

Being the best anorexic: A grounded theory of adolescent girls' social processes during compulsory inpatient treatment for anorexia nervosa

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Abstract

Background

Anorexia nervosa is a life-threatening psychiatric disorder associated with the second highest mortality rate of all mental illnesses. In severe cases, compulsory inpatient treatment may be required to prevent life-threatening starvation, although such care is often experienced as highly distressing. This study aimed to explore the social processes experienced by adolescent with severe anorexia nervosa during compulsory inpatient treatment and to develop a grounded theory explaining how they managed their central concerns.

Methods

This qualitative grounded theory study included seven girls aged 14–17 years (mean age 15 years 4 months) who had previously received compulsory inpatient treatment for severe anorexia nervosa for a mean duration of 18 weeks (range 4–38). Individual semi-structured interviews lasting 45–120 minutes were audio-recorded, transcribed verbatim, and analysed using Charmaz’s constructivist grounded theory approach.

Results

The core category, Being the best anorexic, explained how participants’ managed their central concern through four interconnected social processes: Compare, Compete, Control, and Cope. Participants described compulsory treatment as an ongoing battle in which they continuously negotiated their identity in relation to peers, healthcare professionals, and parents. Striving to become the best anorexic meant competing to be perceived as the sickest patient while simultaneously attempting to preserve a sense of control and self-worth. These processes appeared to reinforce eating disorder behaviours and created challenges for recovery.

Conclusions

This study provides a novel theoretical understanding of the social processes experienced during compulsory inpatient treatment for severe anorexia nervosa. Increased awareness of comparison and competition between patients may help healthcare professionals provide more person-centred care and reduce unintended reinforcement of eating disorder behaviours during treatment.

INTRODUCTION

The incidence of anorexia nervosa among adolescents in Western countries has increased over the past decade. Lifetime prevalence is estimated at approximately 4% among females and 0.3% among male [1].

Anorexia nervosa is a life-threatening and disabling disorder and has the second highest mortality rate of all psychiatric illnesses [2]. In a Danish cohort study, the weighted average mortality risk peaked within ten years of diagnosis and was seven times higher than in matched controls. Fourteen percent of all deaths among patients with anorexia nervosa during the study period were due to suicide [3]. Almost half of the patients (47%) had at least one comorbid psychiatric disorder, which was associated with an even higher mortality risk [1].

The aetiology of anorexia nervosa remains incompletely understood, although genetic factors are thought to account for a substantial proportion of susceptibility to the disorder [4]. Deliberate weight loss is a major precipitating factor, while a strong need for control, low self-esteem, and stressful life events may contribute to its development. Familial tensions may also be exacerbated by the onset and progression of the disorder [5]. Recent research has also highlighted the importance of social comparison, particularly through social media, where young people frequently compare themselves with others affected by eating disorders. Exposure to body- and food-focused online content appears to reinforce eating disorder symptoms by increasing preoccupation with weight, shape, and dietary restraint. Algorithms used by platforms such as TikTok and Instagram rapidly personalise content based on users' viewing behaviour, potentially increasing exposure to harmful ideals, although they may also facilitate access to supportive recovery-oriented content [6].

Outpatient treatment is recommended as the first-line intervention for adolescents with anorexia nervosa. However, compulsory inpatient treatment may be necessary for patients with severe, life-threatening disease. Because this phase of treatment is often experienced as highly distressing, continuous efforts are needed to optimise care and provide person-centred support. One of the major clinical challenges is that patients with severe anorexia frequently experience profound ambivalence towards treatment, as the disorder may be perceived as an important part of their identity and a source of safety and control [7, 8]. Consequently, compulsory inpatient treatment is often associated with fear, loss of autonomy, and feelings of entrapment. Nevertheless, many patients later describe this period of care as a necessary turning point in their recovery [9]. Previous qualitative studies have shown that comparison and competition are central features of anorexia nervosa and may be reinforced when patients receive treatment alongside peers. For individuals with perfectionistic or highly competitive traits, the illness may become a means of achieving mastery and maintaining a sense of control in areas of life where they otherwise feel vulnerable [10, 11].

Although previous qualitative studies have described patients' experiences of anorexia nervosa and inpatient treatment, little is known about the underlying social processes shaping adolescents' experiences during compulsory inpatient treatment. In particular, there is limited knowledge of the central concerns that dominate patients' experiences and the strategies they use to manage these concerns. A better understanding of these social processes may help clinicians optimise inpatient care and minimise unintended consequences of treatment.

The aim of this study was to explore the central concerns of adolescent girls with severe anorexia nervosa during compulsory inpatient treatment and to develop a grounded theory explaining how they managed these concerns. Specifically, we sought to identify their core concern, the social processes through which it was expressed, and the strategies they used to manage it throughout treatment.

METHODS & SAMPLE

Design

This empirical qualitative study aimed to describe and understand the social processes involved in compulsory admission to a paediatric psychiatric in-patient unit for eating disorders. The choice of research design was dependent of the nature of the issues addressed. The design made it possible to gain extensive knowledge and understanding about a sparsely investigated area and to build a theory grounded on the data collected. The rationale behind the grounded theory [12] approach was an assumption that this type of compulsory care involves social processes as well as a process of change. Since no previous study with this specific research question has been performed, we sought to be truly inductive, while at the same time able to identify a possible theoretical frame.

Participants

Potential participants that previously had been treated as in-patients at the Paediatric eating disorder unit, Malmö University hospital, Sweden, were identified by searching for the diagnosis registered in medical administrative systems during January 1, 2021, to December 31, 2023. The clinical context is further described in box 1. Inclusion criteria were: Patients treated for anorexia nervosa, 13–17 years old and able to understand the Swedish language. They should be without severe co-morbidity and have had no hospital admission in the previous three months.

The selection of participants was in accordance with Morse [13]. Morse emphasized that participants in qualitative studies should be selected because they can provide rich, relevant, and detailed information about the phenomenon being studied – not to statistically represent a population:

1. *Convenience sampling.* Accessible previous young patients were recruited to identify the scope, major components and trajectory of the overall process. After four interviews, we moved on to the next sampling step.
2. *Purposeful sampling.* During this step we wished to maximize the variation in meaning. The three new interviews revealed in greater detail how the participants themselves were integrated in the emerging phenomenon of being the best anorexic. From their responses a conceptual scheme as well as the trajectory identified during the convenience sampling emerged more clearly and was confirmed.
3. *Theoretical sampling and validation.* First, we re-coded the data pertaining to the identified trajectory. Then we allowed the emerging categories and our increasing understanding to direct the final

sampling where we returned to two participants and posed targeted questions concerning the meaning of each concept to enable grounded definitions and clarify the links between the categories. These two interviews served as validation where we also worked deductively and asked the participants if the analysis made sense to them and if there was a match between their experiences and the emerging theoretical model.

Potential participants and their legal guardians received written and oral information about the study. Seven girls aged between 14 and 17 years (mean age 15 years 4 months) agreed to participate and gave their written informed consent. All participants had been diagnosed with anorexia nervosa and in three cases it was their only diagnosis. Four participants had a comorbid anxiety disorder and three a comorbid depression. Two participants were later diagnosed with autism. The participants on average had been unwell for 10 months before their admission. The mean age when undergoing treatment was 13 years and 11 months (range 11–17 years). The mean duration of their inpatient care was 18 (range 4–38) weeks. Six had experienced multiple treatment periods and six had undergone compulsory care more than once. The interviews took place on average 17 (13–24) months after their most recent discharge. At the time of their admissions, the participants were unable to attend school or take part in social activities and all described themselves as being cut off from friends and family. Two participants required parenteral feeding via a nasogastric tube during their treatment and at some point, six of them drank feeding solution to avoid the feeding tube. All participants were admitted with a parent, in six cases their mother. Five of the participants had parents that lived together. After discharge they were followed in various outpatient settings. At the time of the interviews all participants had returned to their usual activities, including attending school and contact with family and friends.

Data collection

A semi-structured interview format was used to provide answers to questions pertaining to the main concern of young anorexic girls when involuntarily admitted to psychiatric care, how they dealt with it, their thoughts and decision-making strategies. The analysis was performed in line with the grounded theory approach developed by Charmaz [12]. Charmaz's constructivist Grounded Theory approach views knowledge as co-constructed between researcher and participants. Using iterative data collection and constant comparative analysis to generate theory grounded in participants' experiences.

An interview guide with open-ended questions was used. To obtain a more in-depth description of the participants' experiences, various follow-up questions were posed, e.g., "Could you tell me more?", "How do you mean?", "How?". This approach encourages participants to expand their initial answers [14]. The interviews were conducted between by the first author (HH) at the eating disorder unit outpatient unit in Malmö. The interviews, which lasted from 45 to 120 minutes, were audio recorded and transcribed verbatim.

Data analysis

As recommended by Glaser [15] and Hallberg [16], we first investigated whether similar studies had been conducted with a grounded theory approach. No comparable studies were found. Data collection and analysis were conducted concurrently. The transcribed text was read carefully and after each interview an initial line-by-line coding was performed. Focus was on the main concern of the participants as well as the strategies used to deal with it. Words or phrases, actions and processes indicating important categories related to the research questions were highlighted. Focused coding was conducted to detect and explain the most frequent and significant codes, which illuminated the tentative main categories as well as strategies used by the participants in relation to their greatest concern. In the theoretical coding, relationships between the categories generated during the focused coding were identified and the main concern as well as the categories conceptualized. Two (HH and AF) out of the five authors performed the main parts of the analysis, which was subsequently confirmed and validated by the other authors. Throughout the analysis, the constant comparative method was used on the data, i.e., comparing incidents to incidents, incidents to concepts and concepts to concepts throughout the dataset. A constructivist approach was employed, meaning that the categories and theory were developed from the patterns revealed by the researchers' theoretical constructions of the participants' narrative, in line with constructivism [12]. Memos were written during the interviews. Saturation was achieved after the model was validated by two participants. The rich interviews were also analysed in a phenomenological hermeneutic approach to obtain further understanding about the participant's lived experiences, which will be presented in another paper.

FINDINGS

Being the best anorexic

The participants' central concern was to preserve their identity and self-worth as a person with anorexia nervosa despite compulsory treatment. This concern was managed through the core narrative, *Being the best anorexic*, which summarizes a process wherein the generated grounded theory is presented through four main categories; *compare, compete, control and cope*. Being the best anorexic meant winning the competition of being the sickest girl with the lowest weight in the eating disorder unit and thus in need of the treatment and resources provided. It also described as being the best to avoid following the treatment and remain somatic instability.

It was about how fast she [a fellow patient] is eating. I will eat more slowly. I will be the slowest eater. It was about the competition. I will be the best anorexic here.... I had to achieve a certain level of illness to deserve the treatment.

"Well, it mattered a lot how worried they [the staff] were about you. If you needed some extra help or if they were concerned about my labs or vital signs that triggered the eating disorder even more. If I was good at being sick".

The theoretical link between the strategies is fighting for one's position around the kitchen table and in the unit, described by the participants as a war zone. The fight included one's control over the disorder and the desire to be acknowledged as a human being and not only an eating disorder defined by one's weight, circulatory status and solid calorie intake.

Additionally, the main categories contain several subcategories presented in bold italics in the text. In conjunction with the process, the temporal aspect is anchored in the participants' thoughts and feelings pertaining to the competition and the treatment, which is interpreted as an overall sense of a power struggle between the patients and the staff, and the impotency experienced by the participants throughout the whole treatment course. The outline of the results is presented in Fig. 1.

Please insert Fig. about here

The common denominator for all participants was a wish to win the competition, i.e. to be the best and sickest anorexic. The core category comprises all the participants' descriptions of the various phases in the process. The main categories are linked to the core category and represent the primary concern among the participants. Being the best anorexic was preceded by an effort to *compare* to ensure one's position in the competition. The second main category involved how to *compete* with fellow patients in the eating disorder unit. The participants chose to *control* everything involved in food intake to pursue their overall goal of being the best anorexic. To endure the care environment and the treatment as well as the ever-present anxiety it was important to *cope*, which meant adapting, enduring, comprehending and fighting for dignity against the disorder. The theoretical link between the main categories served as a catalyst for the decision to survive and finally overcome the eating disorder.

Compare

One key strategy for being the best anorexic in the unit is to constantly compare oneself with the rest of the patients, particularly in meal situations and when parents serve the food. Eating in the eating disorder unit concerns having a meal in a context of comparison, mastery and control, where everyone around the table watches each other. The participants stated that the tense situation made the disorder even worse.

"In the beginning everyone was sad and angry. There was a lot of shouting and fighting around the table. You were sitting opposite of each other, watching each other all the time.... fiddling with the food. You can't find any joy in eating in a situation like that. Then suddenly someone starts screaming about getting fat and bla, bla, bla. It made it all worse".

Life in the eating disorder unit is like a game, and the girls practice the game by being the person eating the slowest. You take one bite and then wait for the next patient to take a bite. The key is to always be one bite behind the rest.

"You're supposed to be the slowest eater. Like taking a bite every two minutes. And that was exhausting for me. And for anyone I guess, to take a bite and then not allowed to take another one for two minutes. And when you're allowed to take the next one depends on when someone else is taking their bite. You're supposed to be one bite behind all the time".

Comparing also involves practicing abnormality, where manipulation of the staff starts immediately after admission to the eating disorder unit, constituting the social interaction between the participants and the staff. Seeing different therapists becomes a way to escape from the comparison, competing and control, thus the therapy constitutes a social escape rather than actual treatment.

"All these therapists, they helped a lot. Not the actual therapy, but the fact that you got away from all the patients walking round the table in circles, all the extra milk and so on".

The strategy of comparison involves viewing oneself as judged by others. If the staff showed concern, it was confirmation that one was doing well in the competition, which increased the eating disorder even more.

"The first time I was [admitted] in the emergency unit, I was the only one with an eating disorder. The rest had other problems. It meant that I couldn't compare myself with other patients. Instead, it was more in relation to the staff. When they were worried it confirmed my disorder".

Comparing oneself with other patients enabled adopting the other patients' illness behaviour, e.g. how to eat as slowly as possible or avoid the nutritional shots.

Compete

Being admitted to the eating disorder unit meant being in a competition. The girls compete and the winner is the one with the lowest weight who manages to eat more slowly than the rest. During temporary leaves and after discharge to their homes it involved competing with oneself about how to master the food intake or competing with others on the internet to be visible and boast that one is the sickest of them all.

"At home it was more about competing with myself. And then other persons on the Internet. You wanted to show off, being the sickest of them all, which of course was really stupid".

Control

The category control includes different subcategories. To control the food situation, they wrote memos about their food intake and their whereabouts in the eating disorder unit. Sometimes it was a relief to hand over control to the staff. To maintain control, they pretend and manipulate depending on who they are interacting with.

"It was a matter of pretending to be sicker than you actually are. Or at least trying to. But when seeing the physicians it was the opposite, pretending that I am doing very well. So, I tried to convince the physicians

that I could make it on my own, to the rest of the group [patients] that I was as sick as possible. And at the same time, I couldn't eat a tiny pea, and it became obvious how little control I had when trying to control one tiny pea".

Control is also about maintaining the power over food in the eating disorder unit as well as at home. In the eating disorder unit one can allow oneself to eat, which is experienced as a relief. At home one had the power to refuse to eat without suffering any consequences. In the eating disorder unit the obvious consequence was a feeding tube.

"Here [in the eating disorder unit] you were forced to have the feeding tube if not eating. And then I felt it was better to just eat those calories instead. I simply didn't want the feeding tube. But to be honest, the only thing I wanted was to get out to starve myself (again). The freedom to do that.... to decide for myself. At home I was (the one) in charge. I had the power. My mum could tell me, but she couldn't do anything".

Control also means deliberately handing over the power to one's parent at home. This involves making a pact and collaborating with one's parent based on mutual trust.

The only thing I live for is my eating disorder, to reduce weight. I don't want that anymore... My mother didn't submit herself to my eating disorder. She served the amount of food that was supposed to be served and then she helped me to cope with the anxiety afterwards.

Cope

The main coping strategy is adapting to compulsory care, the encounters with the staff, one's parents and the treatment. The participants try to take the easy way out and not make things more difficult than necessary. When asking for psychological treatment, they adapt to the physicians' judgment that they are not receptive to such treatment in the acute phase when in severe starvation. Adaptation involves mastering the staff's experienced as judgmental and concealing one's feelings. They feel their parents' shame and deal with the trust-related issues involved in the child-parent relationship both in the hospital and at home.

Coping also involves balancing between the present and the future and try to understand what is going on, to focus on their healthy person and find out who they really are behind the disorder.

I understand that there must be a strong focus on food and weight. But you also need to make the patients understand that they are more than their disorder... Who am I without this disorder? It is very important to say you are more than your disorder.

When coping the girls interact with the eating disorder by means of a social processes. Being forced to have a feeding tube is helpful for some, as it is used to control and threaten the eating disorder, which is viewed as a separate entity from oneself. Thus, they talk to the eating disorder as if it has its own personality.

If I had known for sure that I would always get a feeding tube I could have told my eating disorder that: - hey if you don't eat you will get a tube. But most times I didn't get one [a feeding tube] and then it became difficult for me to motivate the eating disorder to eat.

Coping includes splitting oneself into two parts, i.e. different personalities, oneself and the eating disorder. The part that constitutes oneself speaks with the part that constitutes the eating disorder, and these parts are positioned against each other in an inner battle. When oneself is experienced as weak, i.e. not fit enough to fight the battle against the eating disorder, there is a need for support from staff to fight the battle by means of replacing the girl's inner voice with an external professional voice mediating in the perceived inner conflict.

That is how I became well, maintaining an ongoing discussion with myself. When the eating disorder said something, I discussed it in my head. But if someone else [a staff] could have had that conversation with me instead, I could have managed to maintain myself against the eating disorder even when I wasn't strong enough. It would have been very helpful instead of just sitting beside me while I was eating.

Finally, coping means putting one's life on the line as experienced by the girls. Every step of the day, from being micro-monitored regarding when to play and when to take a shower to possibly life altering decisions made by the physicians, the patients felt their whole life situation was challenged.

"This is my life. They work in my life. Everything they do and then let go of after work affects me for the rest of the month or the time I am in hospital. You need to think about that. At best you let it go after discharge but that is not always the case. People's whole lives are affected here [the eating disorder unit]. Decisions made by physicians in a split second, at least it feels like that, leave very strong marks in my life. It is their job. But it is my life".

Fighting as the theoretical link

Fighting was identified as the theoretical link between the categories and the glue that keeps the social process together. The girls fight anxiety, the staff, the disorder and the environment. The fight aimed at winning the competition of being the sickest and the thinnest.

Everything is about the eating disorder. Nothing is healthy. The staff are eating disorder, the food is eating disorder, the room, all parents, everything is eating disorder. You get admitted and unburdened from responsibility. But if you don't fill that space with something healthy it only gets worse, and the eating disorder will fill that space instead.

A health process is initiated when the girl is respected as a capable person and makes the decision to fight against the disorder and end her participation in the competition. A healing process can begin without the fight when she is continuously invited into a caring relationship with staff focusing on normal aspects of everyday life.

"You had your own contact person who sat beside you at every meal. They sort of matched the staff to fit you. And we had rather normal conversations at the dinner table because I didn't want to hear anything about food. I just needed some peace when I was eating. When I decided to eat, I ate. No conversations about food were needed. Just about normal stuff and that they supported me when I had a lot of anxiety".

Follow-up with participants

When presented with the findings the participants stated that the topics addressed were important as they were relevant feelings that they had experienced. They could relate to and understand the findings and asked for a treatment that takes the person behind the disorder into consideration and that the staff would listen to them.

DISCUSSION

Reflection on the findings

In this qualitative study, we explored the social processes experienced by adolescent girls with severe anorexia nervosa during compulsory inpatient treatment for a life-threatening condition. The findings suggest that the participants' central concern was preserving their identity and self-worth as a person with anorexia nervosa despite treatment aimed at restoring health. The core category, *Being the best anorexic*, explained how they managed this concern through four interconnected social processes: *Compare*, *Compete*, *Control*, and *Cope*.

Participants described being caught in a continuous battle that began before admission, persisted throughout compulsory treatment, and continued after discharge. They struggled with the illness as both an ally and an enemy, negotiated silent hierarchies among peers, and experienced conflicts with healthcare professionals and parents. Within this social context, striving to become *the best anorexic* represented a way of maintaining identity, status, and self-worth despite treatment. The four social processes—comparison, competition, control, and coping—constituted interconnected ways of managing this central concern. Together, they provide a novel theoretical understanding of how adolescents experience compulsory treatment for severe anorexia nervosa.

Clinically, the theory illustrates that behaviours often interpreted as resistance to treatment may instead represent attempts to preserve identity during an exceptionally vulnerable phase of illness. Recognising these underlying social processes may therefore help healthcare professionals better understand patients' behaviour and tailor person-centred interventions accordingly.

Several participants expressed ambivalence towards staff taking control of their care. While relinquishing control could be experienced as a welcome relief from the relentless demands of the illness, it could simultaneously evoke feelings of losing an important part of themselves. This finding

highlights the complex role of control in anorexia nervosa, where surrendering control may represent both a threat to identity and an opportunity for recovery.

Competitiveness can promote achievement in many contexts but may become destructive when directed towards body image and weight control [17]. A Norwegian qualitative study similarly described participants striving to prove that they were "ill enough," often in the context of perfectionism and competitiveness. The illness became a domain in which success could be achieved, and many participants reported wanting to be "the best" anorexic patient on the ward [18]. Success thus became closely intertwined with thinness, while external validation increasingly outweighed personal well-being [19, 20].

In the present study, comparison with peers emerged as one of the primary social processes through which participants managed their central concern. Meals were experienced as highly charged situations characterised by constant observation, comparison, mastery, and control. Rather than facilitating recovery, these interactions frequently intensified eating disorder symptoms. Participants described competing to attain the lowest weight while simultaneously demonstrating the greatest degree of dietary restraint, for example by eating more slowly than others. Similar findings have been reported in a UK qualitative study, where communal meals fostered competition and rivalry among patients [21]. Participants described feeling as though they were on a battlefield, not only struggling against themselves but also competing with peers and, at times, resisting staff. The constant cycle of comparison and competition appeared to reinforce eating disorder behaviours, creating a self-perpetuating social process that complicated recovery.

The urge to compete may drive disordered eating behaviours, while subsequent weight loss can generate a misleading sense of achievement and superiority, making it more difficult for patients to recognise the harmful consequences of the illness [22]. Similar findings have been reported in a Chinese qualitative study, where participants frequently compared food intake and body weight with one another. These comparisons intensified fears of eating and weight gain, while peers also introduced and reinforced maladaptive eating disorder behaviours that persisted after discharge [20]. Likewise, participants in the present study described continuing the competition after leaving hospital, either by challenging themselves to further restrict food intake or by comparing themselves with others online in an effort to remain the sickest.

The interviews also revealed profound ambivalence towards treatment. Participants consistently described compulsory inpatient treatment as necessary for survival, yet emphasised that recovery ultimately required their own commitment. Their resistance to treatment should therefore not be interpreted as an absence of motivation to recover or a rejection of psychiatric care. Rather, it reflected the conflict between preserving the identity that had developed around the illness and engaging in recovery. All participants expressed a desire for help, particularly in managing anxiety, improving self-esteem, and reducing overwhelming stress. The primary source of conflict with healthcare professionals concerned disagreement about how recovery should be achieved, particularly regarding food intake and

weight restoration. Consequently, resistance to weight gain may easily be misinterpreted as resistance to treatment itself.

These findings suggest that future research should further explore patients' own perspectives on recovery and identify ways of strengthening intrinsic motivation while acknowledging the social processes that shape treatment experiences.

Methodological considerations

To our knowledge, this is the first grounded theory study to explore the main concerns of adolescent girls subjected to compulsory care for severe anorexia nervosa. The study was conducted in accordance with Charmaz's criteria for quality in grounded theory research [12].

Credibility was achieved by methodological accuracy. By performing line by line coding, we searched for words or phrases indicating important categories, qualities or contexts related to the research questions. Memos were written for each interview including reflections during the data analysis. In the third step, the focused coding, the main concerns were illuminated. Subsequently, theoretical coding was employed to describe the relationships between the codes. We used the constant comparative method (CCM) simultaneously on data, codes and categories. The categories and theory were developed from the patterns revealed by the researchers' theoretical constructions of the participants' subjective experiences in line with Charmaz [12]. Finally, credibility was further enhanced by including elucidative and descriptive quotations in each main category.

Quotations from the participants support the principle that the theory is based on the coding process. Originality was ensured by the fact that the study describes the young girls' social process when in compulsory care for severe eating disorder. Resonance is evident in the grounded theory, while the main categories illustrate the richness of the participants' experiences during the treatment.

The findings highlight how social processes within treatment may unintentionally reinforce eating disorder behaviours and demonstrate the need for person-centred interventions that acknowledge these dynamics. The theory also extends existing clinical knowledge by identifying the participants' primary concern and describing how they navigated treatment through the interconnected processes of comparison, competition, control, and coping. Although developed from a Swedish cohort, these processes are likely to be relevant for adolescent girls receiving specialist eating disorder treatment in similar healthcare settings. Future studies should examine the transferability of the theory to other cultural contexts and to boys with anorexia nervosa.

Several strengths should be acknowledged. The study provides rich, longitudinal qualitative data, allowing participants to reflect on their experiences during different phases of illness and recovery. Giving voice to adolescents with lived experience offers valuable insights into compulsory treatment from the patient perspective. The findings also have clear clinical implications by identifying potentially modifiable social processes that may influence treatment experiences and outcomes.

The study also has limitations. First, it was conducted at a single specialist centre in Sweden, which may limit the transferability of the findings. Second, although the sample size was small, it is consistent with grounded theory methodology, where sampling continues until theoretical sufficiency is achieved. The rich interview material enabled an in-depth understanding of the social processes under investigation, and the sample was considered adequate according to the principle of information power in qualitative research [23]. Trustworthiness was further strengthened through participant validation of the findings. Finally, as the study included only girls, the findings cannot be assumed to apply to boys with anorexia nervosa.

Conclusion

This study provides a novel understanding of the social processes experienced by adolescent girls undergoing compulsory treatment for severe anorexia nervosa. The grounded theory identified *being the best anorexic* as the participants' core concern, reflected in four interconnected strategies: comparing, competing, controlling, and coping. These processes appeared to preserve identity and self-worth during treatment but also risked reinforcing eating disorder behaviours and interfering with recovery.

The findings highlight that compulsory care, while often lifesaving, takes place within a complex social context in which interactions with peers, healthcare professionals, and parents shape patients' experiences. Recognising these dynamics may help clinicians identify behaviours that are driven by the illness rather than by an unwillingness to recover.

Greater awareness of competitive processes, together with person-centred care, regular staff supervision, and active involvement of patients and their families, may reduce the unintended negative effects of treatment and strengthen support for recovery. Future research should examine how these social processes can be addressed within treatment programmes to improve both patients' experiences and long-term outcomes.

Declarations

Ethical approval

Ethical approval was granted by the Swedish Ethical Review Authority (Dnr 2023-01026-01-365901), and the ethical requirements outlined in the Declaration of Helsinki were fulfilled. All participants and their legal guardians provided informed consent, both verbally and in writing.

Consent for publication

Not applicable. No identifiable personal or clinical details of individual participants are presented in the manuscript.

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Author Contribution

HH conducted the participant recruitment and interviews. AF and HH performed the qualitative data analysis, with AF providing overall methodological oversight based on her extensive expertise in qualitative research and the specific analytical approach. The resulting model was presented to all authors, whose clinical and subject-matter expertise contributed valuable perspectives to the interpretation and analysis of the findings. The manuscript was developed collaboratively, with all authors contributing to the writing, review, and revision of the manuscript. HH, OR, and BAJ contributed to the background section, and OR finalized the abstract. All authors contributed to the discussion. All authors participated in regular meetings throughout the writing process to review and critically discuss the manuscript. The data collected in this study are also being used in a separate manuscript intended for publication. In that study, the data are phenomenological analyzed to describe the lived experience. The different analytical approaches and methodological frameworks mean that the two studies provide distinct and complementary perspectives on the topic.

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Availability of Data and Materials

The data generated and analyzed are not publicly available to protect the anonymity and privacy of the participants.

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Figures



Figure 1

Grounded theory illustrating the core process *Being the best anorexic* and its four interconnected categories: *compare*, *compete*, *control*, and *cope*.

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