as something that could help hold people safely in the interim.

**2.A. Containment and connection**

Waiting for treatment was described as frightening and destabilising. Contributors spoke about not knowing when support would come, feeling alone, and becoming increasingly anxious or hopeless. One contributor stated:

*“I think it is exceptionally important to provide support to people on waitlists, as people can grow desperate and hopeless when they do not know when support is coming. Communication with people on waitlists is poor, meaning that you often have no idea how long you will be waiting, and if help will arrive.” (C1)*

Again, wait-times and communication while on the waiting list represent another area in which people from marginalised groups may be disproportionately affected, potentially exacerbating existing healthcare inequalities.

*“I have experienced long and often isolating waits for assessment and treatment. Waiting, especially without support, often leads to worsening mental health and increased feelings of being ‘not sick enough’ or ‘not worth helping.’ It is especially hard for people who have spent years being misdiagnosed or dismissed. For disabled and racialised people, waiting can feel like confirmation that your pain is not taken seriously or that services were never designed with you in mind. When referrals are vague or communication is poor, it becomes difficult to hold hope.” (C6)*

FEEL-ED was therefore understood as having the potential to provide a sense of containment during a period when contributors otherwise felt abandoned or suspended, as further illustrated by the following quote “*it will be a lifeline to people who are in that hopeless, uncertain place of waiting. I honestly think it*

*could make all the difference to them…it's especially vital in that waitlist time where people are otherwise very alone" (C1).*

**2.B. Acknowledgement and validation**

Contributors emphasised that being offered something while waiting could itself feel validating. Several described how difficult it can be to ask for help, and how silence afterwards may intensify feelings of not being unwell enough or not deserving support. One contributor explained:

*"The act of asking for help was very difficult for me and I guess will be for many others and having nothing to even acknowledge that you have done this and need immediate support would have made me feel isolated and not valued." (C3)*

FEEL-ED was also viewed as a way of preparing for treatment by supporting emotional awareness, coping skills and readiness to engage. Contributors suggested that it could help people feel they were already beginning therapeutic work:

*"I think this programme would give people a sense that they were already engaging in the therapy that they were going to receive, in a sense - doing preparatory work which would help them when the therapy finally arrived." (C1)*

The value of FEEL-ED therefore lay not only in its specific content but also in the sense of recognition and validation and therapeutic engagement the mini-course could provide.

**Theme 3: Innovating responsibly and ethically**: *"[FEEL-ED must] be positioned as a form of support, not self-responsibility" (C6)*

Although contributors valued the focus on emotion, they also identified risks associated with emotion-based work when undertaken without adequate support. These concerns centred on containment, stigma and the possibility that responsibility for managing distress could be shifted onto individuals rather than services. Additionally, this theme captured contributors' thoughts around how some of these potential risks could be mitigated through careful design, framing, and support of the FEEL-ED intervention.

Contributors focused not only on content, but also on safety, accessibility, flexibility and cultural responsiveness.

# Theme 3A: Risks and responsibilities

Contributors expressed concerns that engaging with difficult emotions alone could be overwhelming, and lead to feelings of hopelessness or self-criticism. One contributor highlighted the possibility that difficulties engaging with the toolkit could themselves become distressing:

*“Someone struggles to implement the activities and feels more hopeless; someone struggles to implement the activities and this weakens their resolve to follow through with treatment.” (C1)*

Another contributor linked this to perfectionism, noting that “*feeling like I was failing at using the tools could create more anguish*” (C2). These concerns suggested that emotional work may be helpful only when accompanied by clear reassurance, preparation and routes to further support.

Contributors also warned that unsupported self-help could reinforce shame or the belief that people should manage alone. This was particularly concerning in systems (e.g. relational, social, cultural, and institutional contexts) where distress is already misread or minimised.

One contributor warned that an emotion-focused approach should not “*imply that emotional dysregulation is a personal failing*” or “*overlook the external systems (racism, ableism, medical trauma) that shape emotional pain*” (C6). The risks of FEEL-ED were therefore not only apparent at an individual level, but also at ethical and systemic levels.

Others emphasised that the toolkit should remain connected to treatment rather than replace it. As one contributor suggested, it could be used “*before, during and after treatment*” (C2), with emotional awareness and understanding developing over time. Contributors viewed the mini-course not as a replacement for treatment, but as something that could hold individuals safely while they awaited treatment and help them prepare for the therapeutic work ahead. In this way the course provides a way to begin working on the emotional component of eating disorders earlier but does not provide a substitute for therapy: *“I would want it to be emphasised that it is a toolkit and offering empowering how one understands themselves and the start of making changes in how to regulate and respond to emotions, rather than as a support in person form.” (C2)*

# Theme 3B: Inclusive design for real-world use:

Contributors emphasised the need for clear guidance, safeguards and routes to support. This included warning users that emotional work may be distressing, providing reassurance, signposting to crisis support, and making it clear that FEEL-ED is an interim resource rather than treatment. One contributor suggested that risks could be mitigated if:

*“extremely clear guidance is provided around individual risk … people are signposted to coping resources and support, and lots of empathic reassurance is provided around these activities being difficult at first.” (C1)*

Safety was therefore understood as something that needed to be actively built into the design, framing and delivery of the toolkit.

Contributors wanted FEEL-ED to be easy to navigate and usable in everyday life. They valued clear language, simple structure, mobile access, worksheets that could be saved, and the ability to revisit material over time. One contributor highlighted the value of permanent access, suggesting that making

videos accessible "*through an app on the phone*" could help people have them "*by their side whenever they need them*" (C1). Another noted that access to the workbook was important so it could be shared with a future therapist (C4).

Finally, contributors emphasised that FEEL-ED should recognise diverse emotional experiences, identities and communication styles. This included plain English, audio, subtitles, visual guides, sensory prompts, creative tools and representation across ethnicity, body size, disability and neurodivergence. One contributor described how: "*it has the potential to be [helpful] but only if it is truly culturally responsive, accessible, and trauma informed*." (C6).

They also recommended that the toolkit acknowledge "*the cumulative barriers people face - poverty, immigration status, caring responsibilities, and language access*" so that people feel the resource is "*for them, not just about them*" (C6). This subtheme highlighted that inclusivity was not simply a matter of format or accessibility, but also of whether contributors' lives, identities and structural contexts were meaningfully recognised.

# Discussion

This paper aimed to explore lived experience perspectives on the utility, acceptability, and potential risks of the FEEL-ED toolkit as an interim source of support while awaiting treatment. Data from individuals with current or past eating disorders were analysed using reflexive thematic analysis, generating three themes: (1) emotional regulation as central to eating disorders and recovery; (2) bridging the gap in care; and (3) innovating responsibly and ethically. Together, these findings highlight the relevance of emotion-focused support for binge eating and recovery, while emphasising the need for careful framing, safeguarding, and inclusive design to avoid inadvertently shifting responsibility for gaps in care onto individuals.

Emotional experience was consistently positioned as central to eating disorders and their recovery, aligning with a substantial body of existing literature. Emotion regulation difficulties are well-documented across diagnoses and are particularly salient in binge-eating presentations (Dingemans et al., 2017; Bodell et al., 2022; Leppanen et al., 2022). Improvements in emotion regulation have also been identified as an important mechanism of change in eating disorder treatment (Brown et al., 2020; Preyde et al., 2016; Sawyer et al., 2025). Contributors' emphasis on emotion-focused support also aligns with growing evidence for therapies targeting emotional processes, including DBT, ACT, and emotion-focused therapy (Rozakou-Soumalia et al., 2021; Osoro et al., 2022; Onnink et al., 2022), alongside emerging digital adaptations (Nicolaou et al., 2022). FEEL-ED does not seek to reproduce these therapies in full but rather offers a lower-intensity, scalable approach targeting shared emotion-based processes that may be suitable while awaiting specialist care. FEEL-ED also aims to address aspects of emotional functioning that are not consistently targeted across existing emotion-focused therapies. For example, while DBT primarily focuses on emotion regulation strategies and distress tolerance, FEEL-ED additionally addresses processes such as beliefs about emotions or alexithymia which have been linked to the

maintenance of ED behaviours and poorer recovery outcomes (Speranza et al., 2007). Consistent with this, our contributors described a range of emotional difficulties, including emotional overwhelm, alexithymia, shame, masking, and the use of eating disorder behaviours to manage distress. These accounts support FEEL-ED's focus on a range of emotional processes, reflecting its development as an integrative intervention that combines elements of DBT, ACT, and emotion-focused therapy with insights from affective science and grounded in the Extended Process Model of Emotion Regulation (Gross, 2015).

Another key contribution relates to waiting list support. Contributors described waiting as a period of anxiety, isolation, uncertainty, and diminished hope. In the UK, waits can exceed six months (BEAT, 2018; Viljoen et al., 2024) and are associated with symptom worsening, reduced engagement, and increased dropout (Carter et al., 2012; Blackburn et al., 2024; Solmi et al., 2024). These findings reinforce that waiting periods are active clinical contexts in which distress may intensify and motivation fluctuate (Sansfacon et al., 2020). Whilst waitlist interventions remain under-researched (Wade et al., 2024; Wade & Schmidt, 2026), emerging evidence suggests that they may be particularly helpful to improve treatment engagement rather than symptom reduction alone. For instance, Keegan et al. (2024) found increased completion of subsequent CBT among individuals receiving a brief waitlist intervention, despite no pre-treatment symptom change. This resonates with our findings as our contributors valued the mini-course (or the concept of the mini-course) not only for its skills content but for the validation it communicated, helping them feel seen, believed, and not forgotten. This suggests that delivering FEEL-ED while patients await treatment could provide validation and support preparedness during a period of vulnerability, alongside its known benefits for emotional functioning and eating disorder psychopathology (Vuillier et al., 2024).

Our third theme, safeguarding, highlights the importance of delivering self-help in ways that promote self-compassion while minimising self-blame and recognising that emotional distress is shaped by broader social and structural contexts, including trauma, neurodivergence, and marginalisation. This challenges purely individualised accounts of distress and underscores the need to situate emotional processes within relational, social, and healthcare contexts (Downs, 2026). Self-compassion is associated with lower symptom severity and improved outcomes in eating disorders (Morgan-Lowes et al., 2023; Kelly et al., 2014), and is often described as central to recovery (Gale et al., 2014). In line with this, contributors emphasised the critical role of compassionate framing in supporting engagement, which may be particularly important in digital interventions, where dropout is common (Boucher & Raiker, 2024; Lipschitz et al., 2023). Given that engagement is shaped by perceived relevance, usability, and personalisation (Borghouts et al., 2021), a compassionate and flexible design may be key to engagement with FEEL-ED. Our contributors also raised concerns about how FEEL-ED is positioned, emphasising that it must not be perceived as a substitute for care. This reflects broader critiques of low-intensity interventions in under-resourced systems (Lawn et al., 2011). Rather, such tools should be clearly framed as adjunctive and supportive. This is especially important in eating disorders, where shame and beliefs about not being "sick enough" may already act as barriers to help-seeking and engagement (Downs et al., 2025; O'Connor et al., 2021).

# Strengths and limitations

This study demonstrates methodological innovation in the co-development of FEEL-ED through the integration of theory, empirical evidence, and lived experience expertise. This approach enhances ecological validity and ethical sensitivity, and responds to growing calls to move beyond extractive research practices in mental health (Beresford;, 2013; Downs, 2026). Importantly, lived experience contributors were actively involved across study design, data collection, and analysis, enabling meaningful influence over the research process and toolkit development. Such an approach positions lived experience as an epistemic resource rather than solely a participant characteristic and contributes to an emerging body of work that centres experiential knowledge in intervention development (Downs, 2025; Downs et al., 2025a; Downs et al., 2025b).

Several limitations should be considered. First, the qualitative sample was relatively small and self-selecting, which may limit transferability and reflect the views of individuals who are particularly motivated to engage with intervention development. Contributors also represented a range of eating disorder presentations, and engagement with FEEL-ED materials varied, with some responding directly to the content and others drawing more broadly on their lived experience of eating disorders and waiting for care. While this variability may limit specificity to binge-eating populations, it provided valuable breadth in identifying potential benefits, risks, and design considerations.

Second, data were collected using an asynchronous written format rather than in-depth interviews. This approach may have constrained opportunities for probing, clarification, and exploration of contradictions within participants' accounts. However, it was intentionally selected to enhance accessibility and emotional safety when discussing sensitive topics such as binge eating, shame, and experiences of waiting for care. The format allowed contributors to respond at their own pace and in their preferred environment and was informed by consultation with the lived experience group. As noted by Braun et al. (2021), such approaches can produce rich qualitative data and remain underutilised within psychological research.

Third, the dual role of the research team as both intervention developers and analysts introduces the potential for bias in data interpretation. While this is a recognised feature of co-produced intervention development, the team's investment in FEEL-ED may have shaped how findings were understood and emphasised. To mitigate this, the analysis drew on reflexive team discussions and actively engaged with critical and cautionary perspectives, avoiding an emphasis on solely positive accounts and ensuring that concerns about harm, shifting of responsibility, and exclusion were included. Nevertheless, independent evaluation by researchers not involved in intervention development would strengthen confidence in the findings.

# Future directions

Future research is in progress to evaluate FEEL-ED with its intended population, focusing on acceptability, safety, engagement, and relevance, including diverse and underrepresented groups. Further

work is needed to determine how it can be safely integrated into NHS waiting list pathways, including referral processes, risk management, and support structures. If feasibility is established, a randomised controlled trial will be required to assess effects on emotional distress, self-efficacy, treatment readiness, engagement, and clinical outcomes. Future studies should also consider which outcomes are most meaningful, including process-based and relational outcomes, given contributors' emphasis on validation and preparation.

# Conclusion

This study presents the theory-informed and co-designed development of FEEL-ED, a brief emotion-focused intervention for individuals awaiting eating disorder treatment. Findings align with evidence that emotional processes are central to binge eating and recovery and extend this by highlighting the relational and ethical value of interim support. For implementation, FEEL-ED must be clearly positioned as adjunctive, delivered with safeguards, and continue to be designed in inclusive and context-sensitive ways. These findings emphasise the importance of lived experience-led approaches to intervention development.

# Abbreviations

ACT: Acceptance and Commitment Therapy

BED: Binge Eating Disorder

BN: Bulimia Nervosa

CBT: Cognitive Behavioural Therapy

DBT: Dialectical Behavioural Therapy

ED: Eating Disorder

FEEL-ED: Fostering Effective Emotional Life skills for Eating Disorders

OSFED: Other Specified Feeding and eating Disorders

# Declarations

### Ethics approval and consent to participate

Ethical approval of the study was granted by Bournemouth University Ethics Committee (ID: 58188). All participants provided fully-informed consent to take part in the study.

### Consent for publication

Consent to publish anonymised data was granted by participants when consenting to take part in the study.

**Availability of data and materials**

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

**Competing interests**

The authors declare that they have no competing interests.

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**Authors' contributions**

LV, EG, and JD designed the study. JD analysed the data and wrote the results section. EG, JD, LV, and ST wrote the introduction. EG and JD wrote the methods and discussion sections. All authors contributed to and approved the final manuscript.

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# Figures

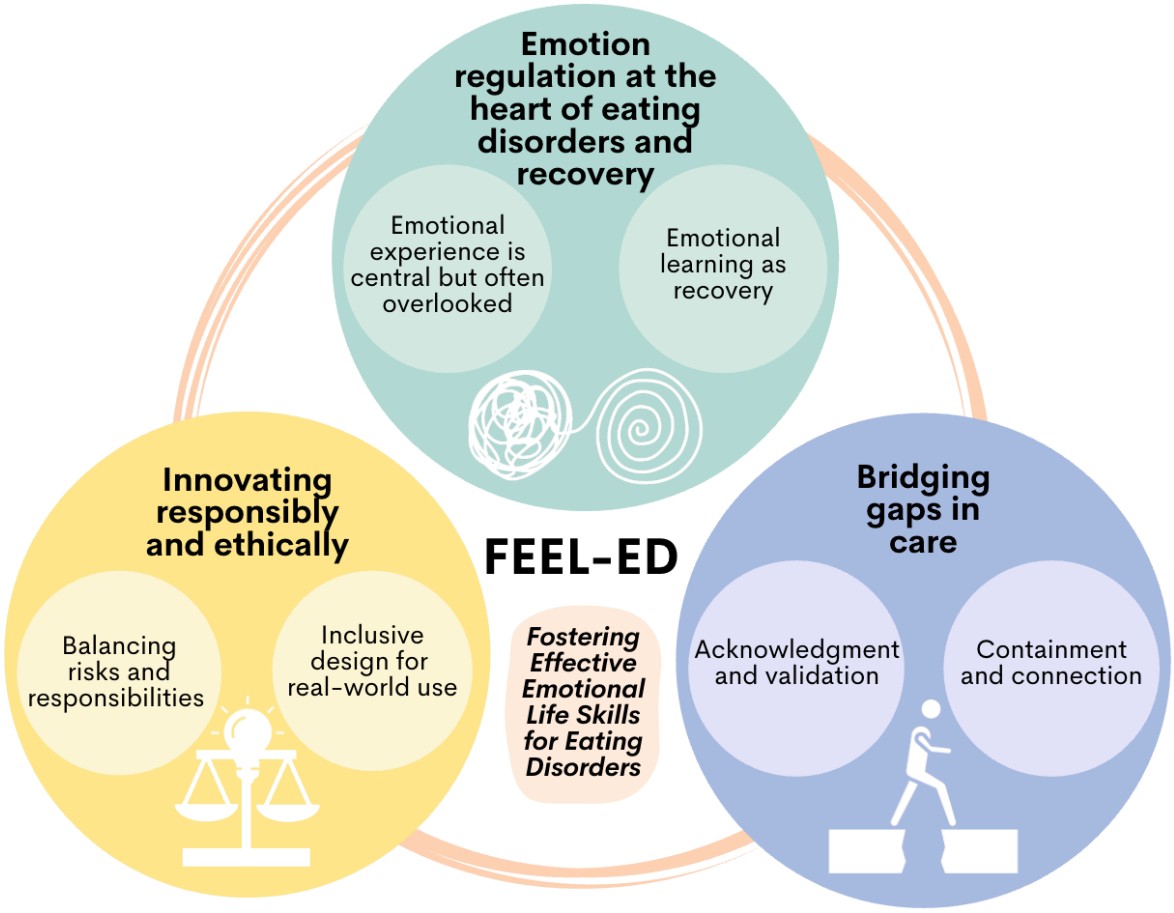


**Figure 1**

Thematic map representing contributor accounts regarding FEEL-ED

## Supplementary Files

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- Appendix.docx