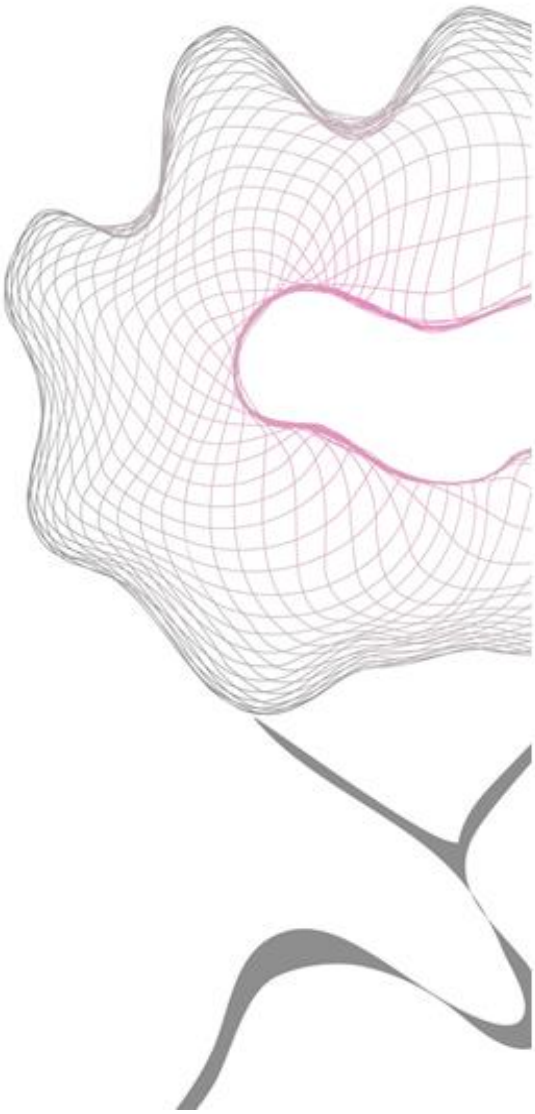

Four decades of qualitative research: A meta-synthesis of intrapersonal helping and hindering factors in eating disorder recovery.

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Abstract

Eating disorders (EDs) are serious and complex illnesses that can have considerable consequences on physical, psychological, and social functioning. Existing qualitative research about perspectives of individuals with lived experiences found several intrapersonal and external factors that help and hinder ED recovery. However, current reviews and meta-syntheses of qualitative studies focused mainly on external aspects of ED recovery or factors within a treatment context. Hence, this study aimed to systematically review relevant original studies to identify helping or hindering intrapersonal factors in ED recovery by using a qualitative meta-synthesis approach. Forty-six original studies examining the experience of personal recovery were analyzed based on the generic descriptive-interpretative framework for analyzing qualitative data by Elliot and Timulak (2005). Five overarching themes regarding helping and hindering intrapersonal aspects of ED recovery were identified: 1) self-determination, 2) self-care, 3) self-compassion, 4) engaging in real life, and 5) personal development. The outcomes of this study resonate with existing qualitative research about patients' perspectives of ED recovery. The provided knowledge may facilitate a deeper understanding of factors that support individuals in the recovery from an ED and could therefore have significant implications for the development of prevention measures, psychoeducation, and guidelines for ED care. Furthermore, the synthesized findings of this study offer a unique, personal perspective on ED recovery and may provide useful information for clinicians, family members, and those affected. Future research should validate and further investigate the mechanisms that are involved in the recovery process and support individuals in their efforts to recover from the illness.

Key Words

Eating disorder recovery; Qualitative meta-synthesis; Intrapersonal; Helping and hindering factors; Personal experiences

Introduction

"The constant pain I lived with was slowly and uncontrollably killing me […]" (Carly, as cited in Weber, Davis, & McPhie, 2006).

Eating disorders (EDs) are enduring and exhausting illnesses with poor prognoses of recovery (Jones, Harris, & Leung, 2005). Among the most common EDs are Anorexia nervosa (AN), Bulimia nervosa (BN), and Binge-eating disorder (BED) (Keel et al., 2012). AN is defined by (extreme) dietary restrictions resulting in severe underweight, preoccupations with food, and body image disturbances (Keel et al., 2012). BN is characterized by episodes of excessive food intake, coupled with abnormal compensatory behaviors such as purging (Keel et al., 2012). BED describes recurrent binge-eating episodes that are not compensated by purging. Next to the three main EDs, the category of "other specified feeding or eating disorders" (OSFED) comprises EDs that do not meet the criteria for the typical classifications, as well as all remaining disorders of eating, such as night-eating syndrome (NES) or purging disorder (PD) (Riesco et al., 2018). While an ED can have various causes, individual reasons for disordered eating seem to have a general theme of avoidance coping (Cockell, Zaitsoff, & Geller, 2004). However, the role of sociocultural pressures and certain beauty standards, that are generally accepted in western countries, cannot be denied (Lemberg & Cohn, 1999).

Prevalence rates for European women range from 1-4% for AN, 1-2% for BN, and 1-4% for BED (Hoek, 2016). In contrast, only 0,3-0,7% of the European male population report an ED. Although incidence rates differ greatly, EDs seem to occur most frequently in western countries and among young women (Hoek, 2016). In conjunction with proceeding industrialization, globalization, and urbanization, prevalence rates of EDs have grown tremendously over the past decades (Hoek, 2016; Lemberg & Cohn, 1999), which is alarming considering the possible repercussions of EDs.

EDs can have detrimental consequences for those affected and may lead to impaired physical, social, and psychological functioning (De la Rie, Noordenbos, & Van Furth, 2005). Medical complications usually stem from disturbed eating and abnormal compensatory behaviors that vary among different types of EDs. Physical consequences of AN include severe underweight, bone loss (osteoporosis), loss of menstrual period (amenorrhea), kidney and heart complications, and vitamin deficiencies that can affect cognitive functioning (Lemberg & Cohn, 1999). With up to 20% mortality at 30-year follow-up, AN has the highest mortality rate among all EDs (Lemberg & Cohn, 1999). Due to the repetitive bingeing and purging process, BN may lead to erosions of tooth enamel, metabolic acid-base imbalances, and mineral deficiencies. Amongst others, consequences of EDs on mental functioning include attentional

and executive function deficits (Duchesne et al., 2004), and difficulties in emotion recognition and regulation (Harrison et al., 2010). Additionally, patients often report comorbid depressive, and anxiety disorders, as well as self-harm behaviors or suicidal ideation (Cockell, Zaitsoff, & Geller, 2004). As a result of the numerous impairments, EDs usually lead to significant decreases in life quality and life satisfaction (De la Rie, Noordenbos, & Van Furth, 2005). Finally, it should be noted that EDs not only affect the diseased, but pose an enormous burden on family members, friends, and caregivers (Highet, Thompson, & King, 2005).

To combat these severe outcomes, a variety of treatment approaches for EDs has emerged over the last decades. Treatment options based on cognitive-behavioral therapy (CBT) are the most researched and usually seen as the front-line intervention for EDs (Grenon et al., 2018). However, recent meta-analyses did not identify any specific superior treatment. Rather, it seems that treatment approaches that are intended to be therapeutic are similar in effectiveness (Grenon et al., 2018). Unfortunately, individuals with EDs are often little responsive to treatment (Cockell, Zaitsoff, & Geller, 2004), and relapse rates after treatments tend to be quite high, with estimates ranging from 22-63% (McNamara & Parsons, 2016; McFarlane, Olmsted, & Trottier, 2008). In addition, treatment outcomes and responses have mostly been defined by physically quantifiable determinants and the remission of core symptoms, such as weight gain for AN (Federici & Kaplan, 2007). However, when treatment goals are defined by clinicians and researchers, important aspects of the concept of recovery might be overlooked (Pettersen & Rosenvinge, 2002). Yet, in most cases, evidence of the effectiveness of ED treatment fails to consider the patient's perspective (Wetzler et al., 2013), which illustrates the importance of investigating aspects that affected individuals experience as important for recovery.

Recovery tends to be the ultimate end goal for both patients and clinicians (Bardone-Cone, Hunt, & Watson, 2018), although a universal definition of the concept of ED recovery seems to be lacking. Yet, without a common definition of recovery, it is almost impossible to compare recovery rates across studies and to draw meaningful conclusions about the effectiveness of different treatments.

The traditional clinical view of recovery focuses mainly on the remission of core ED symptoms, such as the absence of binging/ purging in BED or weight gain in AN (Bardone-Cone et al., 2010). However, simply aiming for symptom remission cannot fully account for the personal experiences of individuals who suffer from an ED (Wetzler et al., 2020). In fact, Bardone-Cone et al. (2010) believe that the exclusion of psychological factors in the assessment of ED recovery might even lead to a state of "pseudo recovery" in which patients contain their disordered cognitions, despite having physically or clinically recovered. Broader definitions of

ED recovery, therefore, tend to include a psychological component, reflecting how individuals think about their bodies, food, and eating (Bardone-Cone et al., 2010). As Wetzler et al. (2020) propose, a more inclusive definition of "recovery" would require an extension of the traditional clinical view and should include a personal understanding of recovery of people with lived experiences.

Over the last several years, research within the ED field has seen a growing interest in incorporating the voices of those with lived experiences (Musić et al., 2021). Qualitative approaches and the direct involvement of affected individuals have proven to be beneficial for clinical practice and advocacy surrounding EDs. According to Timulak (2007), qualitative analysis can be used to acquire a more detailed and comprehensive description of a studied phenomenon and help to identify its core features. Hence, including perspectives of those with lived experience might provide greater insight into important aspects of recovery and highlight potential barriers that might otherwise be overlooked or not sufficiently considered (Musić et al., 2021). Existing qualitative studies about personal perspectives of ED recovery have found several helping and hindering aspects.

In their study, Cockell, Zaitsoff, & Geller (2004) investigated factors that promote recovery and maintenance of change in EDs. The findings showed that patients valued maintaining connections with family members, friends, and professionals. Challenging distorted thinking with accurate information like for instance learning and applying knowledge about daily nutritional requirements was repeatedly mentioned as helpful. Additionally, focusing on meaning in life beyond the ED and making concrete changes such as moving out, further supported recovery behaviors.

Venturo-Conerly et al. (2020) conducted qualitative interviews with 13 recovered patients to examine factors that were experienced as helpful, mixed, or harmful in recovery. Most of the participants described the feeling that family members ignored their disorder or focused only on physical changes (such as weight gain) as counterproductive for the recovery process. In that respect, "rewarding thinness", "reinforcement of societal ideals" and "punishing weight gain", were commonly experienced as detrimental. Furthermore, patients noted that "a lack of hope for the future" and "denying the problem" were primarily harmful to recovery.

In fact, one of the biggest challenges when treating individuals with EDs, from the perspective of researchers and clinicians, is the lack of motivation to change (Carter & Kelly, 2014). Pettersen & Rosenvinge (2002) found that, for most people, the first step in the recovery process is to admit (to themselves) that they have an ED. In that respect, many individuals in, or after recovery, seem to experience a kind of "turning point" in their life.

According to Arthur-Cameselle and Quatromoni (2013), becoming aware of the negative consequences of the disorder further motivates recovery.

In another qualitative study by Linville et al. (2012), 22 recovered women were interviewed about helpful and hurtful factors for ED recovery. Participants reported that reconnecting to themselves through yoga, journaling, and spirituality played an important role in their recovery process. Developing a positive relationship with their bodies and emotions, and an awareness of their ED, as well as learning how to eat healthily and placing the focus on overall health, was viewed as helpful.

To date, several meta-syntheses have been conducted to analyze original qualitative studies of patients' perspectives of the recovery process.

Wetzler et al. (2020) for example systematically reviewed studies looking at the course of recovery of patients who had already recovered and of those who were still in the process. Six key components that patients experienced as helpful for their recovery were consistently mentioned in the reviewed studies: supportive relationships, hope, identity, meaning and purpose, empowerment, and self-compassion. De-identification from the ED was especially valuable in rebuilding one's identity and life without the disorder. Further, finding a purpose beyond the ED, taking responsibility, and self-determination played an important role in the recovery process.

In another meta-synthesis of qualitative studies focusing on helpful and unhelpful factors in ED treatments, Timulak et al. (2013) identified six categories of factors that patients experienced as supporting in recovery. These included feeling cared for and seen as a person (distinct from the ED), cognitive restructuring, and awareness and expression of one's emotions. Other contributing factors were learning about the self, self-acceptance/ self-worth, and the experience of positive life events. Further, Timulak et al. (2013) also discovered 6 different domains of unhelpful events in the recovery process. Among the factors identified as damaging were a lack of trust in others, a lack of involvement in the own treatment process, feeling alone, and experiences of hopelessness, shame, and self-judgment.

Yet, it should be noted that the just mentioned meta-syntheses focused more on personal recovery (see Wetzler et al., 2020) instead of helping and hindering factors for recovery or investigated these factors only within a treatment context (see Timulak et al., 2013). This shows the need for an overview of what helps or hinders ED recovery based on individuals' experiences including aspects that reach beyond the treatment.

Existing qualitative studies have found a substantial number of factors that patients view as important for ED recovery. Generally, these factors seem to have two overarching themes

(Cockell, Zaitsoff, & Geller, 2004): 1) external factors, such as social support from family, friends, and professionals and 2) intrapersonal factors, such as increases in positive emotions, self-esteem, and developing an identity separate from the ED. However, current meta-syntheses primarily focused either on external aspects of the ED recovery process, factors within a treatment context, or sought to analyze factors related to a personal recovery framework (see Wetzler et al., 2020). Intrapersonal aspects of the ED recovery process have been covered less extensively in the existing literature. By systematically reviewing relevant original studies, the present research intended to detect the most relevant intrapersonal helpful and unhelpful aspects of recovery and may therefore contribute to the existing knowledge in the field. Hence, using a qualitative approach and a meta-synthesis, the present study aimed to identify intrapersonal factors that are experienced as helping or hindering in ED recovery.

Methods

Design

A systematic review and meta-synthesis were conducted to identify intrapersonal helping and hindering aspects in ED recovery. Qualitative meta-synthesis is a tool to systematically analyze existing qualitative studies of a given field (Timulak, 2009; Timulak et al., 2013). It is an interpretative process with the goal to provide a comprehensive overview of a researched phenomenon describing differences and similarities within the primary data. The steps taken in this approach are 1) developing a research question, 2) selecting primary studies, 3) qualitative appraisal of the selected studies, 4) preparation of the data, 5) data analysis, and 6) credibility checks (Timulak, 2009). This study was part of a larger research project including another qualitative study that examined external helping or hindering aspects in ED recovery.

Procedure

Search strategy and selection criteria

The studies included in this meta-synthesis were selected through a search on three medical and psychological databases namely Web of Science, PubMed, and PsycINFO. The following search terms were used and connected in the search by the Boolean operator ‘AND’:

1. Qualitative research: ("qualitative" OR interview* OR focus group* OR " semi-structured" OR "structured" OR unstructured OR informal OR in-depth OR "face-to-face" OR guide OR discussion OR questionnaire* OR ethnograph* OR fieldwork*)
2. Recovery: ("recover*" OR "rehab*" OR "healing" Or "improve*" OR "remission")
3. Eating disorder: ("eating disorder*" OR "anorexi*" OR "bulimi*" OR "binge eating" OR "ednos“).

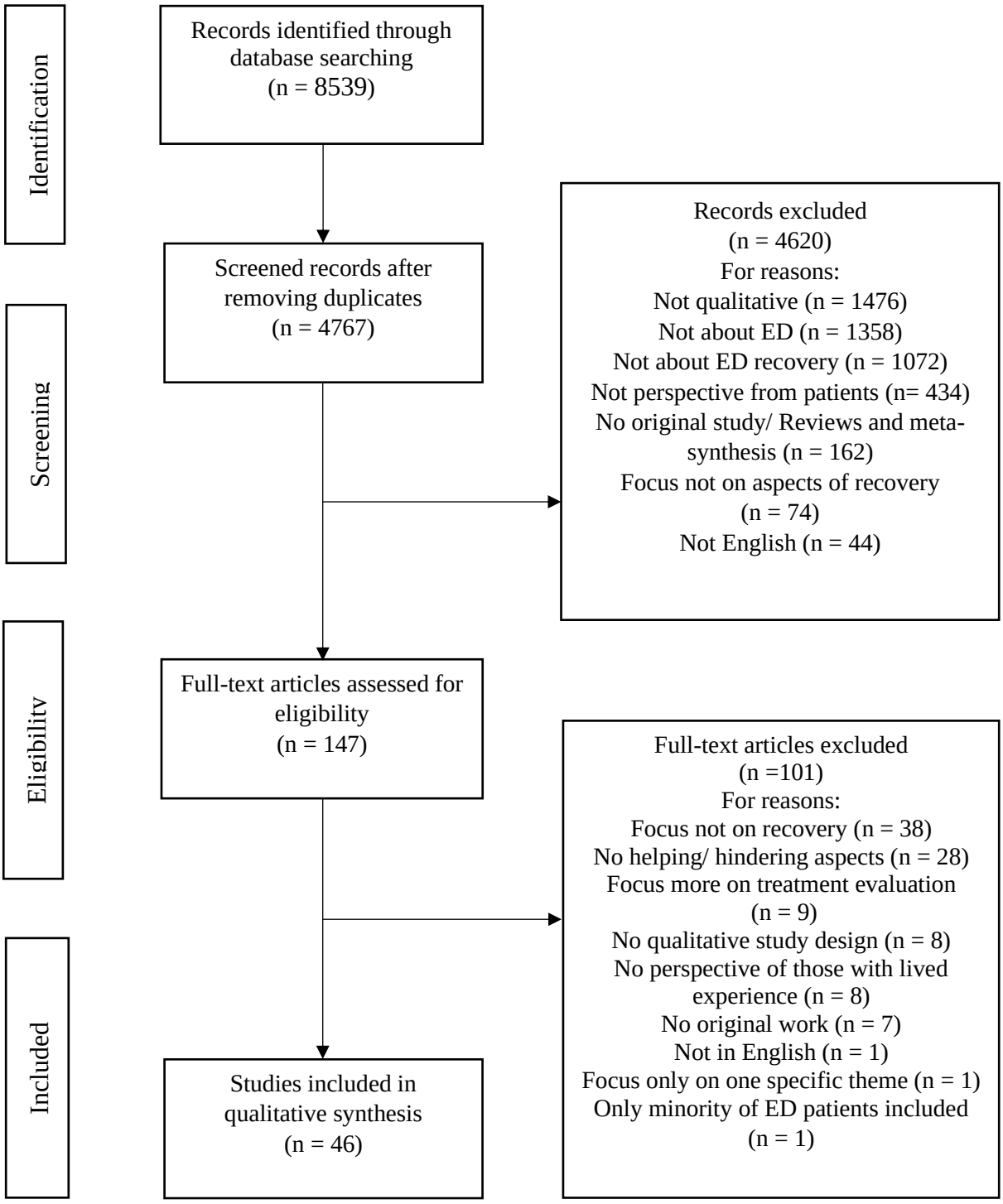
Studies were eligible for inclusion if they fulfilled the consecutive criteria. The studies had to be original as well as qualitative and exploratory research. Only peer-reviewed and English studies were included. Participants in the original studies needed to have a history with or currently have an ED and be either recovered from their ED or in the process of recovery. However, it should be mentioned that papers were also incorporated when participants' diagnoses were not clearly stated (n = 8), for example when the primary study examined transcripts of online support groups. Studies were only included if the main focus was on helping and hindering aspects of recovery, or if these aspects were described in the results within a broader context concerning the process of recovery. No date restrictions were applied, and all available years were searched on the three databases. Furthermore, studies needed to be of sufficient quality and fulfill a minimum of 5 out of 10 criteria of the CASP checklist for qualitative research (CASP, 2013).

The screening procedure was conducted collaboratively and included three consecutive phases. In the first phase, each researcher extracted the records from one database. For each database, all available records concerning the mentioned search terms were collected and imported into the reference manager "Mendeley". In total, the database search yielded 8539 articles (1750 - PsycINFO, 3770 - PubMed, 3019 - Web of Science).

After removing the duplicates, 4767 articles were included for the title and abstract screening in the second phase. Each of the three researchers screened approximately one third of the records individually, while unclear studies were discussed among all researchers. Articles that did not meet the inclusion criteria were excluded from the study and 147 articles remained. See Figure 1 for an overview of the reasons for exclusion. In the third phase, a full-text scan was conducted with the remaining articles. In the end, 46 articles were used for further analysis. In cases of uncertainty whether a study should be included, it was discussed by the researchers until consensus was reached. Details about the number of participants, participants' diagnoses, study foci, data collection methods, data analyses, number of references, and the quality of the included studies were summarized by all three researchers and are displayed in Table 4 (Appendix).

Figure 1

Flow diagram of the search and appraisal process



Critical appraisal

To determine the methodological quality of the selected studies, the Critical Appraisal Skills Program was used (CASP, 2013). The CASP is a method to systematically appraise qualitative studies and serves to assess their credibility, value, and relevance for meta-analysis-

or synthesis (de Vos et al., 2017). As proposed by the CASP, study quality was rated using the following 10 criteria: 1) a clear statement of the research aim, 2) qualitative methodology is appropriate for research aim, 3) research design appropriately addresses research aim, 4) recruitment strategy is appropriate for research aim, 5) data was collected in a way that it addresses the research aim, 6) relationships between researchers and participants are considered, 7) ethical issues are considered, 8) data analysis was sufficiently rigorous, 9) findings are clearly stated, 10) value of research. The 46 studies were equally divided between the three researchers and again, cases of uncertainty were discussed until consensus was reached. Studies that fulfilled a minimum of 5 out of the 10 criteria of the checklist were included for further analysis (see Table 2 in the appendix). More precisely, studies that met 5-8 criteria were classified as having a moderate risk of bias/ quality of the study, and studies that met 9-10 criteria as having a low risk of bias/ high quality of the study. An overview of the individual quality scores of the selected studies is provided in the appendix (Table 3).

Data preparation and thematic synthesis

After the quality assessment, two researchers collaboratively reviewed the results section of each selected study and extracted all text fragments in which participants described helpful or unhelpful aspects regarding their ED recovery into the statistical program IBM SPSS (version 26). Thereby, the original text passages were labeled with headings and subheadings that were used in the original texts. Afterward, the third researcher checked the results to ensure that all relevant original texts were included for further analysis. When it was unclear whether an original text was relevant for the analysis, the respective passage was discussed among the researchers until consensus was reached. Although studies could have a broader thematic focus, the analysis was devoted only to the parts of the studies that focused on factors in ED recovery, that patients described as helpful or hindering. Helping or hindering aspects were extracted irrespective of whether patients had received treatment or not.

The analysis process was based on the generic descriptive-interpretative framework for analyzing qualitative data by Elliot and Timulak (2005). In this approach, the following steps were taken: a) The original text fragments were assigned to different overarching themes. Themes, or meaning units, as defined by Elliot and Timulak (2015) are parts of the data that summarize sufficient information from the original results to convey a meaning when standing independently. Briefly put, the bigger a meaning unit is, the greater is the variety of meanings, but the more understandable the context of the unit (Elliot & Timulak, 2005). b) By comparing the meaning units among themselves and grouping the units with a similar essence, further categories were generated. The categories, therefore, contain clusters of themes that were

grouped based on their similarities and frequencies. c) The main findings were abstracted by summarizing the categories. To ensure the credibility and validity of the analysis, a process of independent auditing was used, as proposed by Elliot and Timulak (2005). After every step, the researchers compared and discussed their results until a coherent outcome was reached. Each researcher separately analyzed the original texts and the identified themes and categories were compared and merged into the final results upon discussion.

Results

Characteristics of the primary studies

The results of this meta-synthesis are based on the analysis of 46 research papers. The total number of participants across all included studies amounts to 1424, of which the majority were female. Twelve studies were conducted in the USA, nine in the UK, six in Canada, six in Australia, four in Norway, and one each in Finland, Belgium, and New Zealand. The most frequent diagnoses were AN and BN, while BED, OSFED, and combinations of diagnoses were also reported. However, in some studies (n = 8), participants' diagnoses were not clearly stated. Most of the studies (n = 34) used interviews to obtain the data, yet a few studies applied open-ended questionnaires or extracted the data from narratives or online blogs. Types of data analysis differed among the original studies, most predominantly used were thematic analysis and content analysis. Other approaches included grounded-theory-method or interpretive description. The years of publication of the selected studies ranged from 1985 to 2021. According to the CASP, 13 records had a moderate risk of bias/ quality, while the remaining 33 had a low risk of bias/ high quality. A detailed overview of the study characteristics can be found in the appendix (Table 3).

Intrapersonal helping and hindering factors in ED recovery

The meta-synthesis yielded five main themes pertinent to intrapersonal helping or hindering factors in recovery, each of which presented with multiple subthemes. The main themes are 1) self-determination, 2) self-care, 3) self-compassion, 4) engaging in real life, and 5) personal development. Each of the themes, the corresponding subthemes, and their role for ED recovery are presented in Table 1 and described in more detail in the following.

Table 1

Intrapersonal helping and hindering factors in ED recovery

Main theme	Subtheme
1.) Self-determination	Recovery motivation
	Becoming aware of negative consequences
	Control
2.) Self-care	Giving health priority
	Ambivalence and reluctance towards recovery
3.) Self-compassion	Self-esteem
	Acceptance and compassion
	Tolerance of emotions
4.) Engaging in real life	Applying cognitive and affective skills
	Seeking support and reaching out
	Focusing on life beyond the ED
5.) Self-knowledge and personal development	Reclaiming oneself
	Wisdom
	Spirituality

Self-determination

This theme was repeatedly mentioned across most of the analyzed studies. It contains the three subthemes recovery motivation, becoming aware of negative consequences, and control.

Recovery motivation. There was a consensus among the participants in the analyzed studies, that recovery must be a daily, conscious, and active choice (Kenny, Boyle, & Lewis, 2020; Maine, 1985). Being intrinsically motivated to recover was commonly seen as helpful and a determining factor for ED recovery. Participants had to choose recovery themselves, instead of having it imposed on them (Arthur-Cameselle et al., 2018; Button & Warren, 2001). To find the motivation to start the recovery process, participants had to acknowledge the problem (Rorty, Yager, & Rosotto, 1993) and admit the ED to themselves as a first step (Pettersen & Rosenvinge, 2002). Other necessary ingredients of the recovery process included willpower and decision-making (Nilsen et al., 2020). A sense of determination to "get the illness out of ones' life" (Tozzi et al., 2003) and to study, work, have children, or quite simply to be free, and happy (Lyckhage et al., 2015) was frequently reported to be useful.

Suffering from an ED was generally associated with a loss of quality of life. Hence, regaining a sense of autonomy (Nordbø et al., 2008) and the desire for a better life without the ED were major motivators for recovery (Rorty, Yager, & Rosotto, 1993; Mitchison et al, 2016). The belief that recovery is possible (Arthur-Cameselle & Baltzell, 2012; Hay and Cho, 2013) and focusing on what is regained in recovery (Arthur-Cameselle & Baltzell, 2012) were further helpful. Noticing that their ED led to unhappiness (Williams & Reid, 2009), and reduced sports performance motivated participants to recover (Arthur-Cameselle & Curcio, 2018), as did having energy and being able to have kids one day (Arthur-Cameselle et al., 2018).

On the other hand, seeing recovery as impossible to achieve (Dawson, Rhodes, & Touyz, 2014) and questioning one's ability to fully recover (Jenkins & Ogden, 2012) were experienced as barriers to recovery.

Becoming aware of negative consequences. Becoming aware of negative consequences was described in many studies as a catalyst for motivation to recover. For instance, many participants reported the experience of a turning point (Tozzi et al., 2003; Nilsson & Hägglöf, 2006; Pettersen, Wallin, & Björk, 2016; Lewke-Bandara et al., 2020), which often included increasing awareness of the medical consequences and the health risks involved (Arthur-Cameselle & Curcio, 2018). Reaching an intolerable point and experiencing moments of epiphany or sudden remarkable change (Venturo-Conerly et al., 2020) drove participants towards recovery. Emotional low points (Venturo-Conerly et al., 2020), being tired of being sick (Nilsson & Hägglöf, 2006), and the ability to see for the first time what others saw (in the mirror) (Matusek & Knudson, 2009), further motivated the desire to recover. Generally, participants experienced the realization of physical concerns caused by their ED as helpful for recovery, to the effect that they came to comprehend the seriousness and urgency of the situation (Tozzi et al., 2003). Besides the physical dimension, becoming aware of negative consequences further encompassed an apprehension for the experiences and opportunities lost due to the ED (Pettersen et al., 2013). Here, participants repeatedly mentioned the ability to have children (Arthur-Cameselle et al., 2018) and to establish a family life (Pettersen et al., 2013) as motivation to recover. Acknowledging the losses associated with the illness led participants to believe that they would be better off without their ED (Jenkins & Odgen, 2012), which consequently facilitated recovery.

Control. The concept of control in ED recovery seemed quite ambiguous for many participants. On the one hand, acknowledging that their lives were further out of control with the ED than without the condition (Patching & Lawler, 2008) and consequently taking control over ones' life was frequently mentioned as a helpful factor in recovery (Krentz, Chew, &

Arthur, 2005; D'Abundo & Chally, 2004). This included establishing an internal locus of control, which consequently increased the motivation to recover (Dawson, Rhodes, & Touyz, 2014). Next to that, gaining control over the "ED voice" led to it losing its' power, which was beneficial for recovery (Jenkins & Odgen, 2012). On the other hand, recovery was described as a process of letting go that was facilitated by relinquishing the control that the ED had given them (Kenny, Boyle, & Lewis, 2020).

Feeling controlled by the ED was experienced as unhelpful (Dawson, Rhodes, & Touyz, 2014), and feeling the need to be in control interfered with the maintenance of recovery behaviors (Cockell, Zaitsoff, & Geller, 2001).

Self-care

This theme consisted of the two sub-themes giving health priority and ambivalence and reluctance towards recovery.

Giving health priority. Valuing one's health and giving it priority (Björk & Ahlström, 2008) was consistently viewed as helpful for recovery. Establishing a positive body image (Lord et al., 2016) and a healthy relationship with the body (Krentz, Chew, & Arthur, 2005) was experienced as valuable for the recovery process and included cooperating with one's body and fulfilling its' needs (Björk & Ahlström, 2008). Participants reported that changing their relationship with food facilitated the development of a healthier relationship with their bodies (Krentz, Chew, & Arthur, 2005). Especially for those who suffered from AN, stabilizing weight and eating in the early phases of recovery was experienced as crucial and beneficial for further improvement (Pettersen, Wallin, & Björk, 2016). The desire to set a healthy example, either for one's children (Linville et al., 2012) or for other young women (D'Abundo & Chally, 2004) was further assisting recovery.

Losing weight or attempting at weight loss during recovery was hindering and promoted more disordered eating behaviors (Lord et al., 2016). Maintaining a "minimum healthy weight" was another barrier to recovery that could even lead to relapse (Mitrofan et al., 2019), and was most frequently mentioned among participants with AN.

Ambivalence and reluctance towards recovery. Participants frequently described the realization that they had a choice (Matoff & Matoff, 2001) and that they were the only ones who could help themselves as invaluable. A reappraisal of recovery as a difficult, but manageable process helped participants to further commit to it (McNamara & Parsons, 2016).

However, for many participants, the ED had been a space to experience, reflect, and control their feelings (Toto-Moriarty, 2013). If what participants received from their ED was perceived as more, or better, than the burden they experienced outside their ED, then

participants had difficulties letting go of the disorder (Nilsen et al., 2020). The fear of not being anything without their ED (Lamoureux & Bottorff, 2005) that some participants reported, led to a reluctance to engage in recovery behaviors. This hesitancy to commit to recovery was reinforced when participants had unrealistic expectations about recovery (Cockell, Zaitsoff, & Geller, 2001). Not wanting to recover, as well as comorbidities of depression and other mental disorders were major barriers to recovery (Arthur-Cameselle et al., 2018).

Self-compassion

This theme consisted of the three subthemes self-esteem, self-acceptance, and tolerance of negative emotions.

Self-esteem. The importance of self-esteem for recovery was reported in many of the analyzed studies. While self-esteem seemed to increase the further participants were in their recovery process (Tozzi et al., 2003; Rorty, Yager, & Rossotto, 1993), the development of a stronger and more confident sense of self (Matoff & Matoff, 2001; Smith et al., 2016) simultaneously facilitated recovery. Hence, engaging in recovery behaviors reinforced participants' self-esteem, and vice versa. Overcoming a victim role (Pettersen et al., 2013), and feeling seen as a whole person and not as "a walking ED" (Smith et al., 2016) was important for participants' sense of self and positively impacted the recovery process. Reaching new personal milestones and goals augmented their self-respect (Nilsen et al., 2020; Rorty, Yager, & Rossotto, 1993), which was experienced as helpful for further improvement. Additionally, finding new intrinsic sources of self-worth (Granek, 2007) not related to their ED helped participants to maintain recovery behaviors.

On the contrary, perceiving oneself as "not good enough" (Lamoureux & Bottorff, 2005), as well as having low self-esteem and a poor body image (Arthur-Cameselle et al., 2018) was detrimental for recovery. Further hindering aspects were feelings of insecurity and powerlessness (Lamoureux & Bottorff, 2005), as well as guilt and self-blame (Lord et al., 2016). Stigma about participants' EDs, both internalized and social, compounded low self-esteem and were seen as a barrier to recovery (McCallum & Alaggia, 2021). On the other hand, feeling overconfident about recovery could lead to relapse (Federici & Kaplan, 2008).

Acceptance and compassion. The concept of acceptance was frequently mentioned in varying contexts and predominantly described as helpful, and by some even considered as the initiator of the recovery process (D'Abundo & Chally, 2004). It included the acceptance of family problems and acknowledgment of ones' family as a system that participants could not change (Maine, 1985). This, in turn, allowed for more self-acceptance and thus helped participants to recover. In line with that, accepting oneself as a person with varied

characteristics (Nordbø et al., 2008) and accepting oneself as good enough (Björk & Ahlström, 2008) was further described as helpful. The journey to self-acceptance was facilitated by accepting one's limitations (Björk & Ahlström, 2008) and lowering ones' self-expectation, which simultaneously drove participants' wish to recover (Nordbø et al., 2008). It was repeatedly mentioned that recovery was proceeded by a shift in participants' thinking about their bodies (Mitchison et al., 2016). This included the recognition that ones' worth as a person was not related to the number on the scale (Granek, 2007) and the feeling of looking good enough without demanding changes (Björk & Ahlström, 2008).

Comparison to others was regularly described as unhelpful for recovery (Arthur-Cameselle et al., 2018; Keski-Rahkonen & Tozzi, 2005), and associating ones' value with thinness was another barrier to recovery (Granek, 2007). Self-hatred, negativity about the self (Williams & Reid, 2009), and using eating restrictions as self-punishment (Williams & Reid, 2009; Arthur-Cameselle & Quatromoni, 2014) were major barriers to recovery, the latter being especially relevant in AN.

Tolerance of emotions. This subtheme concerns participants' emotions and feelings towards their ED and their recovery journey. Learning to identify and tolerate negative emotions was central to the recovery process and unanimously reported as helpful (Federici & Kaplan, 2008). There was general agreement that the recognition of many years of repressed emotions (Pettersen et al., 2013) and finally starting to express ones' emotions was invaluable for recovery (Cockell, Zaitsoff, & Geller, 2001). Furthermore, self-examination (Cockell, Zaitsoff, & Geller, 2001) and gaining an understanding of the connection between ED symptoms and ones' emotions (Toto-Moriarty, 2013) was helpful. Managing a sense of vulnerability (Lamoureux & Bottorff, 2005) and experiencing the necessary discomfort of recovery were essential for progress (Kenny, Boyle, & Lewis, 2020). Relating to that, finding ways to handle unpleasant emotions without blaming themselves or starting to behave destructively, helped participants to maintain recovery behaviors (Björk & Ahlström, 2008). Experiencing loneliness due to their ED was helpful in the sense that it drove participants' wish to recover (Nordbø et al., 2008). Grief over losses made participants stronger (Pettersen, Wallin, & Björk, 2016), and losses that were perceived as "good", such as splitting up when being in a toxic relationship or leaving ones' husband after an unhappy marriage, further facilitated recovery (Pettersen, Wallin, & Björk, 2016).

Recovery was hindered when respondents felt overwhelmed by feelings that were repressed earlier (Björk & Ahlström, 2008) and were unable to express their emotions (Williams & Reid, 2009). Perfectionism and obsessive and negative thoughts were unhelpful

for progress (Macdonald et al., 2018; Arthur-Cameselle & Quatromoni, 2014), as were feelings of being alone and misunderstood (Cockell, Zaitsoff, & Geller, 2001). Experiencing periods of grief made it necessary for some participants to "keep" the ED symptoms for some time to comfort themselves, but did not help them recover (Pettersen et al., 2013). Furthermore, participants reported that recovery was hindered by an intense fear of failure (Federici & Kaplan, 2008), as well as by a general fear for recovery (Williams & Reid, 2009).

Engaging in real life

This theme consisted of the three subthemes applying cognitive and affective skills, seeking support/ reaching out, and focusing on life beyond the ED.

Applying cognitive and affective skills. There was a consensus among participants of the analyzed studies that the development of new coping mechanisms was helpful and essential for recovery to occur (Arthur-Cameselle et al., 2018). Such beneficial coping strategies included cognitive and behavioral challenging, helpful self-talk, self-awareness, and mindfulness (Dawson, Rhodes, & Touyz, 2014), as well as focusing on positive aspects of the self (Federici & Kaplan, 2008). Changing ones' attitudes, thoughts, and reactions (Arthur-Cameselle & Quatromoni, 2014; Macdonald et al., 2018) and having a future- and goal-oriented focus further assisted recovery (Nilsen et al., 2020). Other helpful coping mechanisms that participants repeatedly mentioned were taking time alone, keeping a journal of thoughts and feelings (Cockell, Zaitsoff, & Geller, 2001), as well as meditation, visualization, and yoga (Matusek & Knudson, 2009; Moulding, 2016). Applying nutritional knowledge and psychological skills learned in treatment (Cockell, Zaitsoff, & Geller, 2001) helped to develop a new pathway in life as a "self-healer" (Moulding, 2016), which in turn had a positive impact on the recovery process.

The need for structure seemed to play a crucial role in recovery (Cockell, Zaitsoff, & Geller, 2001). Participants frequently reported that planning meals, activity, and self-care were helpful and gradually led to improvement (Pettersen, Wallin, & Björk, 2016). Relearning how to eat (Pettersen, Wallin, & Björk, 2016) and making eating part of a routine (Cockell, Zaitsoff, & Geller, 2001) also helped. Repeatedly practicing these healthy behaviors (Dawson, Rhodes, & Touyz, 2014) and avoiding ED triggers (Arthur-Cameselle et al., 2018) further supported recovery.

Barriers to recovery included hearing other people talk about dieting, reading fashion magazines, watching TV, and focusing on weight and shape (Cockell, Zaitsoff, & Geller, 2001). Daily hassles (Cockell, Zaitsoff, & Geller, 2001) and having many competing stressors or priorities led to worsening of the ED and triggered relapse (Mitchison et al., 2016).

Seeking support and reaching out. The understanding that one needed help to move further (Pettersen, Wallin, & Björk, 2016) and learning to trust were key ingredients of recovery (Lamoureux & Bottorff, 2005). Talking to someone was very helpful for improvement (Arthur-Cameselle & Baltzell, 2012) while sharing ones' experiences simultaneously promoted a sense of identity and personal power (Toto-Moriarty, 2013). Here, it helped to have an important person (Rorty, Yager, & Rossotto, 1993) and to use language as a communication tool instead of the body (Jenkins & Odgen, 2012). Spending time with other people who do not have an ED (Cockell, Zaitsoff, & Geller, 2001) and receiving consultation for the ED promoted the wish to recover (Nordbø et al., 2008). Experiences of being happy when being with others (Nordbø et al., 2020), and a newfound sense of belonging (Moulding, 2016) further supported recovery.

The perception that nobody knew how to help them (Arthur-Cameselle et al., 2018) and feeling invisible (McCallum & Alaggia, 2021) hindered participants in their recovery.

Focusing on life beyond the ED. A catalyst for recovery was participants' realization that other aspects of life required prioritizing over their ED (McCallum & Alaggia, 2021). This included participation in normal lifestyle activities (Macdonald et al., 2018) and having something meaningful and satisfying in life that was not related to the ED (Cockell, Zaitsoff, & Geller, 2001). Making room for life, thinking about the future, and pursuing ones' hopes and desires (Krentz, Chew, & Arthur, 2005) was experienced as helpful. Relationships and reconnecting with others were very important (Cockell, Zaitsoff, & Geller, 2001). In this context, receiving invitations to parties and being spontaneously made participants feel good about themselves (Nordbø et al., 2008). Leisure activities were consistently described as helpful and made it easier to manage ED symptoms (Pettersen, Wallin, & Björk, 2016; Cockell, Zaitsoff, & Geller, 2001). Traveling and experiences of being happy when engaging in an activity (Nordbø et al., 2020) further assisted recovery. Another helpful aspect was participants' professional life, which was described as a sphere where one could be more than an individual living with an ED (McCallum & Alaggia, 2021).

However, fearing that ones' professional standing would be compromised if others knew about their ED could hold participants back and thus hindered their recovery (McCallum & Alaggia, 2021). While it was predominantly described as helpful, the return to regular life was likewise reported as a trigger for relapse (Cockell, Zaitsoff, & Geller, 2001).

Self-knowledge and personal development

This theme consisted of the three subthemes reclaiming oneself, wisdom, and spirituality.

Reclaiming oneself. Externalizing ones' illness was consistently mentioned among all participants as invaluable for recovery (Dawson, Rhodes, & Touyz, 2014). The adjunctive process of reclaiming oneself was often initiated by identifying the level of disconnection from the self, which increased respondents' desire for recovery (Patching & Lawler, 2008). Hence, reconnecting with the body and the self was helping participants to recover (Linville, et al., 2012). The importance of redefining ones' role (McCallum & Alaggia, 2021) and rejecting the ED as a part of their new self-identity (Jenkins & Odgen, 2012) was consistently mentioned as fundamental and beneficial for recovery. Getting better mainly had to do with giving up their ED-identity (Keski-Rahkonen & Tozzi, 2005) and forming a new identity separate from the ED (Lamoureux & Bottorff, 2005), as well as participants being able to know better who they were, what their needs are, and what they liked (Nordbø et al., 2008). The journey of self-transformation included a deeper understanding of life (Moulding, 2016) and a reconciliation of what defines a good and worthy person (Granek, 2007), as well as learning to set boundaries, and gaining a more realistic perspective of oneself (Lamoureux & Bottorff, 2005). Openness in recovery was helpful for reorientation (Pettersen, Wallin, & Björk, 2016), and making choices not governed by the ED resulted in feelings of empowerment (Smith et al., 2017), which consequently supported recovery. Furthermore, self-monitoring, which created a sense of awareness (Toto-Moriarty, 2013), and gaining a new sense of responsibility for oneself (Maine, 1985) were often reported to be helpful.

Experiencing a sense of disconnection from oneself (Cockell, Zaitsoff, & Geller, 2001), and the thought that without their ED they might not be anything (Lamoureux & Bottorff, 2005) hindered participants' recovery.

Wisdom. Wisdom and experience were frequently reported as helpful to move toward recovery (McCallum & Alaggia, 2021) and work on oneself (Matusek & Knudson, 2009). Wisdom provided the ability to step back and assess life (McCallum & Alaggia, 2021) and to reflect on what is important (Arthur-Cameselle & Baltzell, 2012), which drove participants' wish to recover. This included changes in perception of one's ED from something valuable to something damaging and destructive (Dawson, Rhodes, & Touyz, 2014) as well as increasing awareness of recovery benefits (Macdonald et al., 2018). It was repeatedly mentioned that, for recovery to happen, participants had to find the root of their ED first (Arthur-Cameselle & Baltzell, 2012). Consequently, new insights into the role of their ED (Arthur-Cameselle & Curcio, 2010) and increasing awareness about the possible cause and function of the ED (Dawson, Rhodes, & Touyz, 2014) helped to move further in recovery. Other helping factors

were time (Arthur-Cameselle et al., 2018), maturation, and growing up (Tozzi et al., 2003), and becoming clearer in thinking about managing one's life (Nordbø et al., 2008).

On the other hand, a lack of insight and understanding of one's ED hindered recovery (Dawson, Rhodes, & Touyz, 2014).

Spirituality. Religion (Tozzi et al., 2003) and spirituality (Krentz, Chew, & Arthur, 2005) were repeatedly mentioned as helping factors in ED recovery. Some participants saw their relationship with God (Arthur-Cameselle et al., 2018) and faith as essential to the process of recovery (D'Abundo & Chally, 2004) and reported that the hand of God and the church community changed their life (Matusek & Knudson, 2009). Others felt a spiritual and moral obligation to get better (Matusek & Knudson, 2009), which helped them to move toward recovery. Using faith, prayer, and meditation to surrender the need for control (Arthur-Cameselle & Quatromoni, 2014) was further assisting recovery.

Discussion

This meta-synthesis examined intrapersonal helping and hindering factors for ED recovery from the perspective of individuals with lived experiences. Considering the high relapse rates and modest effectiveness of treatments for EDs, it may be especially useful to examine qualitative studies that investigated the account of those affected regarding the ED recovery process to improve the effectiveness and appropriateness of interventions. Hence, a meta-synthesis of the relevant primary studies may offer a unique perspective on helpful and hindering factors in ED recovery from the perspective of affected individuals and may consequently add to the current knowledge.

Intrapersonal helping and hindering aspects of ED recovery

The meta-synthesis yielded several interesting findings, that will be reflected on respectively for each main theme. Thereupon, it will be discussed how the discovered helping and hindering aspects may be related across the themes, and which aspects might be more important than others.

Reflecting on the first theme, *self-determination*, the outcomes of the analysis showed that the importance of self-determination and intrinsic motivation to recover should not be underestimated. It was evident that, for recovery to happen, participants had to come to a point where they were able to let go of their ED and commit themselves to the recovery process, without having it imposed on them by another person. These findings resonate with the research of past decades, which has repeatedly demonstrated motivational issues among EDs (Vansteenkiste, Soenens, & Vandereycken, 2005). It has been shown that a sustained recovery is more likely among individuals who take an active role in the recovery process and who are

ready to change (Cockell, Zaitsoff, & Geller, 2001). A fair amount of research into motivation to change among individuals with EDs has been based on self-determination theory (SDT) (Vansteenkiste, Soenens, & Vandereycken, 2005). According to SDT, it can be differentiated between two types of motivation: intrinsic motivation and internalized external motivation, while internal motivation is usually equated with a high-quality level of motivation. Regarding ED recovery, Vansteenkiste, Soenens, & Vandereycken (2005) suggest that to enhance motivation to change, people must learn the personal importance of changing their (destructive) behaviors. Outcomes of the present study imply that patients share this perspective and feel that increasing awareness of health consequences might help people with EDs to grasp the urgency of behavioral change, which in turn may increase the motivation to recover.

The concept of control appeared to be a highly controversial aspect, which may be both helping and hindering the recovery process, dependent on its context. Progress in recovery seemed to involve a process of regaining control over ones' life, such as making choices that are not governed by the ED. Simultaneously, relinquishing control as in letting go of ED behaviors like restricting ones' intake, was essential to move further towards recovery. Ergo, gaining control seemed to be helpful when controlling aspects in life that went beyond the ED, while relinquishing control was described as helpful when referring to ED behaviors. This finding is in line with observations in previous research, which led to the proposal that EDs embody an unsuitably adapted search for control, that is caused by the perception of being controlled by external forces (Williams, Chamove, & Millar, 1990).

Regarding the second theme, *self-care*, a worthwhile finding was the frequent observation of ambivalence towards recovery and the ED in general. It appears that, despite an awareness of the tremendous negative consequences, the recovery process might be hindered by the fact that some experience their ED as a "safe space" and continue to value the perceived benefit of engaging in ED behaviors. This finding was consistent with previous research outcomes and seems to be particularly common among people with AN (Adshead, 2009).

Within the theme of *self-compassion,* the outcomes highlighted the importance of self-esteem in ED recovery. Participants consistently reported that low levels of self-esteem were a major barrier to recovery and emphasized the value of developing more self-respect and self-confidence. Strikingly, progress in recovery seemed to facilitate this process and vice versa. This would suggest the usefulness of interventions to increase self-esteem at early stages within the recovery process. Previous research has indeed indicated that deficits in self-esteem may play an important role in the etiology and maintenance of EDs (Grubb, Sellers, & Waligroski, 1993).

An interesting observation was that the concept of acceptance was especially often mentioned in the context of the respondents' families. Familial problems seemed to play a significant role in many participants' EDs. Accepting ones' family situation was often the first step to accepting oneself and consistently described as helpful for recovery. This finding resonates with overwhelming evidence suggesting an association between (perceived) family functioning and the development and maintenance of EDs (Holtom-Viesel & Allan, 2014). In fact, family-focused therapy has emerged as one of the strongest evidence-based treatments for EDs, especially for AN (Jewell et al., 2016). According to Jewell et al. (2016), this treatment is likely to be effective because it aims at providing a non-blaming and supportive context. However, in their critical review of family therapy for EDs, it is emphasized that more research is needed to develop an understanding of the moderators and mediators that are involved in this treatment. The findings of the present study suggest that the concept of acceptance might be one moderator implicated in the effectiveness of this specific treatment approach, nonetheless, further evidence is needed to support this claim.

On reviewing what helps and hinders individuals in recovering from their ED, it became clear that recovery was commonly experienced as an extremely emotional process. Participants often reported that they felt overwhelmed by feelings that were repressed in the past and then suddenly came up once participants let go of their ED. Considering that EDs usually represent an individuals' best attempt to cope (Cockell, Zaitsoff, & Geller, 2001), it is not surprising that many are struggling to recover and even turn back to previous ED patterns. This illustrates that symptom-focused recovery in traditional clinical approaches cannot fully capture the experience of recovery of those who suffer from an ED (Wetzler et al., 2020).

Within theme four, *engaging in real life*, participants repeatedly emphasized the importance of learning new coping mechanisms to substitute these for ED behaviors. Here, a wide array of strategies was mentioned to be helpful, including cognitive restructuring, self-reflection, and mindfulness techniques. It was interesting to observe that many participants valued having a certain structure, especially regarding eating itself. Nonetheless, the mere acquisition of new coping mechanisms was not sufficient; to maintain recovery, participants had to repeatedly practice the newly learned behaviors. Given that most intensive ED treatments are limited in time (Cockell, Zaitsoff, & Geller, 2001), and not available to everyone, these findings may explain to a certain extent, why many patients tend to relapse when returning to their usual environment.

Within the last theme, *self-knowledge and personal development*, and among the most often reported helpful aspects for ED recovery was the externalization of the illness and the

reinvention and development of ones' identity. Since it had taken up so much space in their lives, many participants had started to identify themselves with their ED. With recovery, participants had to reconnect with themselves and form an identity separate from the ED. This finding resonates with overwhelming evidence suggesting that ED recovery involves a process of redefining and rediscovering oneself (Bowlby, et al., 2012; Lamoureux & Bottorff, 2005).

Another interesting, but more general observation concerned the overrepresentation of helping factors within the primary literature. As can be seen in the results section of this paper, many of the original studies tended to focus more on helping aspects for ED recovery rather than on factors that might hinder this process. Nevertheless, it could be argued that in some instances, barriers to recovery might simply be the absence of helping factors, like for example insight into the role of ones' ED was found to be helpful and a lack thereof was hindering recovery.

Reflecting on the relationship of helping and hindering factors across the themes, it became clear that several of the subthemes were interrelated. *Recovery motivation* and *becoming aware of negative consequences* for instance were closely linked since participants' motivation to recover was often evoked by increasing awareness of the physical, psychological, and social consequences of the illness. *Becoming aware of negative consequences* was related to the subtheme *giving health priority*, as the realization of the medical consequences and health risks of the disorder stimulated participants to prioritize their health. Furthermore, *becoming aware of negative consequences* and *ambivalence and reluctance towards recovery* were interrelated and overlapped to a certain extent since the circumscribed ambivalence could also be considered as an (im-)balance in participants' experience of positive and negative consequences of the ED. Still, it was distinguished between these two subthemes, because certain aspects within the theme of *ambivalence and reluctance towards recovery* went beyond the realization of negative consequences, like for instance participants' fear of not being anything without the ED. Another interaction could be observed between the subthemes *self-esteem* and *reclaiming oneself* since both included a process of externalizing the ED, although these appeared to be distinct processes. On the one hand, this de-identification with the ED reinforced participants' self-esteem, which in turn was helpful for recovery. On the other hand, it led to a process of reconnecting with oneself and forming a new identity without the disorder.

Based on the frequency with which these aspects were mentioned in the primary literature, the theme of *self-determination*, including the subthemes of *recovery motivation* and *becoming aware of negative consequences* seemed particularly important for recovery. Additionally, it was crucial for participants to externalize the illness and to build an identity

separate from the ED, which was often circumscribed as a process of *reclaiming oneself*. Contrarily, the subtheme of *spirituality* appeared less frequently in the selected studies and is therefore assumed to play an inferior role in recovery or to be relevant for a smaller and specific group of people. While the analysis was conducted using distinctive themes, within later stages of the analysis it became evident that some overlap between the themes exists when looking at what was important from a broader perspective. Therefore, recovery seems to be an intersectional process involving a combination of the above-mentioned helpful aspects.

Comment on the method and strengths and limitations of this study

When interpreting the findings of this meta-synthesis, several issues need to be considered. Firstly, it should be borne in mind that, while this study aimed at examining intrapersonal helping and hindering aspects in ED recovery, the analyzed original studies had a broader and varying focus. Furthermore, as mentioned before, the present study also included papers, that did not especially focus on ED treatments. While the described helping and hindering factors could refer to aspects of treatments (such as the acquisition of cognitive and affective skills), they not necessarily had to, and could just as well refer to impactful aspects that went beyond the treatment (e.g., becoming aware of negative medical consequences). However, instead of considering this a limitation, it could be seen as an addition to the uniqueness of this study, since a meta-synthesis of treatment-related helping and hindering factors in ED recovery already exists (see Timulak et al., 2013).

Secondly, it needs to be highlighted that the extracted helpful and unhelpful aspects were not reported separately from each other, but rather within each theme they referred to. Although previous studies reported their findings of helping and hindering factors in distinct sections (see Timulak et al., 2013), in this paper both helpful and unhelpful factors were presented concurrently in the description of the respective subthemes, as this order appeared to be more comprehensive for the reader.

Finally, it should be considered that it was not differentiated between types of EDs when analyzing the primary studies about individuals' experiences of recovery. This is important to mention since some of the reported findings might be more significant for certain types of EDs than others (e.g., stabilizing weight and eating in early phases of recovery was found to be especially helpful for AN). However, it was not discriminated among different types of EDs, since most of the original studies used samples with mixed ED types or included participants who presented with multiple diagnoses.

Strengths of this meta-synthesis include the systematic approach of the review, the richness of information, and the quality of the analyzed papers. Another strong point concerns

the combined interpretation, consultation, and comparison among the three researchers, as well as the synthesis of four decades of qualitative research within the field, which provides a unique perspective on helping and hindering factors in the recovery process.

A limitation of the present study revolves around the fact that the method of qualitative meta-synthesis poses several conflicts in itself. First, in the attempt to provide an inclusive overview of the studied phenomenon, natural differences between the analyzed studies, such as sample specifics, and data collection and analysis methods, might be restrained. Hence, it is possible and likely that, while trying to provide a comprehensive picture of the main outcomes, some of the detail within the analysis might have been missed.

The analyzed studies varied in the density of relevant information; hence some studies might have contributed more to the outcomes of this research than others. Furthermore, the analysis was influenced by the researchers' understanding and research experience. In that respect, it should be mentioned that there was a certain extent of overlap across the themes, meaning that some aspects could have been mentioned within other themes as well (e.g., experiencing loneliness was categorized within the subtheme *tolerance of emotions* but might also be compatible with the subtheme *becoming aware of negative consequences*.). Be that as it may, to avoid repetition, these aspects were mentioned only within the theme for which they appeared most relevant. Additionally, in some cases, it could be questioned whether the described aspect referred to an intrapersonal or rather an external process (e.g., hearing other people talk about dieting, watching TV, etc.). Yet, to ensure the credibility and validity of the analysis, a process of independent auditing was used (Elliot & Timulak, 2005).

Implications and future research

The synthesized findings of this meta-synthesis may provide useful information about ED recovery from the perspective of patients and add to current knowledge about factors that help or hinder the recovery process. A clinical implication of this knowledge may be the development of psychoeducation and guidelines for ED care, in which the perspectives of helping and hindering factors of those with lived experience are considered. The information provided in this study may benefit clinicians, family members, and affected individuals by facilitating a deeper understanding of the complexity of the illness and the processes that may eventually lead to recovery. Furthermore, this meta-synthesis highlighted the importance of taking a more inclusive approach towards recovery and focusing on aspects that go beyond mere symptom-remission, such as the externalization of the disorder, and the development of a new identity separate from the ED.

Future research should focus more closely on factors that are hindering ED recovery, as they tend to be underrepresented in the existing literature. Considering the high relapse rates and the fact that many individuals struggle to find the motivation to recover (Vansteenkiste, Soenens, & Vandereycken, 2005), a suggestion for future research would be to investigate factors that support the maintenance of recovery from the perspective of longtime recovered individuals. Considering that this meta-synthesis did not differentiate between ED types, future research is advised to examine whether the helping and hindering aspects vary for different types of EDs. Finally, it should be noted that it is difficult to analyze helping and hindering factors for a concept that itself lacks a common definition. Although this study hopefully contributed to a better understanding of factors that are important in recovery according to individuals with lived experience, future research should further work towards a common conceptualization of ED recovery.

Conclusion

This meta-synthesis aimed to examine helping and hindering intrapersonal factors in ED recovery, based on the perspectives of those with lived experience. The five overarching themes 1) self-determination, 2) self-care 3) self-compassion, 4) engaging in real life, and 5) personal development, emerged from the analysis. According to the participants in the analyzed studies, these themes play a significant role in the process of ED recovery. The synthesized findings described in this study may provide a base of knowledge about ED recovery from the perspective of patients and may thus facilitate a deeper understanding of factors that help or hinder patients in their recovery. The present study adds to an increasing focus on an inclusive and personal concept of ED recovery, which reaches beyond traditional approaches that merely focus on symptom-remission.

This holistic and unique perspective of ED recovery may provide useful information for clinicians, family members, and those affected. Outcomes of this study may have implications for the development of prevention measures, psychoeducation, and guidelines for ED care, while the recognition of perceptions of individuals with lived experience could be valuable for the development of a common and person-centered definition of ED recovery. However, to this day, the concept of ED recovery remains rather vague and lacks deeper insight. Future research is needed to validate the reported findings, to further investigate what hinders recovery, and to provide a framework for understanding the mechanisms that are involved in the recovery process and may support individuals in their efforts to recover from the illness.

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Appendix

Table 2

Critical Appraisal Skills Programme (CASP): Qualitative Research Checklist

Criteria	Potential score
1. Was there a clear statement of the aims of the research	Yes/ No
2. Is a qualitative methodology appropriate?	Yes/ No
3.Was the research design appropriate to address the aims of the research?	Yes/ No
4. Was the recruitment strategy appropriate to the aims of the research?	Yes/ No
5. Was the data collected in a way that addressed the research issue?	Yes/ No
6. Has the relationship between researcher and participants been adequately considered?	Yes/ No
7. Have ethical issues been taken into consideration?	Yes/ No
8. Was the data analysis sufficiently rigorous?	Yes/ No
9. Is there a clear statement of findings?	Yes/ No
10. How valuable is the research?	Valuable/ Not valuable

Note. The table displays the 10 criteria of the Critical Appraisal Skills Program (CASP) to determine the credibility, value, and relevance of the selected qualitative studies for meta-analysis- or synthesis.

Table 3

Critical appraisal of methodological quality of the selected studies

	Criteria											
Study	1	2	3	4	5	6	7	8	9	10	Score	Label
Williams and Reid (2009)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	10/10	A
Wallström, Lindgren, and Gabrielsson (2021)	yes	yes	yes	yes	yes	-	yes	yes	yes	yes	10/10	A
Venturo-Conerly, Wasil, Dreier, Lipson, Shingleton, and Weisz (2020)	yes	yes	yes	yes	yes	no	no	yes	yes	yes	8/10	B
Tozzi, Sullivan, Fear, McKenzie, and Bulik (2003)	yes	yes	yes	yes	yes	no	no	no	yes	yes	7/10	A
Toto-Moriarty (2013)	yes	yes	yes	yes	yes	yes	no	yes	yes	yes	9/10	A
Rorty, Yager, and Rossotto (1993)	yes	yes	no	yes	yes	no	no	yes	yes	yes	7/10	B
Smith, Chouliara, Morris, Collin, Power, Yellowlees, Grierson, Papgeorgiou, and Cook (2016)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	10/10	A
Arthur-Cameselle and Baltzell (2012)	no	yes	yes	yes	yes	yes	no	yes	yes	yes	8/10	B
Arthur-Cameselle, Burgos, Burke, Cairo, Colón, and Piña (2018)	yes	yes	yes	yes	yes	no	no	yes	yes	yes	8/10	B

Arthur-Cameselle and Curcio (2018)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	10/10	A
Macdonald, Kan, Stadler, De Bernier, Hadjimichalis, Le Coguic, Allan, Ismail, and Treasure (2018)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	10/10	B
Maine (1985)	yes	yes	yes	yes	yes	yes	-	yes	yes	yes	9/10	A
Matoff and Matoff (2001)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	10/10	A
Matusek and Knudson (2009)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	10/10	A
McCallum & Alaggia (2021)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	10/10	A
McNamara and Parsons (2016)	yes	yes	yes	yes	no	no	no	yes	yes	yes	7/10	B
Mitchison, Dawson, Hand, Mond and Hay (2016)	yes	yes	yes	yes	yes	yes	-	yes	yes	yes	9/10	B
Mitrofan, Petkova, Janssens, Kelly, Edwards, Nicholls, McNicholas, Simic, Eisler, Ford, and Byford (2019)	yes	yes	no	yes	yes	yes	yes	yes	yes	yes	9/10	A
Moulding (2016)	yes	yes	yes	no	yes	no	yes	yes	yes	yes	8/10	B
Nilsen, Hage, Rø, Halvorsen, and Oddli (2020)	yes	yes	-	yes	yes	no	yes	yes	yes	yes	8/10	B
Nilsson and Hägglöf (2006)	yes	yes	yes	yes	no	yes	yes	yes	yes	yes	9/10	A
Nordbø, Gulliksen, Espeset, Skårderud, Geller, and Holte (2008)	yes	yes	-	yes	yes	yes	-	yes	yes	yes	8/10	B

Pettersen and Rosenvinge (2002)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	10/10	A
Patching and Lawler (2008)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	10/10	A
Pettersen, Thune-Larsen, Wynn, and Rosenvinge (2013)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	10/10	A
Pettersen, Wallin, and Björk (2016)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	10/10	A
Arthur-Cameselle and Quatromoni (2014)	yes	yes	yes	yes	yes	yes	no	yes	yes	yes	9/10	A
Beresin, Gordon, and Herzog (1989)	no	yes	yes	yes	yes	yes	no	no	yes	yes	7/10	B
Björk and Ahlström (2008)	yes	yes	yes	yes	yes	no	yes	yes	yes	yes	9/10	A
Button and Warren (2001)	yes	yes	yes	yes	yes	yes	no	no	yes	yes	8/10	B
Cockell, Zaitsoff, and Geller (2001)	yes	yes	yes	yes	yes	yes	no	yes	yes	yes	9/10	A
Dawson, Rhodes, and Touyz (2014)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	10/10	A
Federici and Kaplan (2008)	yes	yes	yes	yes	yes	no	yes	yes	yes	yes	9/10	A
Granek (2007)	yes	yes	yes	yes	yes	yes	no	yes	yes	yes	9/10	A
Hay and Cho (2013)	yes	yes	yes	yes	yes	yes	-	yes	yes	yes	9/10	A
Jenkins and Odgen (2012)	yes	yes	yes	yes	yes	-	yes	yes	yes	yes	9/10	A
Kenny, Boyle, and Lewis (2005)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	10/10	B
Keski-Rahkonen and Tozzi (2005)	yes	yes	yes	yes	yes	-	yes	yes	yes	yes	9/10	B

Krentz, Chew, and Arthur (2005)	yes	yes	yes	yes	yes	-	-	yes	yes	yes	9/10	A
Lamoureux and Bottorff (2005)	yes	yes	yes	yes	yes	-	-	yes	yes	yes	8/10	A
Lewke-Bandara, Thapliyal, Conti, and Hay (2020)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	10/10	A
Linville, Brown, Sturm, and McDougal (2012)	yes	yes	yes	yes	yes	-	yes	yes	yes	yes	9/10	A
Lord, Reiboldt, Gonitzke, Parker, and Peterson (2020)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	10/10	B
Lyckhage, Gardvik, Karlsson, Mulari and Berndtsson (2015)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	10/10	B
D'Abundo and Chally (2004)	yes	yes	yes	yes	yes	yes	no	yes	yes	yes	9/10	A
De Ruysscher and Vandevelde (2015)	yes	yes	yes	yes	yes	yes	-	yes	yes	yes	9/10	A

Note. The table displays the individual scores of the quality assessment (CASP) of the selected studies.

Table 4

Details of the studies included in the analysis

Authors	Year	Country	N. of Participants	Diagnosis	Study focus	Data collection	Data-analysis	No. of references	Quality assessment
Williams and Reid	2009	United Kingdom	14	AN (*n* = 14)	opinions and experiences about maintain or recover from an ED	online focus group	Interpretative phenomenological analysis (IPA	44	10/10 A
Wallström, Lindgren, and Gabrielsson	2021	Sweden	27	unknown	experiences of inpatient care supporting recovery	via online blogs	Interpretative description	40	10/10 A
Venturo-Conerly, Wasil, Dreier, Lipson, Shingleton and Weisz	2020	USA	13	AN (*n* = 6) BN (*n* = 2) OSFED (*n* = 5)	factors promoting motivation for ED recovery	interviews with follow-up questions	Thematic analysis	40	8/10 B
Tozzi, Sullivan, Fear, McKenzie, and Bulik	2003	New Zealand	70	AN (*n* = 70)	causes and recovery in AN	interviews with open-ended questions	unclear	82	7/10 A
Toto-Moriarty	2013	USA	14	BN (*n* = 14)	efficacy of psychodynamic psychotherapy for BN	a semi-structured interview	Narrative inquiry	32	9/10 A
Rorty, Yager, and Rossotto	1993	USA	40	BN	describing experiential aspects of women's recovery from bulimia nervosa	semi-structured interview	Thematic analysis	21	7/10 B
Smith, Chouliara, Morris, Collin, Power, Yellowlees, Grierson, Papageorgiou, and Cook	2016	UK	21	AN	exploring women's experiences of specialist inpatient treatment for AN during their treatment admission	semi-structured interview	Thematic analysis	58	10/10 A

Arthur-Cameselle and Baltzell	2012	USA	16	AN (n = 8) BN (n = 2) EDNOS (n = 2) AN > BN (*n* = 3), AN > EDNOS (*n* = 1)	giving advice on how to facilitate recovery in athletes from personal experience	in-depth interview	Thematic analysis	31	8/10 B
Arthur-Cameselle, Burgos, Burke, Cairo, Colón, and Piña	2018	USA	154	AN (n = 47) BN (n = 27) BED (*n* = 12) OSFED (n = 20) multiple (n = 48)	examining on factors that assisted and hindered participants' progress towards recovery	qualitative survey	An inductive approach: Consensual Qualitative Research	34	8/10 B
Arthur-Cameselle and Curcio	2018	USA	29	AN (n = 17) BN (n = 3) BED (*n* = 1) both AN and BN (n = 8)	to identify turning points that initiated recovery from clinical EDs	semi-structured interview	The inductive coding protocol outlined in Consensual Qualitative Research	44	10/10 A
Macdonald, Kan, Stadler, De Bernier, Hadjimichalis, Le Coguic, Allan, Ismail, and Treasure	2018	UK	9	AN (*n* = 4), BN (*n* = 3) OSFED (*n* = 2)	explore perspective of people with Type 1 diabetes and eating disorders to understand the experience	semi-structured interview	Six-stage framework of thematic analysis	31	10/10 B
Maine	1985	UK	25	AN (*n* = 25)	establish efficacy of treatment for ED recovery through the experiences of patients	in-depth, semi-structured interview guide	Holsti's (1968) thematic content analysis	26	9/10 A
Matoff and Matoff	2001	UK	1	AN	analyze some of the coping skills and important elements in the recovery process	two in-person interview sessions	Restrospective examination	14	10/10 A
Matusek and Knudson	2009	USA	3	AN (*n* = 2), BN (*n* = 1)	we portray women’s experiences of long-term recovery	semistructured interview	Thematic analysis	43	10/10 A

McCallum and Alaggia	2021	Canada	19	AN (*n* = 19)	understanding of what it means to be living with AN in midlife	in-depth narrative analysis	Constructivist grounded theory methodology	67	10/10 A
McNamara and Parsons	2016	UK	75	AN (20%), BN (28%), BED (32%)	explores how a sense of shared identity helps individuals with eating disorders manage their condition and promotes recovery	transcripts from 18 online support sessions involving	Thematic analysis	67	7/10 B
Mitchison, Dawson, Hand, Mond, and Hay	2016	Australia	19	AN (*n* = 3), BN (*n* = 7), BED (*n* = 5) OSFED (*n* = 4)	explore individual sufferers' perspectives on the influence of QoL on the onset, maintenance, and/or remission of ED symptoms.	semi-structured interview	Thematic analysis	47	9/10 B
Mitrofan, Petkova, Janssens, Kelly, Edwards, Nicholls, McNicholas, Simic, Eisler, Ford, and Byford	2019	UK	19	AN (*n* = 16), BN (*n* = 1), OSFED (*n* = 2)	to explore young people's and parents' experiences of care for eating disorders, both positive and negative	six online focus groups	Thematic analysis	40	9/10 A
Moulding	2016	Australia	14	AN (*n* = 5), BN (*n* = 2), AN/BN (*n* = 1), recovered (*n* = 8)	explicitly situate women's experiences in day-to-day intersubjective gender relations, discourses, and practices through a feminist theoretical frame and explore the connections between anorexia, gender, and spirituality	in-depth interview	Thematic analysis	45	8/10 B

Nilsen, Hage, Rø, Halvorsen, and Oddli	2020	Norway	37	AN (*n* = 37)	investigate the reflections of young persons with a lived experience of anorexia nervosa, and what factors they consider important for the recovery process	semi-structured interview	T Thematic analysis	58	8/10 B
Nilsson and Hägglöf	2006	Sweden	68	AN (*n* = 10), recovered (*n* = 58)	describe the patients' per- spective of the recovery process from anorexia nervosa.	interview	Content analysis according to definitions by Graneheim and Lundman (2004) and Kvale (1996).	16	9/10 A
Nordbø, Gulliksen, Espeset, Skårderud, Geller, and Holte	2008	Norway	18	AN (*n* = 18)	investigated the content of patients' wish to recover.	in-depth interview	Verbatim-transcribed interviews were analyzed by means of The software program QSR-N*Vivo.	27	8/10 B
Pettersen and Rosenvinge	2002	Norway	48	AN (*n* = 10), BN (*n* = 10), BED (*n* = 28)	describe (1) factors that are identified by sufferers of eating disorders as contributing to their recovery, (2) how sufferers define recovery from eating disorders, and (3) to relate the subjective experiences with measures of eating disorder symptom load, personal health control	open interview	Interviews were coded according to a detailed categorical system	20	10/10 A

Patching and Lawler	2008	Australia	20	AN (*n* = 6), BN (*n* = 2), AN/BN (*n* = 12)	gain a greater understanding of the entire experience of developing, living with and recovering from an eating disorder.	life-history interviews with	Interpretative description	25	10/10 A
Pettersen, Thune-Larsen, Wynn, and Rosenvinge	2013	Norway	13	AN, BN	to describe patients experience of the later recovery phases of eating disorders	interview	Content analysis	40	10/10 A
Pettersen, Wallin, and Björk	2016	Sweden	15	AN (*n* = 10), BN (*n* = 4), OSFED (*n* = 1)	investigate what males experience as helpful in their recovery process from eating disorders (ED).	in-depth interview	Content analysis	26	10/10 A
Arthur-Cameselle and Quatromoni	2014	USA	16	AN (*n* = 8) BN (*n* = 2) BED (*n* = 2) AN > BN (*n* = 3), AN > BN (*n* = 3), AN > BED (*n* = 1)	to acquire comprehensive information about initiation and achievement of recovery from EDs	semi-structured interview	Thematic analysis with content analysis procedures	56	9/10 A
Beresin, Gordon, and Herzog	1989	USA	13	AN (*n* = 13)	to understand the patient from her perspective regarding causes and recovery, including helpful and harmful experiences	structured interview	Qualitative analysis	43	7/10 B
Björk and Ahlström	2008	Sweden	14	AN (*n* = 4), BN (*n* = 4), OSFED (*n* = 6)	to describe how patients perceive having recovered form EDs	face-to-face interviews	A phenomenographic approach	35	9/10 A
Button and Warren	2001	UK	36	AN (n = 36)	to further understand how sufferers from AN view the disorder, how it affects their lives and	semi-structured interview	Thematic analysis	23	8/10 B

					how they experience treatment and help				
Cockell, Zaitsoff, and Geller	2001	Canada	32	AN (*n* = 21) EDNOS (*n* = 11)	to identify factors that help or hinder the maintenance of change and the ongoing promotion of recovery during the critical 6 months immediately following ED treatment	in depth interview	Grounded theory approach	29	9/10 A
Dawson, Rhodes, and Touyz	2014	Australia	8	AN (*n* = 8)	to eplore the process of recovery over time from the perspective of those who had fully recovered	face-to-face interview	Narrative inquiry	52	10/10 A
Federici and Kaplan	2008	Canada	15	AN (*n* = 15)	to explore the subjective accounts of weight-recovered female patients, regarding their views of their illness following weight restoration	semi-structured interview	Qualitative analysis	33	9/10 A
Granek	2007	Canada	5	AN (*n* = 5)	the subjective experience of AN	interviews	Grounded theory method		9/10 A
Hay and Cho	2013	Australia	31	AN (*n* = 31)	to explore factors that might contribute to a 'tipping-point' and recovery in personal published accounts	purposive sampling to identify written narratives in English and public domain	The framework approach to qualitative analysis	33	9/10 A
Jenkins and Ogden	2012	UK	15	AN (*n* = 15)	to explore how women made sense of their recovery	semi-structured telephone interview	Interpretative phenomenological analysis	28	9/10 A

Keski-Rahkonen and Tozzi	2005	Finland	158	AN (*n* = 32) BN (*n* = 52) AN/BN (*n* = 29) BED (*n* = 12) not clearly defined (*n* = 30)	to understand what ED sufferers suggest when they mention the word recovery	extracting messages of an ED discussion group	Detecting and measuring the frequency of recovery-related words and further explored in accordance with the principles of constant comparative method	25	10/10 B
Krentz, Chew, and Arthur	2005	Canada	6	BED (*n* = 6)	to characterize the psychological processes of recover from BED	semi-structured interview	Grounded theory method	62	9/10 B
Lamoureux and Bottorff	2005	Canada	9	AN (*n* = 9)	investigating the process of recovery	open ended interview	Grounded theory method	28	9/10 A
Lewke-Bandara, Thapliyal, Conti, and Hay	2020	Australia	8	AN (*n* = 4) BN (*n* = 3) orthorexia (*n* = 1)	to explore recovery from men's perspectives	semi-structured interview	Inductive thematic analysis	26	8/10 A
Linville, Brown, Sturm, and McDougal	2012	USA	22	AN (*n* = 12) BN (*n* = 5) EDNOS or comination of EDs (*n* = 5)	examine how social supports were helpful and hurtful during ED recovery process	face-to-face interview	Generic qualitative analysis	33	10/10 A
Kenny, Boyle, and Lewis	2020	Canada	120	*n* = 90 self-reported specific ED diagnosis: AN (*n* = 61) BN (*n* = 21) BED (*n* = 2) orthorexia (*n* = 4) other (*n* = 2)	examine how individuals with lived experience of an ED define recovery	blog posts in 'recovery' categories were retrieved	Inductive thematic analysis	25	9/10 A

Lord, Reiboldt, Gonitzke, Parker, and Peterson	2016	USA	65	BED (*n* = 65)	understand more fully how guilt and self-blame affect recovery, and explore the perceived motivators and challenges to recovery	extracting anonymous postings of a pro-recovery website	Thematic analysis	41	10/10 B
Lyckhage, Gardvik, Karlsson, Mulari, and Berndtsson	2015	Sweden	13	AN (*n* = 13)	to describe how young women living with self-identified AN narrate about their lives by means of blogging	extracting blogs	Qualitative content analysis	46	10/10 B
D'Abundo and Chally	2004	USA	20	unknown	to explore the process of recovery in women and girls with EDs	in-depth semi-structured interview, participant observation at an ED support group, and a focus group	Grounded theory approach: the constant comparative method	23	9/10 A
De Ruysscher and Vandevelde	2015	Belgium	17	AN (*n* = 17)	gaining insight into the personal meaning of QoL and specifying the indicators of QoL	In-depth interview	Qualitative interviewing	29	9/10 A

Note. The table displays study-specific information of the 46 records that were included in the systematic literature review and meta-synthesis.