

Living with an eating disorder while striving for recovery: Patients' experiences of peer-led online group forums

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Abstract

Background.

Recovery from eating disorders (EDs) is increasingly understood as a multidimensional, non-linear process that extends beyond symptom remission to include emotional, relational, and identity-related change. Peer-led digital interventions have attracted growing interest as they may support change processes. This qualitative study explored how individuals with eating disorders make sense of their experiences of illness and recovery through participation in synchronous online peer-led forums, with particular attention to emotional, interpersonal, and identity-related processes and to participants' experiences of the relational context of the forum.

Methods.

The present study examined data from 37 female participants (mean age = 27.3 years) who participated in weekly synchronous online forum groups as part of two parallel randomized controlled trials evaluating the efficacy of a guided self-help mobile intervention. The sample comprised 25 outpatients with a formal ED diagnosis and 12 individuals with subthreshold ED symptoms. The forum groups were facilitated by five peer mentors with lived experience of recovery from an ED. 32 transcripts of forum group sessions were analysed using Reflexive Thematic Analysis (RTA), combining inductive and deductive approaches.

Results.

Four themes and ten subthemes were developed through RTA, alongside an overarching theme. The four themes captured the eating disorder as a restrictive yet protective trap; its role in regulating difficult emotional experiences; the central role of social relationships in both illness and recovery; and recovery as an ongoing process involving metacognitive awareness, values, and renewed engagement with life. The overarching theme, "Identity differentiation: redefining the boundaries between self and the eating disorder", integrated these patterns, capturing a progressive shift from an illness-dominated sense of self toward greater differentiation, agency, and relational openness. The synchronous peer-led forum was experienced as a protected relational space characterized by validation, connection, and shared understanding.

Conclusions.

The results of this study suggest that ED recovery can be understood as the progressive differentiation of personal identity from the illness, supported by emotional regulation, interpersonal engagement, and renewed investment in meaningful life domains. Synchronous peer-led forums may represent valuable

relational environments within broader recovery pathways, although further research is needed to establish their specific contribution to recovery-related change.

Background

Eating disorders (EDs) are severe and often long-lasting conditions associated with psychological, physical, and interpersonal problems. Although considerable progress has been made in developing evidence-based treatments, many individuals continue to experience recovery as a difficult, fluctuating, and uncertain process. Longitudinal findings suggest that even when behavioural symptoms improve, difficulties with emotion regulation, relationships, self-worth, and identity often persist [1]. Relapse rates remain particularly high in anorexia nervosa, especially in the years following treatment discharge [2].

Traditionally, recovery from an eating disorder has been defined based on restoration of weight and improvements in eating disorder-related attitudes and behaviours [3]. However, in recent years, the literature has progressively moved away from narrow symptom-focused definitions of recovery toward broader more person-centred perspectives, conceptualizing recovery as a multidimensional process that includes psychological, relational, and identity-related changes [4–6]. Qualitative research on lived experience demonstrates that individuals often describe recovery not only as the remission of eating-disorder behaviours, but also as reconnecting with themselves and others, rebuilding trust in their own experiences, and gradually developing a life worth living [3]. Recovery, from this perspective, is rarely described as a linear or all-or-nothing process [7]. Rather, it is often experienced as an ongoing negotiation between adherence to the disorder's valued aspects and the desire for change and freedom.

Within this evolving framework, increasing attention has been devoted to the role of identity in both the maintenance of EDs and the recovery process. Individuals with eating disorders frequently report difficulties related to self-definition, including low self-concept clarity, identity diffusion, and a tendency to define themselves through the illness [8]. For some, the eating disorder may provide a sense of predictability, coherence, control, or even personal value, particularly during periods marked by emotional vulnerability or relational disconnection. Although these experiences may initially feel protective or stabilizing, over time they can become increasingly restrictive, narrowing emotional flexibility, interpersonal engagement, and ways of experiencing the self [9].

Therefore, recovery may involve more than symptomatic improvement. It may also require a gradual process of disentangling the self from the illness and developing more flexible and integrated forms of identity [10]. Longitudinal evidence supports the relevance of these processes, showing that difficulties in identity functioning remain closely associated with eating disorder severity even after symptom improvement or weight restoration [11]. Furthermore, recent transdiagnostic findings suggest that identity-related difficulties may represent a broader vulnerability linking eating disorders with internalizing and personality-related psychopathology [12].

Contemporary interpersonal and social identity models increasingly emphasize that experiences of the self are shaped within relationships and social contexts. In eating disorders, relational difficulties such

as shame, fear of judgment, social withdrawal, interpersonal sensitivity, and attachment insecurity have consistently been identified as central maintaining processes [13–17]. Individuals may come to experience themselves as fundamentally misunderstood, disconnected, or unsafe in relationships, contributing to further withdrawal and incoherence of self, thus reinforcing the eating disorder as a strategy for managing emotional, interpersonal, and self-related distress.

At the same time, relational experiences may also play a significant role in supporting recovery. Experiences of validation, recognition, and emotional safety can foster openness, reduce defensiveness, and create opportunities for new ways of experiencing oneself and relating to others. Social identity approaches similarly conceptualize recovery as a process of identity transition, in which individuals gradually move away from illness-centred forms of self-definition toward more flexible and recovery-supportive identities [18]. Recovery, therefore, may involve not only changes in symptoms but also a progressive reorganization of how individuals experience themselves in relation to others.

These interpersonal and self-related recovery processes may be enhanced in peer-support contexts [19–21]. In recent years, digital and community-based interventions have incorporated peer mentorship into eating disorder recovery pathways [22]. Peer-led online forum groups may offer a space to experience validation, shared understanding, and mutual recognition [23]. Similarly, recent qualitative findings exploring online recovery communities on Instagram highlighted how peer interactions may promote hope, emotional validation, and confidence in the possibility of recovery [24]. Participants described these spaces as environments in which they could feel understood beyond their symptoms, and begin to imagine alternative narratives of the self.

Despite the growing use of peer-led and digitally mediated interventions, relatively little research has explored how participants subjectively experience online peer-support groups facilitated by recovered individuals. Existing studies have predominantly focused on feasibility, acceptability, or clinical outcomes of peer-led digital interventions. However, there remains a dearth of research on how these online spaces can create a context for the development of self- and identity-related processes [19, 25].

The present qualitative study aimed to explore how individuals with eating disorders make sense of their experiences of illness and recovery within a synchronous online peer-led forum. Particular attention was given to the emotional, interpersonal, and identity-related processes involved in recovery, as well as to how participants experienced the forum's relational context and its perceived role in supporting recovery-related change. Accordingly, the study addressed the following research questions: (1) How do participants describe and make sense of their experiences of eating disorder and recovery within a synchronous online peer-led forum? and (2) How do participants experience the relational processes of the synchronous peer-led forum, and how it supports identity-related recovery processes?

Methods

The analysis adopted a reflexive, theoretically informed approach combining inductive and deductive orientations. Initial coding remained closely grounded in participants' accounts, allowing patterns of

meaning to emerge from the data rather than being organized by a predetermined coding framework. At the same time, the analysis was theoretically informed by the concepts derived from the literature and theoretical perspectives, particularly those concerning interpersonal processes, emotion regulation, and identity in eating-disorder recovery [11, 15, 16, 18]. These concepts did not function as predefined coding categories but informed the researchers' interpretative engagement with the data as themes were progressively developed and refined. Accordingly, inductive and deductive orientations were not treated as separate analytic stages, but as interacting elements of an iterative interpretative process [26, 27].

Participants

The sample comprised 37 women (mean age = 27.3 years, range: 18–48). Twelve participants (32.43%) were recruited from the Instagram ED recovery community (#DicciComeAiutarti) [28] and comprised individuals with ED symptoms who were not seeking or receiving specialised treatment at the time of participation (i.e., community sample). The remaining twenty-five participants (67.57%) received a diagnosis of an eating disorder and were attending outpatient treatment at the time of participation. Within this outpatient group, the most frequent diagnosis was anorexia nervosa (33% of the total sample), followed by bulimia nervosa (17% of the total sample), binge eating disorder (11% of the total sample), and other diagnoses (6% of the total sample). The mean duration of illness was 7.90 years (SD = 7.79), and the mean duration of treatment was 11.1 years (SD = 11.7); six participants (16.2%) had been hospitalised due to their ED. For additional details on the sample's demographics, see Table 1 in Supplementary Materials.

Table 1
Discussion topics across the eight forum groups

Forum Topic	Main Focus
Forum 1. The importance to read and share with others the self-help materials: "What does it mean to suffer from eating disorder difficulties?"	Increase awareness of eating disorders and support recovery through reflection, practical exercises, and peer discussion
Forum 2. Getting Started towards the Journey of Change: Why is it important to change?	Meaning and importance of change, emphasizing motivation, empowerment, and the role of shared experiences in starting and sustaining the recovery process.
Forum 3. The maintenance factors of an eating disorder	Relationship between eating disorders and self-esteem, body image, and self-worth, reflect on how these factors influence well-being and recovery.
Forum 4. By trial and error: improving awareness	How eating disorders and interpersonal difficulties influence each other, the role of social withdrawal, low self-esteem, and support offered by close relationships.
Forum 5. How to manage negative emotions	Connection between emotions and eating behaviors, promoting emotional awareness, acceptance, and the development of adaptive emotion regulation strategies.
Forum 6. Interpersonal relationships and eating difficulties	Understanding interpersonal and social patterns linked to eating disorders, reflection on isolation, trust, and the gradual process of change through new relational experiences.
Forum 7. Interpersonal difficulties: the role played by disputes, life goals, role transitions, interpersonal deficits	Interpersonal skills and self-awareness as essential tools for building meaningful relationships and pursuing personal life goals beyond the eating disorder.
Forum 8. Life is a journey; enjoy it and savour the travel: how to manage relapses	Recovery as a non-linear journey, a constructive understanding of relapse and reflecting on life after an eating disorder.

The forums were facilitated by five female peer mentors with lived experience of an ED and recovery (M age = 34.4 years, SD = 10.45). Three had a previous diagnosis of anorexia nervosa, one had a history of anorexia nervosa and bulimia nervosa, and one had a history of binge-eating disorder. All peer mentors self-identified as recovered and had experienced different treatment modalities, including individual psychotherapy (n = 1), inpatient treatment (n = 1), and outpatient treatment (n = 3). At the time of the study, all were actively engaged in ED-related awareness-raising and dissemination activities in collaboration with mental health professionals and relevant organizations.

Procedures

This study is part of a larger, ongoing INTERconNEcT-ED(s) Project, which comprises two parallel randomized controlled trials (RCTs) designed to evaluate the efficacy of an online Guided Self-Help (GSH) intervention delivered via a mobile application [23]. One RCT targets individuals with a formal diagnosis of an ED, while the second targets individuals presenting with disordered eating behaviours below the diagnostic threshold. In both trials, participants allocated to the intervention arm received an eight-week online GSH program aimed at reducing general psychological distress and ED-related psychopathology. The intervention integrates self-help materials and peer-facilitated support and, for participants with a formal ED diagnosis, also includes interpersonal group therapy sessions. The mobile app provides access to the self-help materials and to the interactive group sessions included in the program [29].

Participants with a diagnosis of an ED attending outpatient eating disorders services at the University Hospitals of Catanzaro or Padova (Italy) were recruited for the first RCT. For the second RCT, people with eating disorder symptoms who were not seeking or receiving specialised treatment were recruited from the community through advertisements posted on the psychoeducational Instagram profile “*Dicci ComeAiutarti – #DCA*” [28].

The recruitment period began in November 2024 and continued until April 2026. Inclusion criteria were: (a) age ≥ 18 years, (b) access to an Internet connection via a mobile device, and (c) being an Italian speaker. For the first RCT, the additional criteria were: (d) a clinician-formulated diagnosis of an eating disorder based on Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) criteria, and (e) having started treatment as usual (TAU) within the previous year. For the second RCT, the additional criteria were: (d) a global score > 2.77 on the Eating Disorder Examination Questionnaire (EDE-Q [30]; Italian validation [31]), indicating clinically significant eating disorder symptoms in community samples [32], and (e) regular monitoring of their health status by their own general practitioner (GP).

Prior to study participation and randomization, participants completed a baseline online assessment collecting demographic and clinical information, including age, gender, occupational status, educational level, eating disorder diagnosis, and illness and treatment history. Baseline assessments were administered through the secure aChiral Capture online platform.

Ethical approval

was obtained from the Psychology Research Ethics Committee of the University of Catanzaro Region, Italy (protocol number 221 27.06.2024). The study was conducted in accordance with the Declaration of Helsinki and the General Data Protection Regulation (GDPR; EU Regulation 2016/679). Written informed consent was obtained from all participants, who were informed of their right to withdraw from the study at any time without consequences.

Online Peer-Led Forum Groups

Participation in the weekly online forum groups - as part of the GSH - was open to all participants who completed the baseline assessment and who were randomized to the intervention condition. The forums consisted of synchronous online chat sessions lasting 1 hour and held once per week throughout the intervention.

The role of the peer mentors was to introduce a weekly discussion theme and facilitate a discussion around the topic (see Table 1). The facilitator’s engagement strategies included open-ended questions, reflective prompts, and sharing personal lived-experience narratives relevant to the topic. Peer mentors were supervised weekly by a clinical psychologist and received targeted training focused on forum management and Motivational Interviewing [33]. This included the use of structured scripts and predefined scenarios designed to address potential difficulties during the discussion.

Participants could engage in the forums either actively or passively. Active participation involved posting written comments during the synchronous chat session, whereas passive participation consisted of logging into the forum without contributing messages. All messages were subject to prior review and approval by a team of psychologists-in-training before being published on the forum. Messages containing content or language that violated forum rules or /considered potentially harmful to group members were not approved. In such cases, participants were notified privately and encouraged to discuss the topic individually with a psychologist from the team.

In addition to the peer mentors, a licensed psychologist from the research team was connected online during each forum session to provide additional support and summarise the main themes and contents that emerged during the discussion. Direct replies between participants were not permitted. Forum group transcripts were downloaded directly from the aChiral Content application for analysis. Chat transcripts remained accessible to all participants, peer mentors, and psychologists on the platform. At any time throughout the intervention, participants could review and consult transcripts of previous forum group sessions.

[Insert Table 1]

Reflexive Thematic Analysis

The initial phase of the reflexive thematic analysis entailed repeated, meticulous reading of the transcripts to facilitate familiarity with the dataset. The four primary coders collaborated in pairs, initially engaging in open, data-driven coding without applying predetermined categories or a pre-existing coding framework. During this preliminary phase, coding remained closely grounded in the participants' accounts and captured features of the data considered potentially relevant to the research questions. Throughout the analysis, the coding pairs met regularly to compare and discuss their interpretations of the data. Differences in coding were used as opportunities for reflexive discussion and for further examination of the transcripts rather than as indicators of coding error or as a basis for assessing intercoder reliability. A shared analytic working document was used to organize coded extracts, analytic

notes, and memos and was progressively revised as the analysis developed. The recurrence and distribution of coded extracts across the dataset were also considered descriptively to support engagement with the data. However, frequency was not used as a criterion for determining the importance of a theme.

The codes were then examined for broader patterns of shared meaning and subsequently clustered into provisional themes and subthemes. The development of the thematic framework was iterative rather than predetermined, with the candidate themes undergoing repeated review against coded extracts and the broader dataset. Discussions within and across coding pairs, and subsequently with the wider research team, contributed to questioning, refining, and developing the analytic interpretations. Themes were initially developed inductively, staying close to participants' own accounts. The analytic team then engaged relevant theoretical concepts (emotion regulation, interpersonal processes, and identity) deductively to guide interpretation, thereby organizing and interpreting the inductively emergent participant accounts in a theoretically informed manner.

Reflexivity

The research team acknowledged that researchers' professional backgrounds, theoretical perspectives, and prior experience in the field of eating disorders inevitably shaped their engagement with the data and the development of analytic interpretations. Rather than seeking to eliminate researcher subjectivity, the team critically examined how these perspectives informed the analytic process. The team recognized that the study's guiding questions drew on existing theoretical frameworks, particularly conceptualizations of identity, which shaped initial expectations about how participants might describe change over the course of recovery. This was treated as an analytic lens to be examined and refined against participants' accounts rather than assumed in advance.

The primary coding team comprised researchers at different stages of academic and clinical training, including doctoral researchers, postgraduate psychotherapy trainees, graduate psychologists, and master's students. This diversity provided different perspectives from which participants' accounts could be approached and interpreted. Throughout coding and theme development, team members regularly discussed their assumptions, interpretative choices, and responses to the data, considering alternative readings and how their different academic and clinical backgrounds might shape the meanings foregrounded in the analysis. These discussions were integrated into the iterative development and refinement of themes rather than being used to establish a single objectively "correct" interpretation of the data. The team also considered its position relative to participants and to the forums themselves, which were facilitated by peer mentors with lived experience of eating disorder recovery. This was held in view when interpreting participants' accounts of illness and recovery.

Results

A total of 32 synchronous online forum transcripts available at the time of the analysis were included in the dataset and analysed using Reflexive Thematic Analysis.

Table 2 summarizes descriptive characteristics of participants’ engagement across forum topics, including active and passive participation, the number of comments posted, and asynchronous consultation of previous forum group transcripts. This information was recorded by the aChiral Content platform, except for participation, which was regularly recorded manually by a member of the research team.

Table 2

Characteristics of group interaction. Active and passive group participation, number of comments, and use of interactional materials by topic and participant group

Topic	Active participation	Passive participation	Number of comments	Asynchronous consultation of forum group transcripts
Topic 1. The Importance of Reading and Sharing Self-help Materials: "What Does It Mean to Suffer from an Eating Disorder?"	n = 4 <i>Community sample</i> n = 16 <i>Outpatients</i>	n = 2 <i>Community sample</i> n = 1 <i>Outpatients</i>	n = 2 <i>Community sample</i> n = 48 <i>Outpatients</i>	n = 2 <i>Community sample</i> n = 8 <i>Outpatients</i>
<i>Total forum 1</i>	<i>20 (15%)</i>	<i>3 (30%)</i>	<i>50 (5%)</i>	<i>10 (33%)</i>
Topic 2. Starting the Path Toward Change: Why Is Change Important?	n = 3 <i>Community sample</i> n = 16 <i>Outpatients</i>	n = 0 <i>Community sample</i> n = 1 <i>Outpatients</i>	n = 37 <i>Community sample</i> n = 164 <i>Outpatients</i>	n = 0 <i>Community sample</i> n = 1 <i>Outpatients</i>
<i>Total forum 2</i>	<i>18 (13%)</i>	<i>1 (10%)</i>	<i>201 (19%)</i>	<i>1 (3%)</i>
Topic 3. Maintaining Factors in Eating Disorders	n = 3 <i>Community sample</i> n = 13 <i>Outpatients</i>	n = 1 <i>Community sample</i> n = 0 <i>Outpatients</i>	n = 22 <i>Community sample</i> n = 120 <i>Outpatients</i>	n = 2 <i>Community sample</i> n = 1 <i>Outpatients</i>
<i>Total forum 3</i>	<i>16 (12%)</i>	<i>1 (10%)</i>	<i>142 (14%)</i>	<i>3 (10%)</i>
Topic 4. Interpersonal Relationships and Eating Difficulties	n = 3 <i>Community sample</i> n = 13 <i>Outpatients</i>	n = 0 <i>Community sample</i> n = 0 <i>Outpatients</i>	n = 28 <i>Community sample</i> n = 140 <i>Outpatients</i>	n = 0 <i>Community sample</i> n = 3 <i>Outpatients</i>
<i>Total forum 4</i>	<i>16 (12%)</i>	<i>0 (0%)</i>	<i>168 (16%)</i>	<i>3 (10%)</i>
Topic 5. Emotion Regulation	n = 5 <i>Community sample</i>	n = 2 <i>Community sample</i>	n = 33 <i>Community sample</i>	n = 1 <i>Community sample</i>
<i>Note. Percentages refer to the overall total across all topics and participant groups.]</i>				

Topic	Active participation	Passive participation	Number of comments	Asynchronous consultation of forum group transcripts
	n = 15 <i>Outpatients</i>	n = 2 <i>Outpatients</i>	n = 131 <i>Outpatients</i>	n = 3 <i>Outpatients</i>
<i>Total forum 5</i>	<i>20 (15%)</i>	<i>4 (40%)</i>	<i>164 (16%)</i>	<i>4 (13%)</i>
Topic 6. Trial and Error: Learning New Ways of Thinking	n = 8 <i>Community sample</i> n = 14 <i>Outpatients</i>	n = 0 <i>Community sample</i> n = 1 <i>Outpatients</i>	n = 52 <i>Community sample</i> n = 124 <i>Outpatients</i>	n = 0 <i>Community sample</i> n = 3 <i>Outpatients</i>
<i>Total forum 6</i>	<i>22 (16%)</i>	<i>1 (10%)</i>	<i>176 (17%)</i>	<i>3 (10%)</i>
Topic 7. Interpersonal Challenges and Life Goals	n = 4 <i>Community sample</i> n = 15 <i>Outpatients</i>	n = 0 <i>Community sample</i> n = 0 <i>Outpatients</i>	n = 29 <i>Community sample</i> n = 102 <i>Outpatients</i>	n = 1 <i>Community sample</i> n = 3 <i>Outpatients</i>
<i>Total forum 7</i>	<i>19 (14%)</i>	<i>0 (0%)</i>	<i>131 (13%)</i>	<i>4 (13%)</i>
Topic 8. Toward Recovery and Relapse Management	n = 1 <i>Community sample</i> <i>treatment</i> n = 5 <i>Outpatients</i>	n = 0 <i>Community sample</i> <i>treatment</i> n = 0 <i>Outpatients</i>	n = 11 <i>Community sample</i> <i>treatment</i> n = 40 <i>Outpatients</i>	n = 2 <i>Community sample</i> <i>treatment</i> n = 0 <i>Outpatients</i>
<i>Total forum 8</i>	<i>6 (4%)</i>	<i>0 (0%)</i>	<i>51 (5%)</i>	<i>2 (7%)</i>
<i>Total</i>	<i>137 (100%)</i>	<i>10 (100%)</i>	<i>1033 (100%)</i>	<i>30 (100%)</i>
<i>Note. Percentages refer to the overall total across all topics and participant groups.]</i>				

[Insert Table 2]

Themes and subthemes.

The analysis proceeded in two concurrent phases: (1) an inductive phase, developing a description that stayed close to what participants said, and (2) a deductive phase, in which these descriptions were

interpreted through a theoretical lens related to experiential avoidance, psychological flexibility, relationships, and identity. This process resulted in the 4 main themes and 10 subthemes, that were consolidated into an overarching theme (see Fig. 1).

[Insert Fig. 1]

Theme 1. The Trap of the Eating Disorder

Across participants' accounts, the eating disorder was experienced as progressively narrowing everyday life. Attention became increasingly organized around food, the body, and the pursuit of control, shaping daily routines and how participants perceived and evaluated themselves. Although these patterns could provide familiarity, structure, and a sense of stability, they also progressively restricted participants' sense of agency and their ability to imagine alternative ways of being. The eating disorder was therefore described through a central tension: as something that could feel protective and self-defining while simultaneously becoming increasingly restrictive and difficult to escape.

1.1. The vicious cycle of self-protection and lack of freedom

Participants described the illness as a protective refuge, capable of providing structure and psychological safety during periods of heightened distress. As one participant said, *"I often seek refuge in my eating disorder and see it as a safe place, a shelter, when things outside are not going as they should"* (CZ01-112-00102). In other cases, the ED conferred a sense of control that makes the person feel capable and powerful: *"it puts order in the chaos that's out there and I feel better"* (CZ01-112-00093). For some participants, this protective function became closely intertwined with their sense of self, making the prospect of change feel not only threatening but also potentially destabilizing: *"I often think that I am nothing more than my illness and my thoughts"* (CZ01-112-00088). However, this sense of comfort was often followed by a return to negative emotional states and a feeling of being trapped in repetitive behavioral patterns, as described by participant DCA01-110-00085: *"...but then, paradoxically, it throws you back into the same cycle."* This cycle yet became at the same time a safe place, *"leaving my comfort zone feels as if I were losing control over my life"* (CZ01-111-00064) and a trap: *"[...] it is as if I were truly trapped. Almost like slavery"* (CZ01-110-00028). Narratives were accompanied by feelings of passivity and resignation, where behaviour seemed inevitable and individuals perceived themselves as unable to alter the course of events. One participant (DCA01-110-00085) stated: *"I find myself going into a sort of shutdown without any clear trigger, almost as if returning to binge eating is, sooner or later, inevitable"*.

1.2. Body-Contingent Identity: Physical Appearance as Measure of Personal Worth

Weight, body shape, and eating-related evaluations emerged as central lenses through which participants constructed a sense of self and interpreted their experiences. Rather than being peripheral aspects of daily life, these domains became key reference points for self-evaluation and meaning-making. Eating, body and weight acquired moral significance, becoming inextricably linked to self-worth and personal discipline in life: *"I think my worth depends on my appearance: if I am thin, I am acceptable."*

(CZ01-112-00088). The body was described as a medium for communication and visibility - with thinness becoming the sole pathway to social recognition: "[...] *the only way I have found to be seen is through thinness*" (CZ01-110-00033), and bodily transformation as the only means of expressing what cannot be articulated verbally: "[...] *the only possible and desirable evolution for me is linked to the transformation of my body, because through that I can communicate very strong messages that I have tried to express in words without being heard*" (DCA01-110-00057). This body-centered preoccupation extended into relational life, with participants describing their capacity to engage with others as contingent upon bodily comfort: "*if I don't feel good in my body, I can't be with others*" (DCA01-110-00085). The body became an object to monitor, manage, and control, disconnected from internal bodily signals - a loss of access to hunger and satiety cues: "*honestly, I had never thought about it, being used to always keeping hunger under control*" (CZ01-111-00066).

1.3. Maintenance factors and barriers to recovery: low self-esteem, perfectionism, and cognitive rigidity

Participants' accounts also highlighted recurring patterns of perfectionistic self-evaluation, low self-worth, and rigid standards that appeared to reinforce eating-disorder difficulties and make change more difficult. Perceived failures were often followed by intense self-criticism, while achievements tended to be minimized or attributed to external factors. Perfectionism manifested as unrealistically high personal standards coupled with intense self-criticism upon perceived failure: "*the problem is that my self-esteem is zero, and if I fail in one of the few things I think I am good at, it means falling back into food*" (CZ01-111-00064). Low self-esteem operated through pervasive self-devaluing beliefs and attributional biases, with participants systematically minimizing their achievements and attributing success to external factors: "*another belief I have about myself is that I am not really a good person as others think I am, or that even when I achieve a good result, it is not due to my merit but just luck*" (CZ01-111-00076). Within this rigid evaluative system, eating-related behaviors and relapse became markers of failure and evidence of personal inadequacy: "[...] *every time I eat, I feel bad because, for me, eating means failing to achieve my goal*" (CZ01-112-00088) and "*making mistakes meant failing in my attempt to be 'perfect'*" (CZ01-112-00093). Relapse itself was interpreted through this framework of failure: "*personally, I experience relapses as a failure, a stubborn repetition of the same mistake without learning anything from it*" (CZ01-112-00115). Taken together, these accounts suggested a self-reinforcing pattern in which rigid standards, perceived failure, self-criticism, and eating-related behaviours became closely intertwined, making alternative ways of evaluating the self more difficult to sustain.

Taken together, these subthemes describe psychological inflexibility underlying the eating disorder's 'trap.' The comfort- and control-seeking described in 1.1 functioned as a form of experiential avoidance, regulating the 'chaos' of internal distress at the cost of behavioural rigidity and diminished agency. This was compounded by participants' sense of self becoming substantially defined by the eating disorder, which is evident both in the account in 1.1 of feeling 'nothing more than my illness and my thoughts' and in the description in 1.2 of linking self-worth to appearance, where thinness became 'the only way to be seen.' The rigid, perfectionistic self-evaluative standards described in 1.3, in which failure was internalized and success attributed externally, further limited flexible ways of relating to the self. Theme

1 characterizes the starting point of the recovery process: an identity fused with the eating disorder, sustained by avoidance of internal experience and rigid self-evaluation, against which identity differentiation described in subsequent themes represents a departure.

Theme 2. The Eating Disorder as Emotional Regulator: From Avoidance to Emotional Engagement

Participants described eating-related behaviours and social withdrawal as ways of managing emotional experiences that felt overwhelming, confusing, or difficult to express. Food-related behaviours could provide temporary relief or redirect attention away from distress, while withdrawal offered a way of reducing exposure to difficult emotional and relational experiences. In participants' accounts of recovery, however, a different way of relating to emotions gradually emerged: rather than needing to suppress, escape, or immediately regulate difficult internal states, participants described becoming more able to recognize, tolerate, and respond to them. This pattern was interpreted as a movement from emotional avoidance toward greater emotional engagement.

2.1 Eating behaviors and social withdrawal as emotion regulation strategies

Participants' narratives highlighted an emotional experience characterized by intense negative affective states, including shame, guilt, sadness, loneliness, and anger. Participants often described difficulty distinguishing and identifying emotional states, sometimes experiencing them as confused, undifferentiated, or difficult to name: *"personally, yes, it often happens that I don't understand what I feel or I feel as if I feel nothing at all"* (PD01-110-00144). One participant explicitly reflected on this, recognizing its impact on emotional regulation: *"I struggle to understand what kind of emotion I am feeling... I tend to classify negative emotions only as sadness or anxiety, but I realize this may be limiting, because understanding the emotion I feel could help me manage and cope with it"* (CZ01-112-00115). The focus on eating-related behaviors appeared to shift attention away from internal experiences that were perceived as intolerable and difficult to understand, toward concrete and predictable actions that appeared to provide a temporary sense of control or relief. As one participant noted, *"before I drowned in sweets because of the lack of affection I felt... I was trying to numb that emptiness with food"* (DCA01-110-00059). In addition to eating-related behaviors, participants reported recurrent patterns of avoidance, including social withdrawal and closure, which functioned as attempts to contain and reduce emotional distress. Isolation was represented as an immediate response to distress: *"when I feel bad, I shut myself in my room"* (CZ01-112-00103) and *"I let myself be overwhelmed by anxiety, isolate myself, and then cry for hours"* (CZ01-111-00066).

2.2 The process of learning new emotion regulation strategies

Alongside accounts of avoidance and withdrawal, participants described an emerging interest in developing different ways of responding to emotional experiences. They expressed curiosity about recognizing and understanding emotions and described attempts to broaden the strategies available to manage them. Two interconnected patterns were particularly evident: turning toward others rather than withdrawing and developing more reflective and intentional ways of responding to emotional states.

Participants expressed curiosity and a strong desire to approach emotional experiences differently and to expand their regulation repertoire, as reflected in the following question: *"how did you learn to recognize and manage emotions?"* (CZ01-112-00088). This shift involved two interconnected movements: activating relational strategies by seeking connection with others rather than withdrawing: *"it would be better to talk about it"* (CZ01-111-00070) and *"I think sharing is the best response to emotions"* (CZ01-111-00070), and developing reflective, intentional regulatory practices. These included recognition and labelling of emotions: *"I try to breathe and put things into perspective, and, if possible, find a solution"* (CZ01-111-00064); acceptance of emotional complexity: *"in my opinion, we should accept and manage all emotions, whether positive or negative"* (CZ01-112-00119); and engagement in meaningful activities and distraction strategies. Participants described practical approaches such as physical activity, creative expression: *"writing freely on a sheet of paper, crumpling it up or tearing it into pieces, helps me, it feels liberating"* (DCA01-110-00105), and resuming engagement in past activities: *"I realize that in the past I used to meditate regularly, and that really helped me manage my emotions"* (CZ01-112-00115). This gradual exploration of functional strategies represented a shift from automatic, avoidance-based regulation toward intentional, action-oriented approaches to emotional experience.

Read together, these two subthemes trace a movement in participants' relationship to emotional experience, from avoidance toward psychological flexibility. In 2.1, eating behaviours and social withdrawal functioned as strategies of experiential avoidance. Participants described emotions as confusing, undifferentiated, or intolerable, and behavioural avoidance offered a more concrete, predictable alternative. In 2.2, this pattern gave way to something closer to acceptance and intentional engagement. This was most evident in the observation that 'we should accept and manage all emotions, whether positive or negative', which maps closely onto the acceptance component of the psychological flexibility model. Theme 2 documents the emotion-regulation dimension of the broader movement from experiential avoidance toward psychological flexibility running across the analysis, alongside the identity-related shift already established in Theme 1. The shift from withdrawal to turning to others is developed further in Theme 3.

Theme 3. Social Relationships and their role in the eating disorder and recovery process

Participants' accounts positioned social relationships as an important context in which both the eating disorder and recovery were experienced. The disorder was associated with distance, concealment, fear of judgment, and difficulties trusting or feeling understood by others. In accounts of recovery, by contrast, participants described a growing desire for connection, openness, and more authentic ways of relating. Within this broader relational pattern, the synchronous peer-led forum was experienced as a distinctive context in which participants could share difficulties, encounter similar experiences, and feel understood in ways that were sometimes perceived as difficult to achieve elsewhere.

3.1. How fear of judgement fuelled the eating disorder

Interpersonal difficulties were frequently described as closely intertwined with participants' eating-disorder experiences. Fear of judgment emerged particularly strongly and was often connected to

concerns about self-worth, appearance, and eating. As one participant stated, *"the fear of judgment is often stronger than my willpower, fear of being judged only based on appearance or food, never feeling good enough"* (CZ01-112-00088).

Within this relational context, the ED appeared, at least initially, to provide a sense of protection from perceived judgment and exposure during social interactions. At the same time, participants described how this protective function could contribute to increasing avoidance and withdrawal. Participants described a progressive reduction in social engagement, as reflected in statements such as *"the symptoms create discomfort in my everyday life and lead me to hide and isolate myself from the world,"* and *"since I gained weight due to binge eating, I am even afraid to leave the house"* (CZ01-110-00033). More broadly, the disorder was experienced as shaping one's way of being with others: *"the disorder has negatively changed me, making me more withdrawn, less cheerful, and less willing to socialize"* (CZ01-112-00093), to the point that *"it takes so much away from you, as if you were closed inside a box"* (CZ01-112-00102).

Alongside fear of judgment, participants described a persistent sense of not being understood by others. Attempts to communicate their experience were often felt as ineffective or dismissed, contributing to a sense of relational distance. As one participant explained, *"it becomes difficult to be with others, because you don't feel understood and grasped, but rather 'wrong'"*, while another noted, *"when I open up, I feel that people pretend to listen but are actually thinking about something else"* (CZ01-111-00064).

This lack of perceived understanding was often accompanied by feelings of being a burden or of being seen only through the lens of the illness. One participant expressed this clearly: *"I just needed a hug or someone to say 'everything will be okay'... I lost everything because of the illness. I messaged a friend saying I wasn't feeling well, and she told me to write only when I feel better. I feel abandoned"* (DCA01-110-00054).

3.2. The growing desire to connect to others during recovery

Connection with others increasingly appeared as an alternative to the isolation associated with the eating disorder. Supportive relationships were described as particularly meaningful when others were able to recognize the person's distress without reducing them to their eating difficulties. Participants also reflected on the importance of becoming more open to relationships and taking interpersonal risks that had previously felt difficult or threatening: *"giving others a chance, not being afraid of getting hurt in a relationship of any kind"* (CZ01-111-00066). Vulnerability and authenticity were represented as central to recovery. As one participant stated: *"having the courage to be oneself and to express fears, doubts, and insecurities is the foundation of any relationship"* (DCA01-110-00085). Participants suggested that openness itself could be transformative: *"the thing that could connect me more to others is definitely closing myself off less"* (DCA01-110-00085), and they described relationships that validate their struggle without reducing them to the disorder as particularly meaningful: *"those people who simply ask how you are"* (CZ01-111-00070). This validation was expected to enable the development of new relational strategies, such as communicating struggles to trusted others: *"when I notice that I am engaging in*

unhelpful behaviors, besides trying to distract myself, I try to hint that I am struggling by talking to someone I trust" (PD01-110-00134). As one participant reflected: *"gradually and over time, I learned to trust them; they only want what's best for me"* (CZ01-110-00033).

3.3. The Forum as a "Safe Laboratory" for Recovery

Participants described the synchronous peer-led forum as a protected relational space in which discussing eating-disorder experiences felt easier than in some face-to-face relationships. Anonymity was experienced as an important feature of this sense of safety, reducing concerns about negative evaluation: "we are anonymous so it becomes a bit easier, so nobody can say anything negative" (CZ01-112-00102). Reading and sharing experiences with people perceived as having faced similar difficulties also contributed to a sense of being understood: "it's easier for me to talk about it here because there are people who can understand me" (DCA01-110-00039).

Participants also described value in encountering others' perspectives and experiences within the shared forum space. Others' contributions could provide material for reflection—"I will reflect on what you answered, on what you told us" (CZ01-111-00064)—while the recognition of similar experiences was associated with feeling less isolated and with greater hope regarding recovery: "I find the sharing in this space very useful; it makes us feel less alone and gives us confidence that we can get through this" (DCA01-110-00085). The involvement of people with lived experience was itself perceived as meaningful, with participants emphasizing the value of a space informed by those who had experienced similar difficulties.

Together, these three subthemes trace a movement from interpersonal avoidance toward connection. In 3.1, fear of judgment served as an additional form of experiential avoidance, driving withdrawal and a persistent sense of not being understood. This echoes the avoidance and value of sharing already seen in 1.2 and 2.2. In 3.2, this gave way to a growing willingness to take interpersonal risks and be vulnerable. In 3.3, the peer-led forum emerged as the concrete context for this shift. Anonymity reduced the threat of judgment, and shared experience with facilitators with lived experience offered support that participants found more accessible than face-to-face relationships. Theme 3 thus captures the interpersonal dimension of the movement from avoidance that ran through Themes 1 and 2, with the forum itself as key to making the change possible.

Theme 4. Metacognition, values and Commitment: Recovery as an Ongoing Orientation

Participants described their ongoing process of recovery as a non-linear process involving a gradual re-engagement with life beyond the eating disorder. Their accounts emphasized both the difficulty of moving away from familiar illness-related patterns and a growing orientation toward personally meaningful activities, relationships, and future possibilities. Across these accounts, recovery was represented less as the complete elimination of the disorder and more as an expanding capacity to reflect on its place in one's life, make choices in relation to it, and invest in a life that was not entirely organized around symptoms.

4.1. A meta-cognitive space to evaluate the eating disorder

Participants' reflections suggested that recovery involved developing greater distance from the immediacy of eating-disorder thoughts and behaviours, creating space to question patterns that had previously felt automatic or inevitable. From this position, the disorder could increasingly be considered as something to reflect upon rather than simply follow, opening up the possibility of making choices about how to respond to it: *"I wish I was free to choose but at the same time having someone do it for me makes me feel safe from the fear of making mistakes"* (CZ01-112-00093). Participants acknowledged the difficulty of sustaining forward movement: *"sometimes I wonder... if the people around me are right when they ask me 'are you sure you want to recover' because I take one step forward and two steps back"* (CZ01-111-00070). Participants described this oscillation between progress and setback as an expected part of recovery. As another participant reflected: *"the passage between saying and doing is difficult and painful perhaps"* (CZ01-112-00088). Despite this non-linear trajectory, participants developed a realistic understanding of change: *"you need to understand that it's important to take small steps but always moving forward"* (DCA01-110-00085).

4.2. From symptom-focus to life-centeredness: investing in meaning and identity building

Participants' views of recovery increasingly extended beyond the goal of reducing or eliminating eating-disorder symptoms. They described the importance of reconnecting with future projects, relationships, interests, and everyday experiences that could give life meaning beyond the illness. Investing in these domains was associated in their narratives with a reduced centrality of the eating disorder and with the possibility of imagining themselves in broader and less illness-defined ways: *"having good self-esteem, being more outgoing, looking at things from a positive perspective, and having strong willpower"* (CZ01-111-00076); *"we must rediscover the beauty of small things, and in this LIFE put everything we are into it, qualities and flaws, it doesn't matter - nobody is perfect. but we are US and it is our uniqueness that makes us unique"* (DCA01-110-00085). One participant articulated this shift powerfully: *"being alive is already something beautiful, even if the eating disorder tells you otherwise"* (CZ01-112-00088). Taken together, these accounts reflected an emerging orientation toward a life in which personal meaning, relationships, and everyday experiences could occupy increasing space alongside, and potentially beyond, the eating disorder. As one participant expressed: *"we must be much more than an eating disorder in our lives - the sun, the sea, my daughter telling me I am beautiful ☺"* (DCA01-110-00085), appreciating *"the beauty of the consistency of being, of being present"* (CZ01-111-00066).

This theme indicates a shift from fusion with the eating disorder toward psychological distance and engagement. In 4.1, participants described a growing capacity to observe and self-reflect on eating-disorder thoughts and behaviours rather than being carried along by them automatically while normalizing the non-linear, 'two steps back' nature of that process. In 4.2, this distance created space to reinvest in meaningful relationships, projects, and everyday experience, rather than symptom elimination as the marker of recovery. Read alongside the earlier themes, Theme 4 completes the movement from experiential avoidance and identity fusion (Theme 1) through emotional and interpersonal flexibility

(Themes 2–3) to a reflective, values-oriented relationship with the self leading into the overarching theme of identity differentiation.

Overarching theme. Identity differentiation: redefining the boundaries between self and the eating disorder

Across the four themes, a broader pattern concerned changes in how participants described the relationship between themselves and the eating disorder. In accounts characterized by greater illness dominance, the eating disorder appeared closely intertwined with participants' sense of self, personal worth, emotional regulation, relationships, and everyday life. In accounts oriented toward recovery, participants increasingly described the possibility of relating to the disorder as something that affected them without fully defining who they were. We interpreted this cross-cutting pattern as a process of identity differentiation: a progressive redefinition of the boundaries between the self and the eating disorder.

This process was reflected differently across the thematic structure. The eating disorder as a protective yet restrictive “trap” illustrated how illness-related patterns could become embedded in self-definition. Accounts of emotional engagement suggested an increasing capacity to experience difficult internal states without relying exclusively on eating-disorder behaviours to regulate them. Greater relational openness expanded possibilities for experiencing the self in connection with others, while renewed investment in meaningful activities, relationships, and future goals created space for aspects of identity extending beyond the illness. Read through our theoretical lens of psychological flexibility, this process traces a movement away from experiential avoidance and fusion with an identity defined by illness toward greater flexibility across emotional, interpersonal, and values-based domains. Identity differentiation therefore did not represent a discrete or linear stage of recovery, but an interpretative thread connecting changes in participants' relationships with their internal experiences, other people, and life beyond the eating disorder.

Where the illness was more prominent, participants described a self almost entirely absorbed by the disorder: 'I am nothing more than my illness and my thoughts' (1.1). But regarding the process of recovery, participants' accounts pointed toward a self that extended beyond the disorder: 'we must be much more than an eating disorder in our lives' (DCA01-110-00085), and the value of simply 'being present' (CZ01-111-00066).

Discussion

This qualitative study set out to explore how individuals with eating disorders made sense of their experiences of illness and recovery within a synchronous online peer-led forum. The study focused particularly on emotional, interpersonal, and identity-related processes, as well as on participants' experiences of the relational context of the forum. The results of the study indicate that recovery from eating disorders can be conceptualized as a dynamic and non-linear process, extending beyond the scope of changes in eating-disorder symptoms. Across the four themes, participants described the

eating disorder as protective yet restrictive and closely intertwined with emotional regulation, self-definition, and interpersonal difficulties, whereas recovery involved greater emotional engagement, relational openness, and renewed investment in life beyond the disorder. At an interpretative level, these patterns indicated an overarching theme of identity differentiation, reflecting a progressive redefinition of the boundaries between the self and the eating disorder. Within this broader process, the synchronous peer-led forum was experienced as a protected relational context in which participants could share difficulties, encounter similar experiences, and feel understood.

Consistent with contemporary conceptualizations of eating-disorder recovery, participants described recovery as non-linear and characterized by ambivalence, fluctuation, and gradual re-engagement with life beyond the illness [5, 34, 35]. A particularly salient feature was the paradoxical function of the eating disorder, experienced as both restrictive and protective. Although it progressively narrowed everyday life and relationships, it also provided structure, predictability, and a sense of control when emotional experiences felt difficult to understand or manage. This is consistent with evidence conceptualizing eating-disorder behaviours as strategies for regulating or avoiding distressing internal experiences [16, 36–38], as well as with transdiagnostic models emphasizing mood intolerance, low self-esteem, perfectionism, and rigid self-evaluation as maintaining processes [39]. Participants' accounts of recovery, however, involved developing alternative ways of recognizing and tolerating difficult emotional states, suggesting a broader movement from avoidance and rigidity toward psychological flexibility and greater engagement with internal experience.

The overarching theme of identity differentiation provides a broader interpretative framework for understanding these changes. Previous research has highlighted difficulties in self-definition among individuals with eating disorders, including reduced self-concept clarity, identity diffusion, and incorporation of the illness into the sense of self [8, 9]. Qualitative accounts similarly suggest that recovery may involve gradually disentangling the self from the eating disorder and developing an identity beyond illness [10]. The present findings extend this perspective by suggesting that identity differentiation may be a cross-cutting process that connects emotional, interpersonal, and life-oriented dimensions of recovery. As participants described greater capacity to experience difficult emotions, reconnect with others, and invest in meaningful activities and future possibilities, the eating disorder appeared progressively less central to self-definition. This interpretation is also consistent with evidence indicating that identity-related difficulties may remain associated with eating-disorder psychopathology even following symptomatic or weight-related improvements [11]. Thus, rather than representing a discrete stage of recovery, identity differentiation may provide a useful lens for understanding how different dimensions of recovery become interconnected.

Interpersonal processes were also central to participants' accounts. Fear of judgment, difficulties trusting others, feeling misunderstood, and social withdrawal were described as closely intertwined with eating-disorder experiences, consistent with evidence identifying interpersonal difficulties and attachment insecurity as relevant maintaining processes [13, 14, 16, 17, 40]. Conversely, recovery was associated in participants' narratives with a growing willingness to connect with others, tolerate

vulnerability, and experience relationships in which their difficulties could be recognized without being reduced to the eating disorder. This is compatible with social identity perspectives conceptualizing recovery as involving movement away from illness-centred forms of self-definition toward broader and more recovery-supportive identities [18]. Relational openness and identity differentiation may therefore represent interconnected aspects of participants' experiences of recovery.

Within this interpersonal context, participants experienced the synchronous peer-led forum as a protected space in which discussing eating-disorder experiences could feel easier and less exposing. Anonymity, exposure to the experiences of others facing similar difficulties, and the involvement of peer mentors with lived experience were perceived as meaningful features of this environment. These findings are consistent with literature suggesting that peer support and lived-experience involvement may contribute to feelings of understanding, validation, hope, and reduced isolation in eating-disorder contexts [19–22], as well as with qualitative findings from digital recovery communities [24]. Nevertheless, the present findings do not provide evidence that forum participation produced recovery-related change. Rather, they suggest that participants experienced the forum as a context in which difficult experiences could be expressed and reflected upon alongside others. Further research is needed to establish whether and how specific characteristics of peer-led synchronous environments contribute to recovery processes.

From a clinical perspective, these findings reinforce the importance of conceptualizing recovery as extending beyond symptom reduction to include emotional, interpersonal, and identity-related change. While symptom-focused interventions remain central to eating-disorder treatment, participants' accounts suggest the potential relevance of addressing the functions served by the disorder and supporting alternative ways of managing difficult emotions, relating to others, and developing aspects of self and life that are not organized around the illness. These processes are compatible with therapeutic approaches that address psychological flexibility, self-compassion, values, and broader self-development [41–43]. Similarly, participants' experiences suggest that carefully moderated peer-led digital spaces warrant further investigation as adjuncts to established eating-disorder care.

Limitations

Several limitations should be considered. First, the sample comprised heterogeneous eating-disorder presentations, including both individuals with a formal eating-disorder diagnosis and individuals with clinically significant subthreshold symptoms, which may limit the transferability of the findings. Second, the data consisted of written contributions produced in a specific synchronous, peer-led forum embedded within a broader guided self-help intervention. Participants' accounts may therefore have been shaped by the discussion topics, peer-mentor facilitation, moderation procedures, and broader intervention context. The findings are accounts of illness and recovery produced within this particular relational and digital setting rather than as context-independent representations of recovery. Third, although the dataset comprised multiple forum sessions, the analysis was not designed as a longitudinal qualitative investigation of within-person change. References to change, therefore, reflect

how participants described and made sense of recovery rather than demonstrating change over the course of forum participation. The study also did not examine whether experiences described within the forums were associated with subsequent clinical outcomes. Finally, participation in a digital peer-supported intervention may have attracted individuals relatively willing to engage with and discuss recovery-related experiences, potentially limiting the range of perspectives represented.

Conclusions

Overall, the findings portray eating-disorder recovery as a multidimensional and non-linear process involving emotional, interpersonal, and identity-related change. Identity differentiation emerged as an overarching interpretative pattern reflecting a progressive redefinition of the relationship between the self and the eating disorder. This differentiation was supported, in part, by participants' experience of the synchronous peer-led forum as a protected relational context for sharing and reflecting on recovery experiences. Further research is needed, using longitudinal designs and with closer attention to the role of lived-experience facilitators, to examine how peer-led digital environments contribute to these recovery-related processes.

Abbreviations

DSM-5-TR: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision

ED: Eating disorder

EDE-Q: Eating Disorder Examination Questionnaire

EU: European Union

GDPR: General Data Protection Regulation

GP: General practitioner

GSH: Guided self-help

M: Mean

RCT: Randomized controlled trial

RTA: Reflexive thematic analysis

SD: Standard deviation

TAU: Treatment as usual

Declarations

Ethics approval and consent to participate:

Ethical approval was obtained from the Psychology Research Ethics Committee of the University of Catanzaro Region, Italy (protocol number 221 27.06.2024). The study was conducted in accordance with the Declaration of Helsinki and the General Data Protection Regulation (GDPR; EU Regulation 2016/679).

Consent for publication:

Not applicable.

Competing interests:

The authors declare that they have no competing interests.

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Author Contribution

G.A.: Conceptualization, Methodology, Supervision, Writing – Original draft preparation. C.T.: Investigation, Formal analysis, Validation, Writing – Original draft preparation. V.C.: Conceptualization, Methodology, Supervision, Writing – Original draft preparation. M.S.: Data Curation, Formal analysis, Validation, Writing – Original draft preparation. G.A.T.: Conceptualization, Methodology, Writing – Review & Editing. M.G.: Formal analysis – Review. M. F. P. G.: Formal analysis – Review. G.L.C.: Conceptualization, Supervision, Writing – Review & Editing.

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Data Availability

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

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Figures

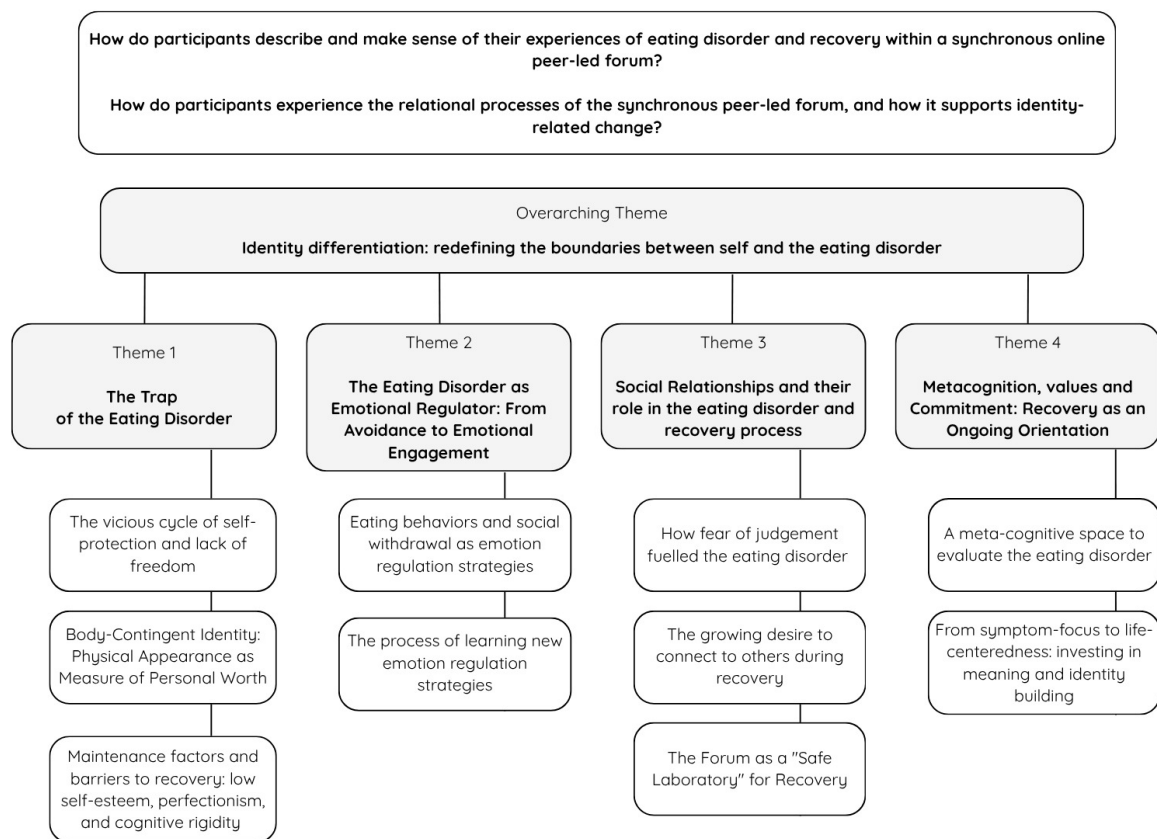


Figure 1

Visual map of themes and subthemes identified through reflexive thematic analysis

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