

Exploring Consumer and Carer Experiences of a Therapeutic Group Yoga Program for Eating Disorder Recovery—A Qualitative Evaluation

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Abstract

Background: Eating disorders remain complex and costly conditions, and while evidence-based treatments address behavioural and weight-related symptoms, they often neglect embodied aspects of recovery. This study examined consumer and carer experiences of an 8-week Yoga for Eating Disorder Recovery intervention (YEDRi) offered within a regional eating disorder service.

Methods: A constructivist realist qualitative design was used to recruit twelve consumer–carer pairs; ten completed the program and undertook post-program semi-structured interviews. Template Analysis guided iterative coding, stakeholder templates, and team consensus.

Results: Four themes characterised participant experiences. Getting to the Mat showed mixed motivations and early hesitations. On the Mat revealed physical, psychological, and relational benefits. Off the Mat demonstrated how yoga practices supported daily regulation and strengthened family connection. Beyond the Mat identified safety-enhancing features and practical recommendations for future programs.

Conclusions: Therapeutic yoga was experienced as a safe and valuable adjunct to treatment, offering benefits in emotional regulation, embodied awareness, and family connection. Carer-inclusive yoga programs show promise within eating disorder care and merit further investigation across settings and stages of recovery.

Trial registration: The trial was registered through the Australian and New Zealand Clinical Trials Registry (ANZCTR) (trial ID: ACTRN12625000274471).

Plain English Summary

Many young people with eating disorders want to move their bodies, but exercise can feel unsafe or overwhelming during treatment. Families also carry a heavy emotional load, often feeling stressed, isolated, and unsure how to help. This study explored what it was like for young people and their carers to take part in an eight-week therapeutic yoga program offered alongside regular treatment.

Young people said yoga felt gentle, safe, and different from the pressured or exhausting exercise they had experienced in the past. They described feeling calmer, more connected to their bodies, and better able to manage difficult emotions. Carers were surprised to find the sessions also helped them feel more grounded and supported.

Doing yoga together strengthened family relationships. Many families continued practising at home, using breathing and grounding techniques during stressful moments. Young people appreciated having their carer with them, and carers valued sharing an activity that wasn't focused on food or treatment. Overall, yoga offered a supportive space for movement, connection, and emotional wellbeing. Families felt it complemented standard treatment and would be helpful for others at different stages of recovery.

Background

Eating disorders (EDs) are complex mental health conditions characterised by an unhealthy preoccupation with eating, exercise, and body weight or shape, often manifesting in behaviours such as food restriction, excessive exercise, binge eating, and purging [1, 2]. In Australia, the prevalence of EDs continues to rise, with an estimated 4.5% of the population currently living with an ED [3] and up to 16% affected at some stage in their life [4]. It has been estimated that the social and economic costs for Australia are \$67 billion, equating to approximately \$60,700 per person annually [3].

International guidelines recommend a comprehensive, multidisciplinary approach that integrates nutritional, medical, and psychological treatment [2]. Evidence-based psychological treatments, such as family-based therapy (FBT) [5], cognitive behavioural therapy enhanced (CBT-E) [6], and dialectical behavioural therapy (DBT) [7] have shown moderate efficacy in treating EDs. For children and adolescents with anorexia nervosa (AN), FBT is considered the gold standard [8-11], underscoring the central role of family in treating this condition [12].

FBT employs a family systems approach with caregivers initially assuming responsibility for all food-related decisions [13]. Although FBT can be effective in treating AN in children and adolescents, particularly in promoting weight restoration [14], it can be challenging for families, as it requires parents to assume a high degree of control over food and eating, a responsibility that often leads to significant emotional strain [15, 16]. Dropout rates of up to 27% have been found, often occurring during the early phases of treatment [17], as both caregivers and adolescents report experiencing distress during the parent-supervised mealtimes [18, 19]. The intensity of FBT can also leave caregivers feeling isolated and ill-equipped to manage conflict [20], while adolescents report experiencing guilt, shame, sadness, and embarrassment [21, 22].

Whilst FBT and CBT-E appropriately target eating and weight concerns, they often overlook broader psychosocial needs and the ways individuals relate to and experience their bodies during recovery, a factor critical to treatment outcomes [23, 24]. Most approaches focus on modifying eating behaviours and emotional regulation but neglect the body as a lived and subjective experience, [25-27], which for individuals with an ED is often associated with distress or disconnection [28, 29]. Conceptual models of human functioning further emphasise how disruptions in lived bodily experience can undermine agency, engagement, and participation in everyday life [30]. Without addressing this embodied dimension of ED experience, recovery may remain incomplete [23].

In response to these concerns, there are calls to broaden the definition and conceptualisation of ED treatment and recovery to encompass improvements in psychological wellbeing, social functioning, and overall quality of life, rather than narrowly focusing on symptom reduction and weight restoration [31]. This expanded understanding of recovery is increasingly reflected in calls to broaden ED treatment and recovery to encompass psychological wellbeing, social functioning, and quality of life, rather than narrowly focusing on symptom reduction [2, 31]. One such approach is yoga, which has shown promise

as a complementary intervention through targeting broader dimensions of ED recovery, such as emotional regulation, body awareness, and stress reduction [32].

Hatha yoga (herein referred to as yoga) integrates physical postures (asana), breath regulation/exercises (pranayama), and relaxation or meditation (dhyana), with a focus on calming the nervous system and promoting physical, psychological and spiritual wellbeing [33]. Preliminary evidence suggests yoga improves body responsiveness and awareness [34, 35], interoception and embodiment [36-38], mindfulness, self-compassion, self-efficacy [39, 40], body satisfaction, body appreciation and positive body image [41-44]. Yoga has also been found to be beneficial in reducing global ED psychopathology, body image concerns [45], binge eating and bulimia [32, 46] emotional regulation, difficulties, self-criticism, whilst improving self-compassion [47].

Notably, yoga has also shown benefits for caregivers in contexts such as oncology [48], dementia care [49], Alzheimer's [50] and chronic illness [51], which, like ED treatment, involve high emotional strain, isolation, and relational challenges [15, 16]. Emerging evidence suggests that when carers participate in yoga alongside the person they support, both experience benefits, including reduced stress and relational gains such as better co-regulation, emotional attunement, and relationship satisfaction [49-51].

To our knowledge, yoga where an individual with ED participates alongside their carer has yet to be examined as an adjunct to standard ED treatment. This gap is unfortunate given the relational intensity of ED recovery [21, 22] and the central role caregivers play in it [15], which often leads to high stress [16]. Joint participation in yoga may offer a context in which adolescents can develop skills and agency while simultaneously strengthening the caregiver relationship. In doing so it may foster shared agency and relational connection [49-51], factors linked to improved engagement and recovery [52, 53].

This paper reports the qualitative findings from a pilot evaluation of YEDRi, a therapeutic yoga program co-designed for use alongside outpatient ED treatment [54]. Guided by the research question, 'How do young people and carers describe their experiences of participating in a therapeutic yoga program delivered alongside their usual outpatient ED treatment?', this study contributes qualitative insights to the growing literature on yoga in ED recovery and informs future program development and evaluation.

Methods

Study Design

A constructivist realist approach was taken, which argues that research is not independent of the clinical researchers' perspective but that meaning is observed, described, and even co-created [55]. Qualitative enquiry was used to draw out stories and understand experiences [56], with semi-structured interviews being used to capture these rich stories [57]. This approach can offer a nuanced understanding of recovery beyond symptom reduction, capturing personal meaning and embodied experiences often missed by quantitative measures [58]. Given the limited qualitative research in this area, such enquiry is

essential to inform safe, acceptable and person-centred intervention design [59]. The consolidated criteria for reporting qualitative studies (COREQ) checklist guided the reporting of this study [60].

Ethics approval was granted by Barwon Health (RHEA-91526) in July 2024, and the trial was registered through the Australian and New Zealand Clinical Trials Registry (ANZCTR) (trial ID: ACTRN12625000274471).

Participants and Recruitment

Participants were recruited through a specialist regional public ED service in Geelong, Australia, which provides multidisciplinary outpatient care. New and existing consumers of the service were eligible to participate. Eligibility matched the YEDRi program criteria: consumers were required to be medically stable, interested in the program, and able to attend with a carer (family member or support person). Medical stability was determined through a pre-program assessment conducted by the ED multidisciplinary outpatient team. Consumers remained under GP care for ongoing medical monitoring, and anyone who became medically unstable was withdrawn from the program. Written informed consent for participation in the qualitative study was obtained after medical clearance and prior to starting the program.

Treating clinicians informed eligible consumers about the yoga program during routine appointments and directed those interested to an online expression-of-interest form. Those who submitted the form were contacted by the student researchers (JO'B, EH or SB), who explained study requirements, answered questions and provided the Participant Information Consent Form (PICF). The student researchers were not involved in participants' treatment or treatment decisions. As outlined in the PICF, participation did not affect access to care or service position, and participants were informed they could withdraw at any time without consequences.

A total of 12 consumer–carer pairs (n=24) enrolled in the therapeutic yoga program and consented to participate in the qualitative study. Of these, 10 pairs completed the program, and participated in interviews. Two consumers withdrew prior to program completion: one consumer was withdrawn by the treating team due to medical instability, and the other consumer withdrew because their carer was unable to attend the yoga sessions at the scheduled sessions. Among the 10 consumer–carer pairs that attended the program, participants attended 72.5% of classes (averaging six of the eight sessions). See Table 1 for participant details.

Table 1
Consumer Participant Information

Participant ID	Age	Gender	TAU	Diagnosis
1	21	Male	CBT-E	AN, ARFID, OCD
2	18	Female	FBT	AN, GAD, MDD
3	18	Female	FBT	OSFED
4	15	Female	FBT	OSFED, ADHD
5	16	Female	FBT and CAT	AN, MDD
6	18	Female	FBT and individual psychotherapy	AN (prior Dx: brief psychotic disorder)
7	13	Female	FBT	AN
8	24	Female	SSCM	AN, ASD
9	12	Female	FBT	AN
10	21	Female	SSCM	OSFED

*Key: AN: Anorexia Nervosa, ADHD: Attention Deficit Hyperactive Disorder, ARFID: Avoidant Restrictive Food Intake Disorder, ASD: Autism Spectrum Disorder, CAT: Cognitive Analytical Therapy, CBT-E: Cognitive Behavioural Therapy – Enhanced, Dx: Diagnosis, FBT: Family Based Therapy, GAD: Generalised Anxiety Disorder, MDD: Major Depressive Disorder, OCD: Obsessive Compulsive Disorder, OSFED: Other specified Feeding Eating Disorder, SSCM: Specialist Supportive Clinical Management.

Sample adequacy was considered in terms of information power—the degree to which the available data can support the study’s aims [61]. Several factors supported the adequacy of the current sample. The study had a clearly defined and specific aim, focused on a relatively bounded experience (participation in an 8-week program) within a single service context. Participants shared a common experience of the intervention, supporting within-sample coherence. Data collection used semi-structured interviews with in-depth exploration, and analysis prioritised conceptual richness through template analysis. Taken together, these factors supported a sample of ten consumer–carer pairs as sufficient to address the research question with adequate information power.

Intervention

YEDRi is an 8-week therapeutic yoga program co-designed with consumers, clinicians, and carers at the regional ED service. It involved weekly group sessions and a personalised home practice. It was informed by consensus-based recommendations for yoga interventions targeting eating disorders [62]. Group sessions were 60 min each and occurred weekly over eight weeks. Sessions combined relaxation, breathing, gentle physical postures and movements from standing, lying, or sitting positions, suitable for all levels of experience and utilising modifications where necessary. For details on the program and its development, see O’Brien et al. [54]. The therapeutic yoga program was delivered by a Yoga Therapist, with a mental health clinician present to ensure safety and support engagement throughout. Unlike a

yoga teacher who runs general classes, a yoga therapist works in a clinical context and can adapt yoga practices to specific health conditions.

Before commencing the weekly group sessions, each consumer participated in an individual yoga therapy assessment with the yoga therapist to explore goals, readiness, and suitability. During this assessment, a personalised 15–20-minute home practice was developed, tailored to the consumer's current health status and any physical injuries. This home practice, typically involving simple movement and breathing techniques, was designed to support skill development between sessions.

Procedure

The 8-week yoga program was delivered twice between July 2024 and June 2025. Within one month of program completion, consumers and carers participated in individual semi-structured interviews conducted by one of three female student researchers (JO'B, EH, or SB), all of whom were trained in qualitative interviewing. Interviews were held either in a private room at the service or via secure videoconferencing, according to participant preference. The semi-structured interview guide was developed by the research team based on the program aims, existing literature, and input from clinicians in the ED service. The consumer interviews included questions such as: 1) Why did you engage with the yoga group? 2) What was your experience of doing yoga? 3) Were there any similarities or differences between yoga and typical treatment? 4) What was it like going with your carer? and 5) What recommendations do you have for the program? Carers were asked parallel questions tailored to their role, focusing on their experience of attending yoga, perceived benefits for their young person and themselves, and recommendations for the program. Interviews lasted 30-40 minutes and were audio-recorded for transcription. Demographic data were collected, and pseudonyms were used to maintain confidentiality. Consumer–carer pairs received a \$50 voucher as a gesture of thanks for their time.

Data Analysis

Data were analysed using template analysis, a structured yet flexible approach to thematic analysis that emphasises hierarchical coding [55, 63, 64]. This method is well suited to applied health research, particularly when exploring intervention feasibility, acceptability, and safety [63, 65].

Template analysis was conducted following the six steps outlined by Brooks et al., [63]. In line with Step 1 (familiarisation) JO'B, EH and SB read and re-read the transcripts from their assigned interviews (10 consumer interviews for JO'B; 6 carer interviews for LH; 4 carer interviews for SB) to immerse themselves in the data. Consistent with Step 2 (preliminary coding), each coder then manually generated initial codes under the supervision of MOS and SE.

Following this, and in accordance with Step 3 (developing an initial template), the research team began grouping related codes and considering how these could be organised into broader clusters. This process resulted in preliminary templates for the consumer and carer datasets. In Step 4 (organising

codes into meaningful clusters), these templates were refined into hierarchical structures, with higher-order themes encompassing related lower-order themes.

The initial templates were then applied to the full dataset in Step 5 (applying and modifying the template). Through iterative review, discussion, and comparison with the research aims, modifications were made to strengthen conceptual clarity and consistency. Discrepancies were resolved through discussion until consensus was reached, and credibility was supported through multiple coders and ongoing analytic meetings. Separate stakeholder templates are provided in Supplementary Material (Appendices A, B and C).

Finally, consistent with Step 6 (finalising the template), the consumer and carer templates were combined using the study's a priori analytical focus on feasibility, acceptability, and safety. Following Brooks et al. [63], MO'S and JO'B brought all codes from both templates together into a single dataset and examined them against these higher-order concepts. Codes reflecting similar underlying ideas were merged, stakeholder-specific insights were retained where they offered distinct perspectives, and codes not relevant to the research aims were set aside. This process generated a coherent combined template that captured shared and unique elements of each stakeholder group. The final template was refined through team discussions and approved by all authors, supporting investigator triangulation and analytic rigour.

Themes were conceptualised as patterns of shared meaning across the dataset rather than as frequency counts. Subthemes were included when present across more than one participant account, with analysis prioritising conceptual richness and depth over prevalence. Indicative language (e.g., 'most', 'many', 'several') is used throughout the Results to convey variation in how widely an experience was shared, without implying precise quantification.

In keeping with a reflexive qualitative approach, the research team, comprising mental health clinicians and qualitative researchers with experience in ED treatment and yoga-informed practice, considered how their professional backgrounds, assumptions, and investment in the topic could shape data generation and interpretation. The team acknowledged that these perspectives might influence what they attended to within participants' accounts and how meaning was constructed. Reflexive strategies were used throughout the study, including documenting assumptions and analytic decisions, and engaging in regular discussions to examine how individual and shared perspectives informed the developing analysis [66].

Results

Analysis of interviews identified four themes: *Getting to the Mat: Arriving at Yoga as a Place of Possibility*; *On the Mat: Discovering Yoga's Benefits Together*; *Off the Mat: Transformations Beyond the Program*; and *Beyond the Mat: Program Experience and Recommendations*.

Theme 1: Getting to the Mat—Taking a Leap of Faith Together

This theme captures consumers' and carers' initial motivations and hesitations around joining the yoga program. Although both groups were generally optimistic about yoga's potential value in ED recovery, they also expressed reservations, particularly about participating in an ED-specific group and the emotional and interpersonal challenges this might entail.

Most consumers were motivated by a desire to move their bodies and improve their physical health, especially those who had been medically restricted from participating in exercise. For some, the appeal lay in the opportunity to move again; for others, it was the reassurance that yoga could be undertaken safely within treatment parameters. Clinician endorsement further supported participation. As Consumer 2 noted, *'I can't really do any extensive exercise... and I was allowed to do this as it is not that rigorous'*. Many consumers also hoped to build strength and physical capability, often describing a wish to *'feel strong'*. Carers similarly viewed the program as a safe way to re-engage with movement and hoped it would rebuild a more positive relationship with exercise. As Carer 5 explained, *'This was a way for her to learn that exercise is about wellness, not for weight loss'*.

Consumer and carers also anticipated psychological benefits, believing yoga might help consumers feel calmer, more focused, and better able to regulate emotions. As Consumer 6 described, *'I thought maybe it could help me with mindfulness... to be able to relax'*. Carers echoed this, expecting yoga to support grounding and emotional steadiness.

The group-based format was seen as holding potential social benefits, including opportunities for connection and a sense of shared experience. As Consumer 3 expressed, *'I thought just being in a room with other people recovering would be good'*. Carers likewise hoped the group would reduce isolation and foster belonging.

Despite these anticipated benefits, several consumers and carers described apprehension about joining. Concerns centred on uncertainty about other group members, fears of comparison, and broader social anxiety. The most prominent worry was that an ED-specific group could trigger unhelpful thoughts or behaviours. As Consumer 2 explained, *'When you put all those people... in the same room, it just fires up a lot of things you thought you were kind of over'*. Some consumers described feeling uncertain about what they were expected to wear and expressed concern that seeing other participants in tight/fitted yoga attire might prompt comparison or exacerbate ED thoughts.

Carers echoed these hesitations, with several referencing previous negative experiences in ED-specific groups. As Carer 10 described, *'She has hesitations about being in a room with others with an ED... I don't think she wants to see others struggling'*. Additional concerns related to physical ability, health limitations, and uncertainty about what the yoga sessions would involve. As Consumer 4 shared, *'I was a bit concerned because I have like one out of nine flexibility, and I've got some other medical issues'*.

Carers played a central role in helping consumers overcome these initial hesitations. Many expressed strong enthusiasm for the program and saw its focus on the mind–body connection as addressing a gap in standard ED treatment. As Carer 1 explained, *'I think it's that missing link... they lack that mind–body*

connection. For several consumers, this encouragement was essential. As Consumer 4 reflected, *'If it had just been me... I wouldn't have gone'*. Participation often required what Consumer 2 described as *'a leap of faith'*, made possible through carer support.

Theme 2: On the Mat—Discovering Yoga's Benefits Together

This theme describes the physical, psychological, and social benefits experienced by consumers and carers as they engaged in the yoga program. Once consumers arrived on the mat, yoga was often experienced as a gentle, safe, and restorative way to reconnect with their bodies. Several contrasted this with the strenuous or punitive forms of movement characteristic of their eating disorder. As Consumer 7 explained, *'Yoga was good because it allowed me to be present with my body; it was gentle movement that wasn't in the form of over-exercising or punishment'*.

Through slow, mindful movement, consumers described relating to their bodies in new ways. Mindful movement provided a counterpoint to the rigid, compulsive, or avoidant patterns that had previously shaped their relationship with exercise. Consumers described developing greater bodily awareness and reduced self-judgement, with some beginning to explore body neutrality or acceptance. As Consumer 8 reflected, *'I spent so long hating my body... I don't have to love my body... but just to be okay with it'*.

These embodied shifts appeared to support broader psychological changes. Consumers described experiencing fewer ED-related thoughts and a greater capacity to tolerate distress, including around meals. Breathwork emerged as particularly helpful, offering a concrete strategy for managing physiological arousal and everyday anxiety. As Consumer 10 described, *'It helps me to slow down my breathing when it goes really fast'*.

Initial concerns about participating in a group often softened as consumers settled into the sessions. Many valued the sense of shared understanding that developed through practising alongside others with similar experiences. The gentle pace and minimal verbal demands reduced initial discomfort and allowed consumers to focus on movement and breath without pressure to perform or compare. As Consumer 3 noted, *'It was quite confronting at first. But I found it quite nice to feel that unspoken connection with others'*. Carers also observed these shifts and interpreted them as meaningful developments in consumers' recovery. Improvements in strength and physical capability were often linked to increases in motivation, confidence, and engagement with life outside the program. As Carer 2 reflected, *'Since starting yoga... it's like a switch has flipped'*.

In addition to witnessing consumer change, several carers described experiencing unexpected personal benefits. Although they initially attended to provide support, carers reported feeling calmer, more grounded, and grateful for moments of respite from the emotional and practical demands of caregiving. As Carer 4 explained, *'It was nice to just take the time out for yourself... FBT is a very stressful process... and I got great benefit from it'*.

Across accounts, yoga was seen as distinct from, yet complementary to, other components of ED treatment. Rather than replacing therapy or medical care, consumers and carers described yoga as addressing aspects of recovery not fully met elsewhere, particularly those related to embodiment, emotional regulation, and connecting mind and body. As Consumer 6 observed, *'It helped me to be more in tune with my thinking, which then helped me be more in tune with my body... it all works together'*. Carer 4 emphasised that yoga offered something missing from standard treatment, noting that although hospital-based care had restored her daughter's weight, this was only one aspect of recovery; as they reflected, *'there's still such a strong disassociation in her thinking, and she needs to learn to love herself again'*.

Theme 3: Off the Mat—Transformations Beyond the Program

This theme captures how consumers and carers experienced benefits from yoga beyond the formal program. Participants described yoga shifting from a shared activity within treatment to something they continued together at home. This helped reshape how families spent time together and provided a way to connect that was not centred on food or treatment demands. As Carer 10 said, *'Everything else in our relationship is about food at the minute... this was something we could do together that wasn't about food'*.

For many families, the home practice gradually became a meaningful routine. Yoga moved from a structured program component to a familiar part of daily life. As Carer 4 explained, *'even when we were home late... we'd do the yoga, that was the routine we had'*.

Consumers described that the grounding, mental clarity, and bodily awareness they first noticed in sessions began to show up in daily life as they continued practising at home.

Consumers and carers also described taking these yoga-based skills such as breathwork, grounding, and mindful attention into everyday life such as during stressful moments or ED-related challenges.

Consumer 8 described using breathwork during difficult appointments: *'If I'm really anxious... I do the technique she taught me'*. Carers described using similar strategies to support their young person and themselves, including co-regulation during periods of intense distress. One carer reflected on feeling utterly unsure how to help in those moments, until remembering the breathing practices from the yoga session. As Carer 5 shared, *'I could just hold her and slow my breathing right down and get her to tune into that too'*.

Practicing yoga together also supported shifts in family relationships. Over time sharing a yoga practice contributed to calmer interactions at home and a renewed sense of connection. Carer 4 reflected, *'It was calmer as the weeks went on... we were calmer'*. Consumers similarly described feeling less alone and more understood. As Consumer 7 explained, *'It just brought us together... eating disorders are very isolating... having her there was good'*.

Carers described that yoga offered a different way of relating to their young person. In contrast to the directive roles they often take in ED treatment, such as prompting eating, monitoring behaviours, and

enforcing appointments, yoga allowed them to step back and participate alongside their young person in a shared activity. This shift from ‘directing’ to ‘doing together’ fostered a sense of mutual involvement. As Carer 5 said, *‘Doing the yoga together was different... we were sitting next to each other doing the same thing’*. Some carers noticed their young person taking more responsibility during sessions, reducing the need for prompting. As Carer 6 described, *‘Instead of me nagging at him’*. Consumers, in turn, reported that their carer’s presence signalled genuine interest and support, helping them feel more understood and more open about their ED. As Consumer 9 shared, *‘To have her ask was really nice... and feel a little bit more understood’*. These relational shifts supported easier communication and helped strengthen family connection over time. As Carer 2 reflected, *‘It was really good to reconnect again... it mended some bridges’*.

Theme 4: Beyond the Mat—Program Experience and Recommendations

This final theme reflects consumers and carers’ perspectives on the yoga program’s strengths, safety considerations, and areas for future refinement. Consumer and carer reflections on the program’s strengths and suggested refinements are summarised in Table 2, which outlines participant-informed recommendations for future iterations of the program.

Consumers consistently described the program as supportive and helpful, emphasising the containing atmosphere as a program strength. As Consumer 4 reflected, *‘It just felt calm and safe... which made it easier to relax’*. Environmental aspects such as soft lighting, cooler temperatures, and the absence of mirrors were also described as easing body-image distress and promoting comfort. Carers also reported that knowing the program was led by the ED service increased their confidence in its safety. While clinical oversight was reassuring, consumers emphasised that the community-based setting made the program feel more accessible and less clinical, supporting engagement.

Facilitator qualities were frequently highlighted as a strength of the program. Consumer and carers felt that the yoga facilitator demonstrated an understanding of EDs and created a calm, supportive environment. As Carer 2 explained, *‘She just got it... the way she got us to just breathe and meditate and let the feelings and the emotions go’*. The presence of both a yoga teacher and a mental health professional during sessions was also described positively, as consumers and carers felt reassured that support was available if needed without interrupting the practice.

Table 2
Participant-informed Recommendations for Iterating the YEDRi Program

Participant Insight	Design Recommendation
Family encouragement was a key motivator for initial engagement	Involve carers in pre-program outreach and orientation to support attendance.
Consumers felt safer attending with a support person	Offer the option for carers to engage in initial yoga therapy assessment session and provide home practice to both.
Initial anxiety and social concerns were common	Provide clear pre-program communication, including what to expect, clothing suggestions, and group composition.
Fear of comparison and body image distress in group settings	Reinforce body-neutral messaging and ensure facilitators address comparison concerns sensitively. Explicitly encourage participants to wear comfortable, non-form-fitting clothing to reduce body-focused concerns and support a safe, inclusive environment.
Prior negative experiences in ED groups created hesitancy	Emphasise the non-clinical, non-food-focused nature of the program in recruitment materials.
Physical health concerns and low flexibility caused worry	Offer modifications and reassure participants that yoga is adaptable to all bodies and abilities.
Non-clinical setting fostered emotional accessibility and safety	Continue offering sessions outside clinical environments to reduce stigma and foster ease.
Facilitator qualities (trauma-informed, ED-aware, relational) were essential	Ensure facilitators are trained in trauma-informed care and ED-specific knowledge.
Environmental features (no mirrors, soft lighting, cooler temps) enhanced comfort	Retain these features and allow flexible clothing choices.
Group diversity (carers + consumers) fostered inclusivity and mutual respect	Continue mixed-group format.
Desire for ongoing access and engagement at different recovery stages	Explore options for program continuity or phased re-engagement.
Barriers to home practice included motivation, distractions, and lack of structure	Provide structured home practice resources and reminders; consider follow-up support.
Carers felt increased confidence in program as it was organised by ED service	Continue to ensure that ED clinician is available at each yoga session.

Group composition and practical features of the program were largely viewed as appropriate and supportive. Participants described the mixed group of consumers and carers, along with session timing

and length, as contributing to comfort and engagement. Small group size and the absence of cost were also identified as reducing barriers to participation. As Consumer 5 noted, *'If it had been a big group or expensive, I wouldn't have come... this made it possible'*.

Alongside these strengths, participants made several recommendations to strengthen future groups. Many suggested clearer pre-program communication to address early anxiety and uncertainty, including information about what to expect, group composition, and clothing options. Some recommended involving previous consumers and carers in orientation or information sessions to help normalise initial hesitations. Some consumers who engaged with the home practice described challenges related to motivation, competing demands, or lack of structure, and suggested reminders or follow-up support to sustain their engagement.

A few consumers described feeling unsettled when observing others engage in behaviours such as body checking, echoing their initial concerns about group-based ED settings. In these moments, carer presence was described as a valuable protective factor. As Consumer 7 reflected, *'When I saw her body checking... it was her mum that told her off... it would have been much worse if her mum wasn't there, and her mum wasn't keeping an eye on her'*. Consumers suggested that brief check ins with their ED clinician to discuss concerns such as triggering moments or group dynamics, along with clearer guidance on how facilitators would respond to distress or triggering in the group, would further support their sense of safety.

Finally, several participants also expressed interest in the program continuing beyond an 8-week program. Consumers described wanting access earlier in treatment and the opportunity to return, with Consumer 6 noting it could be *'beneficial at any stage of one's recovery'*. Carers also questioned how to maintain progress once sessions ended. As Carer 6 reflected, *'What am I going to do now to keep this up?'*. This signalled interest in continuity options, such as booster or step-down sessions, to support ongoing recovery.

Discussion

This qualitative study explored consumer and carer experiences of a therapeutic yoga program delivered alongside outpatient ED treatment. The findings suggest that yoga can address embodied and relational dimensions of recovery that consumers and carers described as insufficiently supported in standard care – gaps that align with broader critiques highlighting the limited attention given to psychological wellbeing, embodiment, and relational connection in existing ED treatment approaches [31].

Consumers' experiences with yoga in this study align with growing evidence that yoga can support a range of biopsychosocial outcomes relevant to ED recovery, such as improvements in physical strength [67], emotion regulation and distress tolerance [68], and more positive or accepting experiences of the body [69]. Yoga has also been associated with increases in mindfulness and self-compassion [40], self-efficacy [70], psychological flexibility [71], empowerment [72], positive affect [73], and social

connectedness [74]. Together, these findings highlight yoga's potential to address multiple domains of ED recovery that remain under-represented in standard ED treatment.

Consumers described being motivated to engage with the program because they held an intrinsic desire to move, reflecting prior qualitative findings [75, 76]. Although movement is recognised as both a therapeutic right and a key component of ED recovery [77], reintroducing movement remains challenging due to a lack of clinical guidance [78], particularly following periods of medically necessary movement restriction or abstinence [79]. Consumers also described a range of other apprehensions that are well-documented in the literature, including a general reluctance to join ED-specific groups due to fears of comparison, shame, and social anxiety [80-82], as well as concerns about their physical capability or being in a setting where body-revealing clothing might be worn [78]. Once engaged, consumers described the yoga sessions as calming and containing. The slow, gentle, and largely non-verbal format reduced self-consciousness and social comparison, and attending with a carer eased anticipated fears, enabling participation. Consumers expressed a desire for ongoing or repeated access to the program at different stages of recovery, highlighting yoga's relevance across the recovery continuum and reinforcing calls for flexible, autonomy-supportive approaches to reintroducing movement [78, 83].

Mindful movement helped consumers slow down, notice bodily sensations, and regulate physiologically through breath and grounding. These mind-body processes appeared to reduce ED-related thoughts and support emotional regulation, allowing consumers to relate to their bodies with less judgement and fear. Yoga also supported gradual shifts toward body neutrality and acceptance, characterised by reduced judgement and relief from pressure to feel positively about their body. These experiences align with emerging evidence highlighting the importance of reconnecting with the body in ED recovery [25]. Embodiment, understood as a mindful, compassionate connection to the body [29, 84], has been used to explain how practices like yoga may support changes in body acceptance and body image [41, 69, 84]. Although some yoga research reports increases in positive body image or self-compassion [39-44] consumers in the current study described small but meaningful shifts toward a more neutral relationship with their bodies.

Carers also reported unexpected personal benefits, including reduced stress, improved sleep, and feeling more emotionally regulated. These experiences align with evidence that yoga can support caregiver coping, connection, and emotional regulation in other health contexts [48-51]. Given that carers play a central role in supporting recovery and maintaining the treatment environment in ED contexts [16], these benefits are clinically meaningful. Carers viewed yoga as restorative rather than burdensome, echoing current interest in approaches that support both the individual and the caregiving relationship in ED care [85, 86]. Broader literature emphasises that carer wellbeing plays a key role in supporting family functioning and treatment engagement [87], suggesting that yoga may hold promise in supporting these factors within ED contexts.

Notably, carers and consumers described yoga as a shared, non-clinical activity that contrasted with the directive and treatment-focused interactions common in ED care. Families who engaged in home

practice used breathwork and grounding during stressful moments, supporting both self-regulation and co-regulation. Consumers and carers described calmer interactions, reduced conflict, and greater comfort being together. Such shifts are consistent with broader evidence that embodied practices, including shared breathwork and grounding, can support co-regulation and relational attunement [88-90]. Given the emotional strain and vigilance commonly reported in families supporting ED recovery [15, 16], these changes were experienced as meaningful. These findings are of interest and suggest a promising area for further research, particularly regarding how shared embodied practices may support relational connection in families affected by EDs.

Clinical Implications

These findings suggest that yoga can be integrated safely alongside standard ED treatment when delivered in an ED-informed and trauma-sensitive manner. Rather than replacing established interventions, yoga may complement existing approaches by addressing aspects of recovery that consumers and carers described as insufficiently met elsewhere, particularly embodied experience, emotional regulation, and family support. These insights align with literature highlighting the limited attention given to bodily experience in traditional ED treatment models [23, 24] and the value of integrating embodied practices within multidisciplinary care [84].

Participants also offered specific suggestions to strengthen future delivery of the program, providing clear implications for clinical practice. Providing psychoeducation about how yoga can support ED recovery, using language consistent with existing ED treatments such as CBT-E and FBT [14, 91], may reduce uncertainty about movement reintroduction [78], support early engagement, and help consumers understand how yoga complements existing therapeutic approaches, potentially reinforcing skills taught in standard treatment. Although many engaged in home practice, sustaining this was challenging. Structured post-program supports such as guided resources, booster sessions, or follow-up check ins may help consolidate skills [25, 36]. Participants also emphasised the potential value of peer workers to normalise early engagement and reduce initial barriers, consistent with emerging ED service research [92, 93].

Future research should examine the feasibility of delivering YEDRi in online or hybrid formats to address barriers related to geography, illness severity, or scheduling. Evaluating tele-yoga delivery is important given evidence that adapted digital movement-based interventions can be feasible and acceptable in youth mental health contexts [94]. Longer-term follow-up studies are also needed to determine whether perceived benefits are sustained and to clarify how embodied practices may influence ED recovery trajectories [84].

Strengths and Limitations

A key strength of this study lies in its qualitative design and constructivist realist approach, which enabled in-depth exploration of consumers' and carers' lived experiences of participating in a therapeutic yoga program alongside ED treatment [66]. This approach was well suited to examining the embodied

and relational processes central to recovery. It facilitated the capture of personal meaning and interpersonal dynamics that are often overlooked by symptom-focused quantitative measures [56-58]. The inclusion of both consumer and carer perspectives further strengthened the study by allowing relational processes and shared experiences to be examined from multiple viewpoints. The study's embedding within a real-world ED service and delivery alongside treatment as usual also enhanced clinical relevance [59].

Several limitations should be acknowledged. As a pilot conducted within a single regional service, the findings are context-specific and generalisability to other treatment setting and contexts is unclear. Although the YEDRI program was intentionally designed for use across all ED presentations and informed by consensus-based recommendations indicating that tailored yoga can be safely and therapeutically adapted for individuals with AN, BN, BED, and across the ED spectrum [62], most participants in this study had AN. Given differences in movement needs, safety considerations, future research should examine YEDRI's applicability within more diagnostically diverse groups. Nonetheless, given the high mortality and complex treatment needs associated with AN [95], these findings still provide useful insight into how yoga may be safely integrated for this group. Participants were also those who completed the program and consented to interviews, which may reflect more positive experiences and limit insight into barriers to engagement or discontinuation. Additionally, consistent with its qualitative aims, the study did not assess symptom change or long-term outcomes, for which randomised and sufficiently powered trial designs are required. Finally, while reflexive strategies were employed throughout (see Data Analysis), the research team's professional investment in yoga-informed practice and ED treatment may have shaped data interpretation. Readers should consider these potential influences when weighing the findings.

Conclusion

This study demonstrates that a carer-inclusive therapeutic yoga program can provide a safe, embodied adjunct to standard outpatient ED treatment, offering a range of biopsychosocial benefits. Including carers appeared to extend these benefits, providing shared routines, co-regulation, and moments of respite that supported both individual- and family-level recovery processes. Rather than replacing current evidence-based care, yoga offered a parallel, non-food-centred space that addressed embodied and relational aspects of recovery often overlooked in standard treatment. While preliminary, these findings highlight the potential value of integrating carer-inclusive, embodied approaches alongside standard ED interventions. Future research should examine how such programs can be adapted across diverse service contexts and recovery stages and evaluate their longer-term effects through adequately powered, randomised trials before any conclusions about sustained benefit can be drawn. These findings offer a promising foundation for that future work.

Declarations

Human Ethics: The study was approved by Barwon Health Research Ethics, Governance and Integrity Unit [RHEA-91526] in July 2024.

Consent to participate: Informed consent was obtained from all participants and/or their guardians prior to participation in the study.

Consent for publication: Informed consent was obtained for the results of the study to be published from all participants and or their guardians.

Availability of data and materials: The dataset(s) supporting the conclusions of this article is(are) included within the article (and its additional file(s)).

Competing interests: The authors declare that they have no competing interests.

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Author contributions: JO'B, EH, SB, SE, MO'S, EH, GP, JH and CM contributed to the study's conception and design. JO'B, EH and SB conducted the interviews. All authors contributed to data analysis and interpretation. JO'B drafted the first version of the manuscript under the supervision of MO'S. All authors reviewed, edited, and approved the final manuscript.

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