2023

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Recommended Citation

Jeter, Rosemary Willett, "Impacts of Eating Disorder Recovery on Communication of Identity Through Food" (2023). *Graduate Student Theses, Dissertations, & Professional Papers*. 12126.
https://scholarworks.umt.edu/etd/12126

IMPACTS OF EATING DISORDER RECOVERY ON COMMUNICATION OF IDENTITY THROUGH FOOD

By

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Bachelor of Arts, Salisbury University, Salisbury, Maryland, 2016

Thesis

presented in partial fulfillment of the requirements
for the degree of

Master of Arts
In Communication Studies

The University of Montana
Missoula, MT

May 2023

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Jeter, Rosemary, M. A., May 2023 *Communication Studies*

Abstract

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Using the Communication Theory of Identity as a framework, the purpose of this thesis was to investigate how the experience of eating disorder recovery (EDR) impacts one's communication of identity through and about food, and perceptions of others' communication about and through food. Purposive sampling yielded 20 adult participants who self-identified as having been in EDR for at least one year. Results from a phronetic iterative data analysis of semi-structured interviews yielded several themes. When considering how EDR influences personal communication through food, main themes include: (a) the inability to share meals creates a gap between the enacted and relational identity layers; (b) participants negotiate a personal and relational identity gap via changes in eating behaviors; and (c) sharing meals creates alignment between the enacted and relational identity layers. The main themes in consideration of how EDR influences personal communication about food include: (a) negotiation of a personal and relational identity gap via establishment of boundaries around food; (b) negotiation of a personal and relational identity gap via changes in communication about food; and (c) communicating about food with others in EDR creates alignment of the personal and communal identity layers. Lastly, regarding how EDR influences perceptions of others' communication about and through food, main themes include: (a) how others communicate about food causes feelings of stigmatization and creates a personal and relational identity gap; and (b) how others change how they communicate about and through food creates alignment between the personal and relational identity layers. Together, these themes explain food's role in interpersonal communication as it is used to uphold an individual in EDR's desired identity. They also answer the call for a more person-centered understanding of EDR by identifying how communication about and through food creates identity gaps and alignment, clarifying how individuals in EDR feel they must manage conflicting identities with food and because of food, and providing ways to move forward in combatting and preventing stigma toward eating disorder (EDs) and EDR. Implications include an expanded understanding of recovery identity in an EDR context, a demonstration of persevering stigma toward EDs, and recommendations for social support.

Keywords: Eating disorders, mental health recovery, food communication, communication theory of identity, illness identity, interpersonal health communication

Acknowledgements

I would like to thank the University of Montana’s Institute of Health and Humanities for their generous support of this project. Funding from their 2022 Ridge Scholarship allowed participants in this study to be compensated fairly for their time and efforts in sharing some of the most vulnerable moments of their EDR. It also served to bolster my own mental health by sparing me the time and exertion required for manual interview transcription. Thank you to all of the mental health professionals who I have worked with over the past six years of my own eating disorder recovery process. Without you, I would not be here. I would also like to thank my friends in Missoula for their tireless emotional and instrumental support throughout my time in school, especially my fellow graduate students in UM’s Communication Studies department, and my roommates at Woodworth. Thank you to all of the people in my life who have contributed to my love of food, especially Olivia Lee, and the agriculture nerds I met in southeast Ohio. Special thanks to the dogs who helped me stay emotionally and physically regulated with plentiful pets and hikes, especially Willa, Duke, Tommi, Otto, Hank, and Moose. I owe unending gratitude to the professors who enlightened me to the marvels of Communication Studies, and who showed me patience and kindness when I needed it most. Thank you to the professors who served as my thesis committee members, Dr. Christina Yoshimura, and Dr. Daisy Rooks. You provided me with the feedback I needed to effectively communicate my ideas and conduct quality research. Lastly and certainly not least, thank you to my thesis advisor, Dr. Heather Voorhees, for sowing the seeds of my love affair with interpersonal health communication, and for the constant encouragement that ultimately allowed me to get this thing written.

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Impact of Eating Disorder Recovery on Communication of Identity Through Food

It has been estimated that 9% of the global population will experience an eating disorder (ED) at some point in their lives (National Association of Anorexia Nervosa and Associated Disorders [ANAD], 2021). EDs are mental health disorders often characterized by the affected individual's detrimental relationships with food and body image (Mayo Clinic, 2018; National Institute of Mental Health [NIMH], 2021). An individual recovering from an illness, or mental health disorder, such as an ED will likely redefine themselves through an illness identity (e.g., Cruwys & Gunaseelan, 2016; Koski, 2014; McNamara & Parsons, 2016) or recovery identity (Bowlby et al., 2015; Hastings et al., 2016; Koski, 2014). While an *illness identity* is the set of roles and attitudes that an individual develops about themself in terms of how they experience their illness (Charmaz, 1983; Charmaz, 1994; Yanos, 2010), a *recovery identity* is an identity that is primarily formed by the experience of illness recovery (Bowlby et al., 2015; Hastings et al., 2016; Koski, 2014).

This study utilized the Communication Theory of Identity (CTI) as a lens through which to better understand identity in an eating disorder recovery (EDR) context. CTI posits that identities consist of four layers: personal, enacted, relational, and communal (Hecht, 1993). These layers can align, creating identity congruence, or contradict each other, creating identity gaps. Even when gaps occur, the layers continue to coexist and work together to compose an individual's identity. Several studies have applied CTI in understanding the relationships between various aspects of EDR and identity, such as identity and food (e.g., Ellis, 2022; Paxman, 2021), and identity and body image (e.g., Beckner & Record, 2015). However, none yet have applied CTI to understand the interrelation between identity, EDR, and communication about and through food.

Researchers of various disciplines argue that person-centered conceptualizations of EDR are needed to supplement its predominantly biomedical understandings (Ingram, 2020; LaMarre, 2018; Wetzler et al., 2020). Further, healthcare providers want access to more EDR narratives in order to better serve the individual and nuanced needs of their patients (LaMarre, 2018). Thus, this study utilized semi-structured interviews grounded in the tenets of CTI to expand our understanding of the unique changes that EDR often creates within one's sense of self and how those changes are communicated through food, as well as how those changes impact communication *about* food, and perceptions of communication through and about food.

Literature Review

Eating Disorders

Eating disorders (EDs) are mental health disorders that involve acute disturbances both in eating behaviors and associated thoughts and emotions (NIMH, 2021). They can also impede the affected individual's functioning in important areas of their life, such as the ability to maintain healthy interpersonal relationships, and succeed in their career or at school (Mayo Clinic, 2018). Some clinicians have described EDs as "multifactorial and multilayered problems" (Leichner, 2005, p. 27). Anorexia nervosa, bulimia nervosa, and binge-eating disorder are the most commonly occurring EDs in the United States (Mayo Clinic, 2018). Major symptoms of these EDs include, respectively: severe restriction of food; binge eating large quantities of food followed by compensatory purging via vomiting, laxative use, or excessive exercise; and uncontrollably eating large amounts of food without any purging (NIMH, 2018). Despite the evidence that disproves this idea, EDs remain widely misconstrued as poor lifestyle choices, i.e., prioritizing one's physical appearance over their health (Brelet et al., 2021). This is especially problematic given that nearly 30 million U.S. Americans in their lifetime will develop an ED in their lifetime (ANAD, 2021).

While EDs can affect anyone, certain characteristics can increase the risk of an individual developing an ED. For instance, it's been estimated that about 90% of individuals who experience anorexia nervosa or bulimia nervosa are cisgender females (South Carolina Department of Mental Health, 2006). It has also been demonstrated that Black teenagers are twice as likely as their white counterparts to binge-eat and purge (Becker et al., 2003). Asian American college students have reported higher rates of restriction than their white peers (Uri et al., 2021), and 32% of transgender people in one study reported using their ED to modify their body without hormones (Duffy et al., 2016).

Ultimately, more than 10,000 annual deaths result directly from EDs, and a quarter of people with EDs will attempt suicide (ANAD, 2021; O'Connor et al., 2021). More insight into the EDR process, including the use of food as a tool for communicating one's identity, could potentially mitigate some of the emotional and physical harms that often result from EDs.

Food as Communication

In recent decades, the study of food has expanded beyond the realm of nutritional and biological sciences. Since then, food has become regarded by Communication Studies scholars as a form of non-verbal communication, abundant with signs and symbolism (Henderson, 1970, p. 5), and an expression of our beliefs and values. In other words, "We don't eat stuff. We eat meaning" (Zhang, 2013, p. 175). Henderson (1970) explained the significance of scholars wanting to understand food as communication:

> A special kind of scientist, yet to be named, may be able eventually to solve the problem: show me what a man eats, and I will tell you where he lives, what

> language he speaks, what his mores are, what he works at, how he looks, and what are his general mental and physical states of health. The solution to such a problem would not be inconsiderable in terms of successful human communication (p. 8).

Our relationships with food are multilayered as we interact with it daily and through a myriad of ways: eating, posting pictures of what we eat on social media, cooking, watching cooking shows on television, grocery shopping, sharing meals, emailing a friend a recipe, etc. Spinazola (2018) echoes this sentiment in her autoethnography when she describes the process of eating as not exclusively happening "in the mouth" (p. 26), but instead as a nuanced product of the interactions between our emotions, cognitions, and physiological states.

Social norms can also majorly influence our food choices and eating habits. For instance, sayings like "ladies don't chew with their mouth open" and "real men eat steak and potatoes" (Cooks, 2009, p. 13) can constrain the ways in which individuals want to express their gender identity. Food has the power to facilitate human intimacy and strengthen interpersonal connections (Purnell & Jenkins, 2013), such as participating in a shared cultural ritual, like eating a hot dog at a baseball game (Paxman, 2021). However, food also has the power to divide us (Zhang, 2013), such as with vegans who commonly feel marginalized in their workplaces or socially excluded from their families (Paxman, 2021). Regardless of how food fits into our lives, we need it to survive. As social creatures, communicating about food is just as critical for the survival of many of us as is merely eating it (Cramer et al., 2011).

It's evident that food is a form of communication, that it's a mechanism for communicating who we are, and that we will always need to communicate about food (Schraedley et al., 2020). Thus, if EDs are defined by acute disturbances in one's physiological and emotional relationship with food, it is worth investigating how individuals communicate through and about food in the context of their EDR. Considering that EDs and EDR complicate how we interact with food, it is fair to assume that they also complicate how we communicate about and through food, and our interpretations of how others communicate about and through food. However, a clear picture of how this occurs and why is still lacking. Moreover, there is uncertainty about how communication through and about food supports or inhibits an individual's adoption of a recovery identity. Thus, a clearer picture of how a complex relationship with food influences one's communication will produce a more thorough understanding of identity.

Illness Identity

In the broadest sense, our identity is how we define and categorize ourselves, and differentiate ourselves from others (Charmaz, 1994). Our identity shapes our self-concept, or the relatively enduring and cohesive set of characteristics, evaluations, and sentiments that we hold about ourselves and that in turn, guide our choices and values (Charmaz, 1994). Those who experience a serious or chronic illness will commonly redefine themselves as they integrate it into their identity (Charmaz, 1983). *Illness identity*, then, is the set of roles and attitudes an individual develops about themself regarding how they experience and understand their illness (Yanos, 2010). As an example, adults living with Parkinson's might feel that they are not their authentic selves due to their inability to partake in the same activities they did before the onset of their symptoms (Martin, 2016). Furthermore, illness identity is shaped and sustained by social experiences (Charmaz, 1983), such as when individuals diagnosed with depression were found to be more likely to identify as a depressed person after they had been stigmatized (Cruwys & Gunaseelan, 2015). Charmaz posits the self as "fundamentally social in nature" (1983, p. 170), and thus, individuals will integrate social interactions into the meanings they make of their illness experience. Cultural or social norms that deem certain illnesses taboo, for instance, can reinforce an individual’s belief that their illness makes them burdensome, unhealthy, or undeserving of having their needs accommodated (Crowe et al., 2016).

Illness identity has traditionally been a lens for studying physical disabilities and chronic illnesses that are difficult or impossible to recover from (Charmaz, 1983). Even though some have argued that EDs, like other mental health disorders, can be considered chronic and thus impossible to completely recover from (e.g., Kaplan & Strasburg, 2009), there are individuals who have undergone EDR who have self-identified or been identified by caregivers as being “fully recovered” (e.g., Accurso et al., 2019; Riobueno-Naylor, 2018). Additionally, while many people may struggle to completely recover, the progress made in partial recovery can be significant (e.g., Bardone-Cone et al. 2010; Bowlby et al., 2015; Ingram, 2020). Thus, illness identity has become a commonly used framework in recovery research. For example, Espindola and Blay (2009) found that patients who believed anorexia nervosa gave their lives meaning continued to experience its most deleterious effects on their bodies (Espindola & Blay, 2009). Later research demonstrated that adopting an illness identity can facilitate positive EDR outcomes, but only by way of *motivating* individuals to adopt a *recovery* identity (Koski, 2014). Koski (2014), for instance, observed that after one ED support group member lamented how her ED took time away from her hobbies, the other participants “then envision recovery. More specifically, they envision a life not dictated by the eating disorder and free of its restrictive limits” (p. 82).

Eating Disorder Recovery

Despite their alarming mortality rates, and despite “recovery” remaining poorly defined, people experiencing EDs can significantly reduce their symptoms and improve their overall quality of life by undergoing EDR. Many have attempted to measure successful recovery from mental health disorders, in general, and EDs, specifically. However, there is no universal framework for a successful recovery. On the contrary, recovery from a mental health disorder is often perceived as “anything but systematic and planned” (Anthony, 1993, p. 19) and instead as “fluid and ever changing” (Hine, Maybery, & Goodyear, 2016, p. 17). For instance, in 2010, Bardone-Cone and their colleagues (2010) set out to quantify the physical, behavioral, and psychological components of the EDR process. Based on participants’ questionnaire and interview responses, they found that “recovered” individuals were indistinguishable from either “healthy” controls or individuals with “active eating disorders” (Bardone-Cone et al., 2010).

Another reason why defining recovery is so challenging is because there is no agreement on the feasibility of complete recovery from mental health disorders (e.g., Anthony, 1993; Bowlby et al., 2015; Kaplan & Strasburg, 2009). An individual may return to their normal social roles while not being completely relieved of their symptoms (Anthony, 1993). Despite overcoming many of the challenges created by EDs, individuals in EDR are likely to continue experiencing physical, social, and psychological impairments (Bowlby et al., 2015). Even after minimizing symptoms of a mental health disorder, relapse is a recurrent phenomenon among recovering individuals. The Transtheoretical Model of Behavior Change, a widely and clinically applied model of the recovery process (Ingram, 2020), incorporates relapse as one of its six phases of recovery (Leichner, 2005; Prochaska, 2020).

In addition to its non-linearity, recovery is a highly individualized process. For instance, Anthony (1993) described recovery as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles” (p. 15). Considering this, many scholars agree that recovery from mental health disorders and EDs is best understood through personal narratives rather than clinical constructions (Anthony, 1993; Hine et al., 2016; Ingram, 2020; LaMarre, 2018; Wetzler et al., 2020). Further, we risk delegitimizing individuals' experiences of EDR by suggesting that there is only one correct experience or definition of EDR. To avoid this, LaMarre (2018) explains the approach those researching EDR should take toward making sense of participant narratives:

> Rather than claiming that participants’ accounts can be collapsed to form a coherent representation of a singular pathway to or articulation of recovery, it might be more fruitful to explore how the individual—and yet socioculturally linked and intercorporeal—experience of recovery requires listening to participants as authors of their own stories, while also acknowledging their ‘sources’ and ‘audiences’ that impact their story construction. (p. 285)

The paradigm of narrative medicine carries a similar ethos, that allowing individuals to share the stories of their illness experiences—especially with EDs—has directly therapeutic effects (Grzywna, 2016). A diverse collection of stories from people about their EDR experiences will allow us to comprehend how they make sense of themselves as individuals in EDR and give them control over their own narratives (Grzywna, 2016).

Thus, the purpose of the current study is not to seek a definition of EDR, but instead, to explore some of the many ways it can be experienced. A more robust perspective of how EDR becomes intertwined with an individuals’ identity and interpersonal interactions will also help practitioners and support networks best meet the needs of individuals in EDR.

Recovery Identity

Ample evidence has emerged to support the idea that individuals pursuing recovery from an ED achieve better outcomes by adopting a recovery identity rather than a symptom-centered illness identity. In an interview-based study of ED clinicians with personal histories of EDs (Bowlby et al., 2015) “coming to an understanding that the eating disorder is separate from one’s identity as a person” (p. 7) appeared as fundamental to their success in EDR. Participants also found that naming their ED (e.g., “Ed” as shorthand for eating disorder or “Ana” as shorthand for anorexia nervosa) was useful for de-identifying with their ED symptoms and differentiating the “voice of the eating disorder” (p.7) from their authentic internal voice (Bowlby et al., 2015). LaMarre (2018) found that de-identifying with an ED was beneficial in several other ways. For instance, individuals felt relieved of the burden of constantly answering unsolicited questions from others unafflicted by or unfamiliar with EDs (LaMarre, 2018).

Some scholars have argued that EDs are a form of addiction. As such, it’s been discovered in addiction recovery research that adopting a social identity of recovery (i.e. belonging to the recovery community) has been associated with lower relapse rates and higher levels of self-efficacy (Buckingham et al., 2013), improved treatment retention (Beckwith et al., 2015), and increased length of abstinence (Tombor et al., 2015). This emphasizes a greater need to focus on the relationship between how individuals in EDR communicate and their recovery identity. Additionally, these studies primarily focus on social identities, indicating a need to further explore recovery identity from a more personal and individualized approach. Although plenty of theories could be apt for studying how identity is enacted within EDR, Communication Theory of Identity seems ideal.

Communication Theory of Identity

The goal of the Communication Theory of Identity (CTI; Hecht, 1993) aligns well with the goal of this research—to render identity as a complex and fluid experience. It posits identity as a structure of layers that ebb and flow, and that are unique to the individual while at the same time dictated by their social environment. According to CTI, our identities are fundamentally communicative and social in nature, continuously being constructed, maintained, and expressed via our interpersonal interactions (Hecht, 1993). Hecht (2015) asserts that communication and identity do not occur independently, but concurrently. In essence, "when we talk, we *are* our identities" (Hecht, 2015, p. 180). In that vein, how *others* communicate with us is also a part of our overall identity. An individual's social roles and relationships become internalized as part of their overarching identity, and consequentially are enacted *as* identities through communication (Jung & Hecht, 2004).

CTI organizes identity into four layers: *personal*, *enacted*, *relational*, and *communal* (Hecht, 1993). The *personal layer* of identity consists of the beliefs and feelings an individual holds about themself. Through this layer, we can understand identity as: a) the "hierarchically ordered meanings attributed to the self as an object in a social situation" (Hecht, 1993, p. 79); and b) as the source of an individual's expectations and motivations. For instance, an individual might self-identify as an individual with an ED. Secondly, through the *enacted layer*, identity is performed in social situations via our behaviors, such as how we speak, dress, and gesture. An example of this would be intentionally abstaining from eating in public for fear of harsh judgments, as a way of controlling how we want others to see us. We cannot completely understand identity as it is enacted without knowing how it is relational (Hecht, 1993). Thus, the *relational layer* of identity allows us to see how identity, in those same social situations in which we enact it, is mutually constructed. Specifically, this layer includes how identities emerge in relationships (e.g., someone's friend or colleague), how identities are enacted in relationships (e.g., teacher/student, patient/provider), and how relationships themselves develop identities as social beings (Hecht, 1993). For instance, someone in EDR who believes they rely too much on their romantic partner as a caregiver would be considered to have a relational identity of a dependent romantic partner. Additionally, someone in EDR who doesn't expect or want their romantic partner to take on a caregiving role might enact their relational identity by refusing their partner's caregiving attempts. Lastly, the *communal layer* of identity describes how an individual's overall sense of self is influenced by their membership and alignment with a culture, society, and/or community. A communal identity is shared by a group of people and defined by a sense of belonging. One way this layer could be applied would be toward understanding how an individual might build or maintain a communal identity through their connection with members of an EDR support group.

Identity Interpenetration and Identity Gaps

These four layers are not isolated from each other and as they intersect, or *interpenetrate,* they can overlap, contradict, and complement each other (Hecht, 1993). As an example, someone might enact their identity in ways that reflect their communal identity. Alternatively, they might have a personal identity that conflicts with the roles prescribed for them via their relational identity. While the layers are always intertwined, one layer may be more salient than the others in certain circumstances (Palmer-Wackerly et al., 2018). Alternatively, at any given moment, all four layers might be salient (Hecht, 2015), such as someone who self-identifies as queer wearing pride colors with their romantic partner at an LGBTQIA+ event.

When layers contradict each other, which they sometimes do, *identity gaps* occur (Hecht, 2015), creating tension within an individual and influencing their communicative behavior. For example, someone with a stigmatized mental health disorder, like an ED, might suppress their personal identity as someone with binge-eating disorder by not eating in public, thus creating a gap between the *personal* and *enacted* layers of their identity. Jung and Hecht (2004) assert that identity gaps are inevitably a result of the inherently imperfect nature of communication.

However, some gaps might carry greater weight and worse consequences than others, depending on the size of the gap and to what extent communication satisfaction is achieved (Jung & Hecht, 2004). Communication satisfaction is an emotional response to communication that reinforces our internal standards. Hecht (2015) argues that identity gaps can cause unsatisfactory communication because individuals either feel misunderstood, or that the conversation inappropriately or ineffectively accounted for their sense of self. These lapses in communication, caused by identity gaps, can lead to poor psychological outcomes because, as Hecht (2015) explains, "Our best relationships are typically those in which others see us the way we want to be seen" (p. 180).

In the occurrence of identity gaps, individuals will likely compromise certain aspects of their identities, or undergo *identity negotiation*, in an attempt to achieve communication satisfaction. In their study, Trinh and Faulkner (2022) identified several processes through which LGBTQ+ college students navigate identity gaps: (1) *identity compartmentalization*, in which students only enact the one identity they determine to be a primary marker of in-group membership; (2) *identity prioritization*, which involves prioritizing enactment of one salient identity over another, specifically through the navigation of motivations related to their personal identity and alternating between identities during interpersonal interactions; (3) *identity concealment*, or hiding a salient identity in particular interpersonal contexts that an individual perceives as a risk for negative social consequences; and (4) *gap reconciliation*, involving either *internal resolution* (i.e., neutralizing conflicting identity-related motivations and/or reframing conflicts as beneficial) or *self-advocacy* (i.e., explaining to others how relational-framed identity gaps are common in attempt to normalize having multiple salient identities).

Applying CTI: EDs, Recovery, and Food

Several studies have used CTI to explore the relationships between identity and the various aspects of EDs, namely body image and recovery. For instance, how coaches communicate has been demonstrated to perpetuate the thin-ideal, which then becomes internalized in female athletes' personal identities as an overevaluation of their weight and manifested in their enacted identities as excessive exercise and restrictive food intake (Beckner & Record, 2015). Franken (2014) discovered that participation in Alcoholics Anonymous promoted a personal identity of honesty and selflessness, an enacted identity of sobriety, and a communal identity of successfully recovering alcoholics.

More recent studies have used food as a focal point in identity-based research. For instance, a communal identity grounded in a shared experience with food insecurity was shown to help college students at The University of Alabama cope with feelings of isolation (Ellis, 2022). However, persistent jokes among these in-group members about being a "starving college student" (Ellis, 2022, p. 188) reinforced a communal identity that normalized and accepted food insecurity as a part of the college student experience. Further, concerns from students of minority racial and ethnic groups about fulfilling stereotypes impacted their enacted identities by disinhibiting them from disclosing their food insecurity and seeking assistance with acquiring food (Ellis, 2022). A separate study showed that eating and sharing vegan food was helpful for vegans to enact positive identities by defying negative stereotypes (e.g., vegans are extreme, angry, rude, or militant) (Paxman, 2021). However, participants also reported that additional efforts to enact positive identities included withholding or obscuring certain aspects of their personal identities. For example, one participant described how they chose to not disclose their veganism in social situations in order to avoid being perceived as proselytizing or having veganism overshadow other facets of their identity (Paxman, 2021).

These studies have provided important insight into the relationships between identity and body image, identity and recovery, and identity and food. However, to my knowledge, CTI has yet to be applied to garnering a more robust understanding of the impacts of EDR on identity. Such information can potentially benefit individuals in EDR and those who want to support them. Thus, this study sought to understand the intersections of identity, food, and the experience of being in EDR:

RQ1: How does being in EDR impact the way individuals communicate their identity through food?

RQ2: How does being in EDR impact the way individuals communicate *about* food?

RQ3: How does being in EDR influence individuals’ perceptions of others’ food-related communication?

Methods

Researcher Positionality

I came to this work as someone with a personal history of EDs, and who has now been in EDR for six years. It was my hope that belonging to this often-stigmatized population of people in EDR provided the camaraderie needed to conduct honest and meaningful semi-structured interviews. However, I also recognized that this aspect of my own identity may have potentially biased my perspective on interview data. For instance, as someone who has experienced stigma for having an ED, I was inclined to believe those who report having experienced something similar. Further, as a white, 29-year-old cisgender female raised in a middle-class home in the United States, I acknowledge that my understanding of perspectives shared by participants with backgrounds different from mine was limited.

Recruitment

The criteria for participation in the current study were twofold: (a) First, participants had to self-identify as being in recovery from an ED for at least one year, and (b) secondly, they had to be an "adult," which the University of Montana's IRB defines as being at least 18 years of age. Participants were not required to have had received any official diagnosis of an ED, nor did the type of ED they had experienced influence their eligibility.

After obtaining approval from the University of Montana's IRB, the first phase of recruitment involved posting calls for participants using an IRB-approved message (see Appendix B) in Reddit-based EDR-focused communities including r/fuckeatingdisorders, r/EDAnonymous, r/bulimia, and r/eating_disorders. These communities were chosen as a starting point based on the assumption that their members would be passionate about recovering, and thus eager to discuss their EDR experiences. The majority of participants were recruited from Reddit, unintentionally omitting from the sample individuals in EDR who weren't active social media users, and potentially skewing the data.

The second phase of recruitment involved inquiring with local EDR-based organizations including the Eating Disorder Center of Montana, and Missoula's Eating Disorder Anonymous (EDA) support group. Messages were sent to both organizations' public-facing email addresses outlining this study's goals and methods. It was believed that participants recruited from these organizations would be keen to discuss their EDR experience. This phase of recruitment also involved posting fliers containing IRB-approved language (see Appendix C) around UM's campus. Given that EDs commonly develop after young adults become first-time college students (Birmachu & Heidelberger, 2019), most of the students at UM who have experienced EDs were presumed to had begun the process of EDR, and thus would have been willing and eligible to participate. In total, three participants were from Montana, bolstering the study by diversifying participant perspectives beyond internet recruits.

Participants

After screening responses to an anonymous Qualtrics survey that collected demographic information and confirmed eligibility for participation, a total of 20 participants were interviewed. This was sufficient for achieving *theoretical saturation* (Creswell & Miller, 2000), when no more novel themes were apparent from participant responses. Utilizing funds from the University of Montana's Institute of Health and Humanities' Ridge Scholarship, interviewees were compensated $25 USD via Venmo and PayPal.

For a complete representation of participants' demographics, see Appendix E. Participants ($N = 20$) ranged in age from 18 to 29 years, representing an average age of 23.55 years. The amount of time participants reported having been in EDR ranged from 1.25 to 10 years ($M = 3.6$ years). Most participants identified as cisgender males (60%, $n = 12$), while 30% identified as cisgender females ($n = 6$), and 10% as transgender males ($n = 2$), contradicting most statistics demonstrating that females are more often impacted by EDs than males. Half of the participants identified as "Black/African American" (50%, $n = 10$) while 40% identified as "White/Caucasian/European-American" ($n = 8$), and 10% as Hispanic or Latin, further contradicting the idea that EDs primarily affect white women.

The implications of these demographics are twofold. The first being that recruitment via the internet and monetary incentives may have attracted a skewed sample. The second is that the anonymity of online communities like those on Reddit are appealing to individuals with stigmatized and underrepresented identities. For instance, the narratives supporting modern understandings of EDs are predominantly from white people, reflecting a false assumption that EDs do not affect non-white individuals (Riobueno-Naylor, 2018). Gender barriers to the treatment of EDs exist as well. For instance, it has been documented that upwards of 25% of anorexia and bulimia cases occur in males (Hudson et al., 2006), however, both stigma and a lack of gender-focused research on EDs make it difficult for males to disclose their ED experience and seek treatment (Strother et al., 2012). Anonymous online support groups would unsurprisingly attract people who otherwise feel discouraged from sharing their ED experience where their racial or gender identity is apparent. It's apparent that men of color need more representation in ED and EDR research, and this study helped to fill that gap.

A majority of participants reported their sexuality as "Heterosexual/Straight" (70%, *n* = 14), while three (15%) participants reported their sexuality as "Homosexual/Lesbian/Gay," and three participants reported their sexuality as "asexual," "pansexual," and "bisexual," respectively. Seventy-five percent of participants (*n* = 15) reported having never been married, 20% (*n* = 4) reported being currently married, and one (5%) participant reported being separated. Almost half of the participants (45%, *n* = 9) reported a bachelor's degree as their highest level of education, while 35% reported having received an associate degree (*n* = 7), 15% reported having received a high school diploma (*n* = 3), and one participant reported having received a master's degree (5%, *n* = 1). Most participants (45%, *n* = 9) reported receiving an annual income between $20,001 and $40,000, followed by 20% who reported receiving between $40,001 and $70,000 (*n* = 4), 15% who reported receiving between $0 and $20,000 (*n* = 3), 10% who reported receiving between \$70,001 and \$100,000 (*n* = 2), one participants who reported receiving over \$100,001 (5%, *n* = 1), and one participant did not specify their annual income (5%, *n* = 1).

Without intending to, this study recruited participants who primarily spoke English as their second language. While details regarding ethnic identity and nationality were not collected, location data from Qualtrics associated with survey responses indicated that all participants resided in the United States at the time of survey completion.

Participants were given the options to report any ED diagnoses they had received and any EDs they would diagnose themselves with. No participants reported having never received a diagnosis nor any self-diagnosis. Reported diagnoses included binge-eating disorder (*n* = 6), anorexia nervosa (*n* = 4), pica (*n* = 1), bulimia nervosa (*n* = 1), purging disorder (*n* = 1), atypical anorexia nervosa (*n* = 1), and a combination of EDs including those listed above, as well as avoidant/restrictive intake disorder, and night eating syndrome (*n* = 7).

Data Collection

This study utilized an interpretive approach and to this end, employed qualitative research methods. Qualitative research has earned recognition as a legitimate and reliable way to obtain health-related knowledge, specifically regarding EDs, that might not be accessible via other methods (Espindola & Blay, 2009). Capturing narratives from individuals in EDR through semi-structured interviews provided valuable insight into the experiences and socially constructed meanings of their everyday worlds (Kvale, 2012). It may also have been appropriate to use ethnographic observations for exploring food as communication. This method could have provided insight into non-verbal communication and group dynamics during interactions involving food. However, because observations would have occurred in the presence of others, it would have inhibited participants from sharing their honest thoughts, feelings, and motivations for how they communicate through and about food. Alternatively, semi-structured interviews provided an opportunity for those who have felt stigmatized or isolated because of their ED to feel heard and have their perspectives validated. Certain mental health disorders, like addiction and EDs, are still widely regarded as taboo. Thus, individuals experiencing either are commonly made to feel as though they can't safely or comfortably disclose information related to their mental health disorder. Providing a confidential outlet for these people to share their perspectives was valuable, as it demonstrated how their stories could be received without criticism or judgment.

Twenty semi-structured interviews were conducted between January and February of 2023. Zoom was the preferred channel of communication for all participants, including local interviewees. Interview questions were thematized by the larger topics of identity, EDR, and food (see Appendix A). Interviews lasted between 12 and 52 minutes, with most lasting approximately 25 minutes. Presumably, interviews would have gone longer had there not been a language barrier. After obtaining each participants' consent, interviews were audio- and video-recorded. All participants were required to complete a Qualtrics survey (see Appendix D) prior to interviews to confirm eligibility as well as to collect demographic information. Eligibility to be interviewed was confirmed via questions about age and length of time in EDR. Participants were not required to complete the entire questionnaire and not permitted to be interviewed if they indicated that they were younger than 18 years of age or had been in EDR for less than one year.

Data Analysis

After all interviews were completed, they were transcribed verbatim using a combination of Trint transcription software and manual transcription. The first step of transcription involved the use of Trint to automatically transcribe recordings into rough drafts. These drafts were then manually reviewed alongside interview recordings, allowing for a more thorough understanding of the data and ensuring that transcriptions accurately depicted what was said in the interviews. Each participant was assigned a pseudonym and de-identified in transcripts by removing all references to proper names, specific dates, city names, and other information that could reasonably be used to identify individuals.

An *iterative phronetic approach* (Tracy, 2019) was taken to coding, through which an existing theory was used as a framework for the coding process, at the same time allowing new themes to emerge. In other words, themes related to the Communication Theory of Identity were specifically coded, while unexpected themes that may have been prominent in the dataset (i.e., themes related to the study's overarching concepts of food, communication, and EDR, but not explicitly related to CTI) were also acknowledged.

First Phase of Coding

The first phase of coding involved what Tracy (2019) terms *descriptive primary cycle coding.* This phase began with a close reading of approximately 20% of the transcriptions to identify recurring and relevant units (i.e., words and phrases), that captured the essence of the data. During this phase, units related to the CTI concepts of personal, relational, enacted, and communal identity were sought, and Owen's (1984) criteria of recurrence, repetition, and forcefulness was applied to code units that seemed noteworthy. The codes created in this phase were "first-level" codes (Tracy, 2019, p. 66) that described "the basic ingredients" (p. 66) or the "who, what, when, where" (p. 66). From this, a codebook was created that outlined the common themes that had been found, including quotes for exemplification. This first step of coding was completed with a total of 100 units fitting into 9 codes. Aligning with CTI, under the personal layer, three initial codes became apparent, while three codes fit under the enacted layer, two themes fit under the relational layer, and one theme related to the communal layer.

During the next step of this coding phase, a second coder was trained on the codebook, and, separately from the primary researcher, coded the next 20% of transcripts in search of units that matched the existing codes and denoted new themes that seemed prominent or noteworthy. The primary researcher and second coder discussed coded units to resolve any differences and clarify interpretations of the codes. This helped to strengthen the validity of codes and refine them into a more comprehensive set of ideas.

Using a *constant comparative method* (Tracy, 2018), in which the codebook was modified as needed to better fit newly emerging data, the remaining transcripts were coded. Specifically, data excerpts categorized into a code were examined, and then modified as necessary to more precisely fit into that range of data. This phase of coding was completed with 17 themes, 29 corresponding subthemes, and a total of 297 units. See Appendix F for a complete outline of initial themes and subthemes.

For the sake of familiarity and efficiency of coding, the four layers of identity remained as the main themes under which the aforementioned themes and subthemes were coded, even if they seemed to be representative of more than one layer. For instance, a theme of alignment between the personal and relational layers of identity, "Impacts of sharing meals on relational closeness and vice versa," was coded underneath the relational identity layer.

Second Phase of Coding

The next phase of coding involved Tracy's (2019) *secondary-cycle coding and hierarchical coding*. Themes from the first phase of coding were further interpreted, synthetized, and organized by consideration of CTI, and then analyzed for the most prominent themes. As themes were refined into theoretical categories and analyzed alongside each other, the overarching themes of identity alignment, identity gaps, and identity negotiation began to emerge from the data.

Third Phase of Coding

Themes were analyzed for significance based on novelty and relevance, and then organized to form a cohesive narrative. These final themes are outlined and explained in the remaining sections.

Results

After a thorough analysis of interview data, several overarching themes emerged based on how individuals in EDR communicate their identity through food, the influence of EDR on their communication about food, and the impact of EDR on their perception of how others communicate through and about food.

RQ1: How does being in EDR impact the way individuals communicate their identity through food?

Choosing to share a meal or not and eating a certain type or amount of food to conceal being in EDR were two ways participants reported communicating their identity through food. The inability to share meals created gaps between participants' personal and relational identity layers—their personal layer of identity being someone who has experienced and is now recovering from an ED, and their behaviors in relation to who they were sharing meals with constituting their relational identity—while sharing meals created alignment between these same two layers. Participants also described social situations in which they felt the need to change how they ate in order to conceal being in EDR, which created a personal-enacted identity gap.

Specifically, three main themes emerged around RQ1: (a) the inability to share meals negatively impacted friendships, creating a personal-relational identity gap; (b) altering eating habits in order to conceal being in EDR created a personal-enacted identity gap; and (c) sharing meals positively influenced interpersonal relationships with friends and family members, creating a personal-relational identity alignment.

Personal—Relational Identity Gap: Inability to Share Meals Negatively Influenced Friendships

Several participants discussed how their emotional and physiological relationship with food was a detriment to their friendships. Chuck, a 22-year-old cisgender male recovering from binge-eating disorder, explained why he chose not to attend a New Years party "because of the food" (Line 2224). Similar to the experience of many individuals who struggle with binge eating, Chuck would have felt overwhelmingly distressed by his proximity to a buffet-style setting. Additionally, he felt like he had to lie to his friends that he "wasn't feeling well" (Line 2232) so that they wouldn't become aware of how his EDR impacts his interactions with food. While he wanted to celebrate with his friends, he feared they would be unsupportive of his struggle with resisting urges to binge eat. Penelope, a 22-year-old cisgender female recovering from binge-eating disorder, explained how she was excluded from social events involving food prior to her beginning EDR. Her best friend "wouldn't invite me to do things or to go out with her friends. Or maybe when she was having a dinner with her other friends. Because we all ate different foods" (Lines 599-602) and because "she was afraid that her friends wouldn't accept me the way that she accepts me" (Line 606). Penelope also described another friend with whom her relationship ended after she began recovering:

> I had a friend, and we both had the same problem. And once I decided that enough was enough, I'm done hiding with food, and that I want to change and I want to turn things around, he wasn't comfortable with that. Because he never wanted to turn things around for himself. And he wanted to stick to the whole eating and stuffing your face when you have a problem and all that. So, he doesn't really feel okay with me changing. He feels like I betrayed him or something because I changed the way we used to bond... right now we don't really talk. Because I don't feel like he fits in my space right now. We don't have the same thing that used to bond us before. (Lines 616-629)

Participants believed that their friends either could not or would not accommodate their EDR-related dietary needs, which they interpreted as an unwillingness to integrate their EDR into the interpersonal relationship. This impeded participants' abilities to interact with their friends and created a gap between their personal and relational identity layers.

Personal—Enacted Identity Gap: Altering Eating Habits for EDR Concealment from Friends, Family, and Peers

Participants told stories about when their physiological and emotional relationships with food created personal-enacted identity gaps. For various reasons, participants felt pressure to conceal their EDR from friends, family, and peers, by changing how and what they ate. Juniper, a 21-year-old cisgender female recovering from bulimia nervosa, binge-eating disorder, and avoidant/restrictive intake disorder, described how she felt like she must "put on an act" (Line 1260) when she's eating out with friends by "eat[ing] normally. … By normally, I mean you finish most of the food that you have or all of it. And I guess so then, they wouldn't see how I feel" (Lines 1250-1251). Juniper explained later in her interview how emotionally taxing it could be to describe for people, especially those who have never personally experienced an ED, the complexity of her feelings toward her body and food. Charlie, a 27-year-old cisgender male recovering from purging disorder and night eating syndrome, shared a similar experience. He explained how when he would go out to eat with friends, he tried to eat “something healthier, something different” (Line 931) and to “find a way that’s not suspicious to my friends” (Line 933). He also explained why he kept his food journal, a tool that held him accountable to his dietary goals in EDR, hidden from others, including his friends:

> ...I take it with me, but I don’t show it to people. I keep it in my bag or my inside pocket. I just have it with me. But I try as much as I can to hide it from people. ‘Cause as I told you, I’m ashamed of my eating disorder. (Lines 902-904)

Gerard, a 24-year-old cisgender male recovering from binge-eating disorder, said that he also changed how he ate in front of his friends because he didn’t “want them to realize that I have a disorder that I’m dealing with” (Line 779) and was “afraid that they will make jokes toward me, cause I’ve seen them do it to other problems different from mine. So, I can just imagine if they found out about my problem, how they would react” (Lines 781-785).

Ilana explained how distracting herself by fidgeting with small objects helped her to eat when she was struggling with urges to restrict her food intake. However, she also made sure that whichever object she chose to distract herself with was “normal,” and thus not indicative of her EDR. For instance, at family events, she would choose a fidget cube because “they don’t question a fidget cube, because my brother has one and all my cousins have their own fidget things” (Lines 3088-3089). Ilana described how many of her family members had historically been unsupportive of her EDR, and how that influenced her desire to conceal it from them and other people in general. Chuck also admitted to adjusting his eating habits in order to conform in group settings:

> No one knows I'm in recovery, actually. So, I just tend to socialize with people very freely, even in events. During events, sometimes I bend [my] rules a bit... just to fit in. Eat what isn't required. But that's why I avoid going to events now because when I go, I like to fit in. (Lines 2210-2214)

Robin, a 24-year-old transgender male recovering from purging disorder and night eating syndrome, expounded his "picky" eating when in public and travelling to "avoid the shame that comes about in purging in public places" (Line 1705) and because he doesn't "like it when people show me too much pity" (Line 1715). Sage, a 20-year-old transgender male recovering from purging disorder and avoidant/restrictive food intake disorder, also changed how he ate to avoid purging in public. He stated that he "barely" ate in public "to avoid embarrassment and shame" (Line 1065).

Participants held various motives for changing how and what they ate and concealing their EDR from their friends, family, and peers. The most notable of these motives were avoiding undesirable social situations such as stigma and uncomfortable conversations, and their associated unpleasant emotions. Yielding to these avoidant urges resulted in personal-enacted identity gaps. However, as will be discussed in the next theme, sharing meals was also demonstrated to create personal-relational identity alignment in the context of more supportive interpersonal relationships.

Personal—Relational Identity Alignment: Sharing Meals with Friends and Family Positively Influenced Relationships

Sharing meals was described as an activity that prompted emotional closeness between participants and their loved ones. Ilana explained how food was an impetus for her spending time with her friends because “it fits into making sure we hang out because I get busy and forget that I have a social group” (Line 2842). She also described the time she spent with her friend Abbi as mediated by shared meals: “with how busy our schedules are, that’s the only time we have to hang out is food time and study time” (Lines 2887-2888). For Wendell, a 21-year-old cisgender male recovering from binge-eating disorder, explained how family meals were something that he didn’t “ever miss out on... because food is something that brings us together as a family” (Lines 1540-1542). For Amanita, a 26-year-old cisgender female recovering from anorexia nervosa, eating with her brother was pleasant because “whenever I eat with him, I’m always able to eat. Compared to when I’m alone, I don’t really eat much. But if I’m with my brother... I’m always able to eat more” (Lines 2414-2418). Juniper also sometimes felt more comfortable eating in the presence of others: “I think when I eat with people, it’s easier to kind of put those thoughts away for just a little bit and actually just enjoy and just talk” (Lines 1338-1340). When Ilana ate with one of her friends who was also in EDR, she didn’t have “to be afraid of what I eat around her. It could be the weirdest shit in the world” (Lines 2827-2828).

These situations in which participants felt closer to their friends and family by sharing meals with them and felt comfortable enacting their EDR in front of them, created alignment between their enacted and relational identity layers. More specifically, participants had their enacted identities (i.e., eating as needed per their EDR goals) affirmed via their relational identities as they pertained to their friendships and familial relationships.

RQ2: How does being in EDR impact the way individuals communicate *about* food?

Aligned with RQ2, participants described: (a) verbalizing boundaries around food that were used to negotiate personal-relational EDR identity gaps; (b) changing how they communicated about food to conceal their EDR from people who've not experienced an ED, creating a personal-enacted identity gap; and (c) feeling more comfortable talking about food with other people in EDR than people who had never experienced an ED, creating personal-communal identity alignment.

Personal—Relational Identity Gap Negotiation: Setting Boundaries with Friends, Family, and Peers Around Food

Participants frequently discussed utilizing self-advocacy to resolve relational and personal identity gaps. Specifically, they communicated boundaries around food to their friends, family, and peers so that they could remain accountable to their EDR goals while also avoiding interpersonal conflict. Benny, a 21-year-old cisgender male recovering from binge-eating disorder, explained how he would set a boundary when socializing with friends and they were sharing food that his doctor advised against him consuming. Specifically, Benny wanted them to know that it could be detrimental to his EDR if they gave him food instead of asking him if he wanted it:

> But I realized, most of the time, if I'm not at home and then I'm at a friend's, it's junk food we're all eating... And so, I tried to make it clear to everyone that I am no longer a junk food guy, and they should be careful. And I'd recommend they ask. (Line 453-456)

Wendell explained needing to set boundaries in social situations around food that he shouldn't eat per his doctor's suggestions: "If someone recommends a type of food that I feel I'm not comfortable with, I just tell them, 'Excuse me, I'm very sorry... but I'm in a recovery process and I'm not allowed to take that type of food" (Lines 1719-1722). Aspen demonstrated how she also verbalized boundaries around eating when spending time with her friends. Since her recovery process involved overcoming the urge to restrict her food intake, she tried to create opportunities to eat during social events that otherwise wouldn't involve food: "Yes, I would love to go out, get a drink. And before I do that, I need food from somewhere, regardless of if you need food" (Line 3971). She also spoke about a family member with whom she wanted to maintain a healthy relationship, and needed to set boundaries around how they could talk about food to do so:

> So that creates a lot of sometimes frustrating conversations and times where I've had to very clearly state my boundaries. ...So, she's become someone that I don't talk to as much about it or I'll make the statement of "I'm struggling with food, not in a place to talk about it. Let's move on to other things." (Lines 3944-3950)

Ilana set similar boundaries for similar reasons with her grandmother. She described her grandmother as someone who was raised by an ideology that eating is only for survival, and thus, could at times be insensitive to Ilana's EDR experience. "She would go into constant rants with me, which just made me not want to talk to her. And I love that lady. ... I was just like, 'Okay, this is annoying. No. This will destroy our relationship talking about this" (Lines 2950-2956).

It was also important to Ilana that her gym friends were aware of how detrimental to her EDR progress their frequent discussions about the macronutrients constituting single food items could be. Prior to her EDR, she struggled with obsessive food tracking and had memorized the macronutrients corresponding with certain food items. Hearing about these macronutrients could trigger her anxiety about weight gain:

> Normally what I'll do, because this is a common thing for me in particular, is I'll be like, "Hey, I love hearing that you're happy with your macros. But can we just talk about it in a

> broad range instead of just singular foods?" Because I can talk about macros in a broad range, just like "I hit these macros for the day." I'm just like, "You go! You go for your macros!" But it's just the singular items I can't do. (Lines 2708-2713)

Participants regularly experienced gaps between their personal identity of being in EDR and their relational identity with their friends, family, and peers when they communicated about and interacted with food in ways that conflicted with participants’ EDR needs. Utilizing self-advocacy was a common process for negotiating these gaps.

Personal—Enacted Identity Gap: Strategically Talking About Food to Conceal EDR from Friends, Family, and Peers

Several participants felt pressure to conceal their EDR from their friends, family, and peers, by altering how they spoke about food, creating a personal-enacted identity gap. Participants changed how they communicated about food, either by avoiding it as a topic of conversation with certain people or talking about it in a way that didn’t honestly reflect their own emotional and physiological relationships with food.

Penelope avoided talking about food with her neighbor, who used to "make jokes about the time I was in the disorder” (Line 639). Ilana hid her EDR by using her food allergies as an excuse to refuse certain foods offered to her, instead of admitting that they would trigger her ED symptoms. For Ilana, she didn’t want people to know about her EDR because she didn’t want “everyone to look at me like a pity case” (Line 2744). Additionally, she changed how she spoke about food for years to hide her EDR from her brother, because she “didn’t want him to worry about me, because I’m supposed to be worrying about him. He’s my little brother. I didn’t want him to feel like he had to take care of his big sister... I want him to be a kid” (Lines 2797-2800).

One of Juniper’s reasons for concealing her EDR by changing how she spoke about food was also to preserve an identity as a role model for her younger sister:

> ...And so, when I do talk about food, I just talk about it normally and try to make it positive instead of me expressing to her my negative thoughts about it or my obsessions because I don’t want to rub that kind of influence off onto her. (Lines 1345-1354)

Juniper avoided conversations about food with most other people too, particularly those who've never experienced an ED:

> Especially people who haven’t gone through it, I think if you ever try to express just a little bit of what you’re feeling... they try to give you advice. ‘Well, all you have to do is eat healthy and just limit your portions.’ And all these things. And it's like, ‘I don’t think you understand that just even thinking about that is such a struggle.” (Lines 1221-1227)

Gerard shared several stories about when he altered his communication about food to conceal his EDR. As someone who self-identified as a food lover and being “big-bodied,” Gerard restrained from posting about food on social media “out of fear of being counseled, of being trolled. ...because I’ve seen the way other foodies I know have been trolled online” (Lines 120-123). To Gerard, displaying his love of food on social media would significantly increase his risk of being body shamed and bullied for his struggles with binge eating. Gerard didn’t want his friends to know about his EDR either, and one way in which he felt that he could control this was by avoiding having conversations about food with them.

For various reasons, participants perceived a need to conceal their personal identity of being in EDR by altering their enacted identity, and thus, how they communicated about food. This change in their food communication did not accurately reflect their physiological and emotional relationships with food, creating a personal-enacted identity gap.

Personal—Communal Identity Alignment: Talking About Food with Others in EDR

Conversations about food were described as positive experiences when they were had with other people in EDR. Participants explained how they felt more comfortable talking about food honestly with someone whom they shared an experience of EDR than with someone who hadn’t experienced an ED. These conversations created alignment between participants’ personal and communal identity layers.

Participants explained how feelings of camaraderie with others in EDR surrounding their shared struggles with food allowed them to converse about it more honestly. For instance, Meadow enjoyed talking about food with people she had met through EDR-focused online communities “because they’re all in the same boat. We have deeper conversations because they get it” (Lines 370-376). Juniper described how her friend also being in EDR allowed her to “open up more because they kind of understand” (Line 1213) because “he gets it” (Line 1214). Aspen had a friend in EDR whom she said responded to her disclosures about struggling with food in ways that people without that shared experience could: “...when I’m like ‘Oh, I just don’t want to feed myself,’ they don’t look at me and go like ‘You’re fucking crazy!’ They’re just like ‘Oh my god, I get that” (Lines 3745-3746). Kurt rarely spoke about food with people who hadn’t experienced an ED, reserving those conversations for people he’s met through Eating Disorders Anonymous (EDA) instead: “Definitely some people I’ve met through EDA have been great... we still text pretty regularly about food stuff. I think I kind of only go to people who also had eating disorders ‘cause they get it” (Lines 3472-3474). Kurt also organized his local EDA meeting, in which he said that the prompt of “a ‘good food thing this week’ and a ‘bad food thing this week’” (Line 3421) could spur “a whole conversation that could last us like two hours” (Line 3425).

A shared experience of EDR allowed participants to disclose their struggles with food without fear of harsh judgment. Knowing that their feelings would be validated by those who could relate created alignment of their personal and communal identity layers.

RQ3: How does being in EDR influence individuals' perceptions of others' food-related communication?

Lastly, to address RQ3, participants explained how they felt stigmatized by others' food-related communication, especially regarding their emotional and physiological relationships with food, which created a personal-relational identity gap. Additionally, participants said they felt supported by their loved ones who changed how they ate and prepared food, and how they talked about food with participants.

Personal—Relational Identity Gap: Stigmatization Because of EDR

Participants shared stories about how others spoke to them in ways that made them feel stigmatized because of their emotional and physiological relationships with food. These situations represented gaps between participants' relational and personal identity layers.

Sage described his experience of EDR as "hard. Like, really hard" (Line 987) because of how others have communicated to him about his relationship with food. He explained how his father became upset after Sage involuntarily vomited at a dinner with his colleagues. When they got home, Sage said his father expressed that "he couldn't go anywhere with me, and he was really ashamed of having a [son] like me" (Line 999-1000). Wendell spoke about how his friends pressured him to eat in ways that didn't align with his EDR goals, because they didn't understand how serious it was that he be strict with his eating habits: "I should be vibing with my friends, but they ask a lot of questions like 'Hey, Wendell, why don't you order another plate?' or 'Why don't you pick these?' or 'Why don't you eat this?'" (Lines 1485-1488). Aspen's friends spoke to her similarly when she was struggling to eat: “their reaction of not being able to understand or being like, ‘It’s just food. Just put food in your body. It’s not that big of a deal,’ was so invalidating” (Lines 3769-3772). Meadow found it difficult to talk to her older brother about her EDR. Even though he was one of the only people in her life who knew about it, he also struggled to understand the seriousness of the situation. The times that she did talk to him about it, she said he would respond with sentiments like “’Why? Why do you care? It’s stupid” (Lines 396-397).

Participants cited interpersonal interactions in which they felt hurt and misunderstood by how others communicated about food to them, creating a gap between their personal and relational identity layers.

Personal—Relational Identity Alignment: Loved Ones Changed How They Eat, Prepare, & Talk About Food

In this last theme, participants detailed several different ways in which their loved ones who’d never experienced an ED altered how they ate, prepared food, and talked about food as a means of support. These actions were interpreted by participants as the other person accepting their EDR into the relationship, thus creating personal-relational identity alignment.

One of the most common alterations loved ones made to support participants in their EDR was to their own diets. Specifically, many participants shared that their loved ones changed how they ate to mirror how participants ate out of solidarity. Mortimer, a 21-year-old cisgender male recovering from purging disorder and night eating syndrome, explained that when he shared meals at a friend's house, “sometimes, she would even deny herself” certain foods that Mortimer couldn’t eat per his doctor’s recommendations “just to make sure that I’m feeling comfortable eating with her” (Lines 694-695). Charlie’s mother, whom he lived with, prepared food for him that he was allowed to eat per his own doctor's guidelines, and that they would both enjoy eating so that they could share meals together:

> I think she's always very careful when she's preparing food. And she always makes sure that whatever she prepares is healthy. And she does eat with me when I'm taking healthy foods, even though she is not suffering from an eating disorder. She tries to be supportive and she prepares food that we can both enjoy. (Lines 911-914)

Similarly, Sage's sister and mother stopped eating certain foods at home that would trigger him into purging "so that I might feel included in the family" (Line 1079) and "because they know I'm really having a problem with that" (Line 1074).

Ilana's partner started counting calories after her doctor informed her that she should do so. Penelope's romantic partner also changed his diet to mirror hers as a way of holding her accountable to her EDR goals: "We usually have a diet plan for the day. And he makes sure that we follow that every day" (Lines 610-611). Penelope's parents also changed how they ate, as well as how they spoke about food, and which foods they brought home with them:

> And most times, because they know I can't eat everything they can eat, because I watch what I eat, they avoid bringing up certain topics or bringing such kinds of foods to the house. Or even eating them themselves... Because if they had a choice, they'd eat those foods. But because they don't want to hurt my feelings or make me feel bad about what I eat, they just eat what I eat so that I may not feel so bad about it. (Line 581-586)

In addition to changing *what* they ate, loved ones commonly changed *where* they ate to support participants in their EDR. Gerard noted that even the sight of certain foods could trigger his urge to binge eat, especially baked goods. However, he still wanted to enjoy the pleasure of sharing meals with his friends. With that in mind, his friends "changed the way we usually place orders... we try as much as possible to avoid entering cafes" (Lines 154) and instead chose to go to restaurants that served non-triggering foods. Before he began EDR, Kurt's parents used to suggest visiting a local fried chicken restaurant to celebrate special occasions. After he began EDR and they began to understand his triggers, Kurt shared that "they recently asked me 'Was that a problem?' And I was like, 'No, no, that was fine, but I really appreciate you checking'" (Lines 3529-3530). On nights that they went out drinking together, Ilana's friends let her and another friend who is also in EDR pick the starting place to ensure that they ate.

Lastly, loved ones began changing how they prepared meals so that participants could feel comfortable eating with them. Grant, a 25-year-old cisgender male recovering from pica, appreciated how his parents "prepare meals differently, because they know there are certain foods that I really do not take. So, they're really cautious about that" (Lines 260-261). When Gustav would visit his mother, "she knows the type of food that she is preparing. One that won't give me any problems" (Line 799). Juniper felt closer to her grandmother "because every time [she] comes to our place, she makes food that is fit for me. And every time I go to her place, she does the same thing" (Lines 1121-1123). Robin shared the same experience with his mother: "Food really brings us together. Because, during maybe dinner, she knows what to prepare, one that will not bring me problems" (Lines 1742-1744). Chuck imagined how he would feel if someone prepared food specially for him: "A table full of fruits, man, I would gladly appreciate. I would just feel like you really know my needs" (Lines 2276-2278).

Participants interpreted these ways in which their loved ones communicated to them through and about food as forms of support, creating an alignment between their personal and relational identities.

Discussion

The main purpose of this study was to explore how the experience of EDR impacts: (1) communication of identity through food; (2) communication about food; and (3) perceptions of others’ communication about and through food. Participants discussed the identity alignments that occurred during shared meals and discussions about food, and identity gaps that were created in similar instances. These results move us toward a better understanding of the distinction between illness and recovery identities. Identity alignment encouraged participants to adopt a recovery identity, in which they actively pursued recovery instead of hyper-focusing on their struggles with their ED. Identity gaps, on the other hand, encouraged the adoption of an illness identity, wherein participants’ attention shifted away from the pursuit of recovery and toward its concealment.

Analysis suggested that certain types of communication *about* food and communication *using* food were supportive to individuals’ EDR because they facilitated identity alignment. One instance in which this became apparent was when participants described their feelings about sharing meals with friends and family members. Participants interpreted this communication through food from their friends and family as supportive to their EDR for various reasons. Most notably, these shared meals allowed participants to enjoy eating in accordance with their EDR goals without feeling like they had to put on an act or live up to others’ expectations for them. In this manner, the other person seemed to allow the recovery into the relationship, thereby creating calibration between their personal and relational frames. One of the most challenging aspects of EDR is the often-drastic changes made to an individual’s eating habits. For instance, individuals recovering from anorexia nervosa often experience emotional and physical turmoil when they begin eating larger portions of food, different foods, or eating more frequently. Being able to make these changes at all requires a great deal of emotional energy, and being able to enjoy doing so is worthy of acknowledgment.

Beyond simply sharing meals, the changes loved ones made in how they ate, prepared, and spoke about food in the presence of participants were also described as identity-affirming. The emotions that typically precipitate EDs, such as shame, guilt, and fear, seemed to have been lifted when loved ones accommodated participants' needs around eating and conversations about food. These changes were not only critical to preventing participants from engaging in ED behaviors, but they also communicated to participants their worthiness of EDR. Oftentimes, an illness or disorder can lead to someone adopting an illness identity feeling like a burden, and/or creating feelings of embarrassment or shame about their symptoms. However, the display of loved ones' willingness to support participants through their food choices stymied those feelings for participants, allowing them to eat and talk about food in accordance with their EDR goals. In essence, by focusing on their EDR goals, participants were able to enact a recovery identity of positivity and strength, instead of an illness identity rooted in their symptoms and associated hardships.

The last case of identity alignment occurred for participants when they had friends in EDR with whom they could communicate about food. The ability to communicate about their struggles regarding food with other people in EDR was an invaluable source of comfort and camaraderie. Discussions focused on ED symptoms would typically be associated with an illness identity, as it is often characterized by a fixation on an individual's symptomatology and its detriments. However, in some cases, conversations about the challenges of recovery appeared to be useful in participants efforts toward EDR. This perhaps implies that part of the difference between illness identity and recovery identity is how symptoms are framed in discussions. For instance, by venting about their struggles with food to people who shared and inherently understood those struggles, participants had their feelings affirmed and built camaraderie, which allowed them to continue moving toward their EDR goals rather than become engulfed by their recovery-related challenges.

Certain methods of communication about and through food seemed to invalidate an individual’s EDR-related identity and create identity gaps. Four themes demonstrated this, including the detriment to interpersonal relationships from the inability of participants to comfortably share meals. Participants either chose to avoid or were excluded from social situations involving food, which signaled to them that their friends didn’t believe their EDR needs were worth prioritizing. As mentioned before, illnesses and disorders deemed taboo oftentimes encourage the adoption of an illness identity grounded in feelings of unworthiness of being burdensome. This suggests that those intending to support their friends in EDR should consider the impact of sharing meals with them, specifically as it influences their ability to enact a recovery identity. This theme might also suggest that part of adopting a recovery identity includes discontinuing interpersonal relationships that contradict an individual's EDR-related needs and goals as they pertain to food.

The second theme of invalidating communication about and through food involved participants’ perceptions of how others communicated about food to them. They felt that others did not comprehend the seriousness of their EDR and treated them poorly because of it. Specifically, friends and family members spoke to participants in ways that reflected the misconception that EDs are a choice, either by pressuring them to eat out of alignment with their EDR needs or insulting them when they were struggling with symptoms. The last two themes that demonstrated identity gaps further affirmed that a profound existence of ED stigma.

Participants experienced identity gaps when they felt pressured to change how they ate and spoke about food in order to conceal their EDR. In most cases, participants did this because they had either been stigmatized in the past for their ED or had witnessed other people be stigmatized for EDs or other mental health disorders. Together, these occurrences demonstrated how stigma prevented individuals in EDR from adopting a recovery identity by forcing them to focus on concealing their recovery.

The final theme apparent from analysis was the ability of participants to negotiate a gap between their personal and relational identity layers. Whether it was refusing food or asking for food, participants enacted a recovery identity by advocating for their needs pertaining to EDR. Vocalizing their needs, and in doing so, disclosing the existence of their EDR, juxtaposed enactments of an ED illness identity in other themes in which participants intentionally hid their EDR.

Overall, this study increased understanding of how individuals' perception of communication about and through food impacted how they saw themselves, as well as their ability to comfortably and confidently adopt and enact a recovery identity. It also shed light on how communication through and about food can reinforce a recovery identity, specifically by how participants described primarily communicating their recovery-related needs pertaining to food. For those who felt supported by others—either loved ones or other people in EDR—felt comfortable communicating their EDR-related identity through food. Those who feared being stigmatized or felt that they *were* stigmatized or mistreated because of their EDR felt forced to conceal their personal EDR-related identity in ways that conflicted with their other identity layers. In some instances, this curtailed progress they'd made in their emotional and physiological relationships with food. Such findings aligned with previous research that demonstrates how perceived social support can influence the occurrence of ED-related attitudes and behaviors (Birmachu & Heidelberger, 2019), and how interpersonal challenges, such as miscommunication, negatively correlate with feeling supported (Geller et al., 2017). Additionally, it affirmed previous research that claims acceptance of one's illness, or in this case, their *recovery from* a mental health disorder, correlates positively with adaptive psychological and physical functioning (Oris et al., 2018).

Implications

Several studies have explored relationships between the various aspects of EDs and EDR and identity, such as identity and food, identity and body image, and identity and recovery. However, there is currently a lack of research exploring the interrelation of EDR, food, identity, and communication. The current study contributes to the Communication Studies discipline by applying the Communication Theory of Identity to an important health-related context. To my knowledge, this is the first study to use this theory to explore communication with and about food during eating disorder recovery. Further, most of the existing research has investigated identity and EDs from a social perspective, not a personal one—in other words, extant studies focus on how people strategically or unconsciously align with others to whom they feel they similar, creating "in groups" that are reflections of, and actively influence, their sense of identity. This study added to the collective understanding of EDR by taking a person-centered perspective, focusing on how people in recovery communicated various pieces of their *individual* identity through food, how their recovery influenced their communication about food, and how their recovery impacted how they perceive communication through and about food from others. Additionally, "recovery identity" is not yet an agreed-upon term, and this study helped to clarify how a recovery identity is experienced and communicated differently than illness identity.

Specifically, this study illustrated one manifestation of recovery identity: individuals in EDR primarily communicated about and through food in a way that upheld their recovery-related needs and preferences, and preserved an identity that is not primarily associated with their ED symptoms and hardships.

Secondly, this research provided valuable insight into how support networks can better assist individuals through EDR. Participants' descriptions of how and why they felt mistreated and misunderstood by how others communicated about and through food to them indicated a remaining prevalence of stigma and misconceptions around EDs. Participants were made to feel shame for how and what they ate, which pressured them to change how they talk about food and how they eat in order to conceal their EDR. This pressure, in turn, inhibited their ability to enact a recovery identity. Such communicative patterns indicated the continued need to dismantle the systems of thinking about EDs rooted in stigma, especially amongst those who want to support loved ones in EDR.

Dismantling the stigma around EDs will require collective effort from individuals, advocacy organizations, and healthcare institutions. However, some options for healthcare providers to contribute to this greater effort include assisting patients with learning how to navigate stigma, by reaffirming to them what stigma is and advocating for them when they face it. The current study clarifies the internal struggles of people in EDR, and demonstrates that even if they do not explicitly communicate their discomfort with certain types of communication, some words, phrase, or actions can cause them to question who they really are and how they fit into certain relationships. This is important for friends and loved ones of people in EDR to understand; as with all "invisible illnesses," people need to understand that EDs can profoundly distort an individual's perception of otherwise basic aspects of life, such as food. Being unaware of this was demonstrated by participant descriptions of attempts at support that were more hurtful than helpful. Therefore, healthcare providers could educate their patients' support network about how to avoid unintentionally stigmatizing their loved ones in EDR, because as was explained by participants, sometimes attempts at support were instead unsupportive and hurtful. Equipping support networks with language and communication styles that challenge stigmatic ideas about EDs is important for individuals to be able to focus more on their recovery and less on their ED. Alternately, healthcare professionals should consider how support networks can communicate *positively* through and about food in ways that allow individuals in EDR to feel comfortable sharing "their true selves" with others. . In that vein, when healthcare providers truly understand the identity-related ramifications of eating disorder recovery, they may be more willing and able to help patients find support groups and related resources, so that patients have a safe space to share their victories and frustrations with people who "get it"—this is particularly important if patients are unable to receive this type of support from their friends or family.

Limitations

While purposive sampling was utilized only to specifically recruit adults who had been in EDR for at least one year, most participants in the study also spoke English as their second language. This resulted in some interview transcriptions being difficult to transcribe, and thus, some data had to be omitted from analysis. Additionally, despite my best efforts to consider cultural and language differences in my analysis of interview transcripts and while conducting interviews, it is likely that some of the sentiments shared by participants were lost in translation and thus misinterpreted. Thus, the applicability of this study's findings to broader research about EDR is limited. Future CTI research about EDR should consider more significantly the role of individuals' cultural background in communication and identity.

Participants were only required to have been in EDR for a minimum of one year, allowing for a broad range of EDR experiences to be represented in the sample. However, the average amount of time participants reported having been in EDR was 3.6 years, and the maximum amount of time reported was 10 years. Overall, this represents a sample of individuals relatively new to EDR, and thus, offers no insight into how the early phases of EDR compare to later phases. Future EDR researchers ought to take into account how the duration of an individual's EDR impacts how they communicate about and through food, and their perceptions of how others communicate about and through food.

Jung and Hecht (2004) argue that identity gaps should be studied from the perspectives of each party involved in interpersonal interactions, because gaps arise out of each person's communicative acts and the individually felt gaps of each person are likely related to each other. This study did not specifically seek a dyadic understanding of identity gaps due to time and resource constraints, and I only analyzed identity and communication from the perspective of individuals in EDR. Thus, future research should consider investigating the perspectives from people with whom individuals in EDR communicate through and about food.

Conclusion

This study sought answers to the following research questions: (1) How does being in EDR impact the way individuals communicate their identity through food? (2) How does being in EDR impact the way individuals communicate *about* food? And (3) how does being in EDR influence individuals' perceptions of others' food-related communication? Participants described the identity alignments that occurred during shared meals and discussions about food, identity gaps that were created in similar instances, as well as how they negotiated these gaps. These descriptions highlight some of the many ways in which communication through and about food can facilitate the adoption of a recovery identity, as well as which ways it can inhibit the adoption of a recovery identity.

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Appendix A

Interview Questions

Personal Identity

1. Can you describe for me what being in EDR is like for you?
2. Can you describe what your relationship with food was like before you had an ED?
3. Can you describe what your relationship with food is like now that you're in EDR?

Enacted Identity

4. Are there certain aspects of food that you avoid talking about?
5. Are there certain aspects of food that you enjoy talking about?
6. Can you tell me a little bit about how you display your relationship with food?
7. Can you tell me a little bit about how you display being in EDR?

Relational Identity

8. Can you tell me about someone you feel is supportive of you being in EDR?
    a. How does food fit into your relationship with this person?
9. Can you tell me about someone you feel is unsupportive of you being in EDR?
    a. How does food fit into your relationship with this person?
10. Tell me about how food fits into your social life.
11. Can you tell me about any specific people you avoid talking about food with?
12. Can you tell me about any specific people you enjoy talking about food with?
13. Can you tell me about any specific people who you avoid sharing meals with?
14. Can you tell me about any specific people who you enjoy sharing meals with?

Final Questions

15. Those are all the formal questions I had for us today; is there anything that I didn’t ask you that you were hoping to share today?
16. How are you feeling? (If distressed, refer participant to resources relevant to area and in consent form)

Appendix B

Online Recruitment

Hello, my name is Rosemary Jeter. I am currently a second-year graduate student in the University of Montana's Communication Studies department. For my thesis project, I am studying the experiences of individuals in eating disorder recovery. Specifically, I want to understand how food is used as a tool for communicating identity. As part of this project, I am looking to interview individuals willing to talk about their experience with eating disorder recovery. I am looking for participants who meet the following criteria:

1. Self-identify as being in eating disorder recovery for at least one year **and**
2. are at least 18 years of age.

If you fit these criteria and are interested in participating, please click here. I will contact you to schedule an in-person or Zoom interview at your earliest convenience. Qualified participants who finish an interview will be reimbursed $25 for their time.

It is my goal to help providers, and other support-network members (e.g., friends, family) better understand the complexities of eating disorder recovery so that they might be able to provide effective social support. Thank you so much for your participation. Please feel free to share this post with anyone who may qualify and contact me via email if you have questions: mary.jeter@umconnect.umt.edu.

Appendix C

Flier Recruitment

I am a second-year graduate student in the University of Montana's Communication Studies department looking to interview individuals willing to talk about their experience with eating disorder recovery. I am looking for participants who meet the following criteria:

3. Self-identify as being in eating disorder recovery for at least one year **and**
4. are at least 18 years of age.

If you fit these criteria and are interested in participating, please reach out to me via email: mary.jeter@umconnect.umt.edu. Qualified participants who finish an interview will be reimbursed $25 for their time.

Please feel free to share this information with anyone who may qualify and contact me via email if you have questions!

Appendix D

Qualtrics Demographic Survey

1. How old are you?
    1.1. Please type your response in years_________________________
2. What is your marital status? (Choose all that apply)
    2.1. Married
    2.2. Divorced
    2.3. Widowed
    2.4. Single
    2.5. Other (please specify) ____________________
    2.6. Prefer not to say
3. Please select which option(s) best represent your current living situation.
    3.1. Live alone
    3.2. Live with one or more roommates
    3.3. Live with one or more family member(s)
    3.4. Live with romantic partner/spouse/significant other, with children
    3.5. Live with romantic partner/spouse/significant other, without children
    3.6. Other (please specify) ____________________
    3.7. Prefer not to say
4. How would you describe your sexual orientation? (Choose all that apply)
    4.1. Heterosexual/Straight
    4.2. Homosexual/Lesbian/Gay
    4.3. Bisexual
    4.4. Pansexual

    4.5. Asexual

    4.6. Queer

    4.7. Other (please specify) ________________

    4.8. Prefer not to say

5. How would you describe your gender identity? (Choose all that apply)

    5.1. Cisgender Male

    5.2. Cisgender Female

    5.3. Transgender Male

    5.4. Transgender Female

    5.5. Non-binary/Gender non-conforming

    5.6. Other (please specify) ________________

    5.7. Prefer not to say

6. How would you describe your racial identity? (Choose all that apply)

    6.1. White/Caucasian/European-American

    6.2. Black/African-American

    6.3. Latinx or Hispanic

    6.4. Asian/Asian-American

    6.5. Native American

    6.6. Native Hawaiian or Pacific Islander

    6.7. Other (please specify) _________________

    6.8. Prefer not to say

7. What is the highest level of education you have received?

    7.1. High school diploma

    7.2. Associate degree
    7.3. Bachelor's degree
    7.4. Master’s degree
    7.5. Doctorate
    7.6. Other (please specify) _________________
    7.7. Prefer not to say

8. What is your yearly income?
    8.1. $0--$20,000
    8.2. $20,001--$40,000
    8.3. $40,001--$70,000
    8.4. $70,001--$100,000
    8.5. $100,001 or more
    8.6. Other (please specify) ___________________
    8.7. Prefer not to say

9. How long have you been in eating disorder recovery?
    9.1. 1-5 years
    9.2. 6-10 years
    9.3. 10 or more years
    9.4. Prefer not to say

10. What eating disorder diagnoses have you received? (Choose all that apply)
    10.1. Anorexia nervosa
    10.2. Bulimia nervosa
    10.3. Binge-eating disorder

10.4. Pica

10.5. Purging disorder

10.6. Atypical anorexia nervosa

10.7. Night eating syndrome

10.8. Avoidant/restrictive food intake disorder (ARFID)

10.9. Other (please specify) ___________________

11. If you would diagnose yourself differently than indicated above, please specify what diagnosis or diagnoses you would give yourself. (Open-ended response)

Appendix E

Participant Demographics

Characteristic	**Number (Valid %)**
Age	***N* = 20**
	M = 23.55 years
	Min = 18
	Max = 29
EDR Duration	***N* = 20**
	M = 3.6 years
	Min = 1.25
	Max = 10
Gender	
	***N* = 20**
Cisgender Female	6 (30%)
Cisgender Male	12 (60%)
Transgender Male	2 (10%)
Race/Ethnicity	***N* = 20**
White/Caucasian/European-American	8 (40%)
Black/African-American	10 (50%)
Hispanic or Latinx	2 (10%)
Sexuality	***N* = 20**
Heterosexual/Straight	14 (70%)
Homosexual/Lesbian/Gay	3 (15%)
Asexual	1 (5%)
Pansexual	1 (5%)
Bisexual	1 (5%)
Marriage Status	***N* = 20**
Never Married	15 (75%)
Currently Married	4 (20%)
Separated	1 (5%)
Education	***N* = 20**
Bachelor’s Degree	9 (45%)
Associate Degree	7 (35%)
High School Diploma	3 (15%)
Master’s Degree	1 (5%)
Annual Income	***N* = 20**
\$20,001-\$40,000	9 (45%)
\$40,001-\$70,000	4 (20%)

$0-$20,000	3 (15%)
$70,001-$100,000	2 (10%)
Over $100,001	1 (5%)
Did not specify	1 (5%)
Eating Disorder Diagnosis	***N* = 20**
Binge-eating disorder	6 (30%)
Anorexia nervosa	4 (20%)
Pica	1 (5%)
Bulimia nervosa	1 (5%)
Purging disorder	1 (5%)
Atypical anorexia nervosa	1 (5%)
Combination of several	7 (35%)

Appendix F

Codes and Themes from Phase One of Coding

Main Theme	Subtheme 1	Subtheme 2	Code	Exemplar
Personal Layer	(1) Describing one's personal and emotional relationship with food as it fits into a dichotomy.	(1a) "Normal" or "weird"	(1aa) Normal is quantified by how much food or how often one eats	"Well, my relationship with food before I had an eating disorder was very normal. …three meals a day and maybe some snacks in between." Mortimer (666-667)
			(1ab) Normal is defined as an indifference toward food	"It was normal. Like I used to eat food for growth… When I'm hungry." Penelope (542-545)
			(1ac) Abnormal is defined by its social unacceptability	"Yeah, I think that'd tempt me to eat dinner in a manner that's not civilized." Gustav (835-837)
		(1b) "Good" or "bad"		"Well, to be honest, I've never been a good eater. I've been a poor eater." Robin (1649-1651)
		(1c) "Right" or "wrong"		"My relationship with food currently is health because I don't eat food for the wrong reasons." Penelope (557-558)
		(1d) "Safe" or "unsafe"		"I mean, I have safe foods that I feel I can eat regularly. And I have some food I'm just like *oof* not even touching those in front of anyone!" Kurt (3313-3318)

	(2) Describing one's relationship with food as needing to change.			"Now, I get irritated when I think about food at times. I'm trying to change why I'd feel that way, knowing it's actually out of survival." Merle (3139-3141)
	(3) Defining EDR by what has been lost or sacrificed			"It's been tough because I had to distance myself from some particular locations, due to having to understand my body and understanding my condition." Gerard (69-71)
	(4) Believing that other people can tell they're in EDR because of their body size.			"Due to how I looked previously, and how I am presently. So it's gonna give them an inkling that I am in recovery." Amanita (2383-2386)
Enacted Layer	(1) Indifference towards conversations about food.			"I find I rarely talk about food. But I think it's just something normal to talk about." Charlie (881-882)
	(2) Conversations about food are enjoyable.	(2a) For entertainment.		"I love learning about nutrition facts, honestly. Any sort of new research they find out about the impacts of different digestive enzymes and things like that." Meadow (323-326)
		(2b) Connecting with others.		"Even though I'm not really good at eating, at least there's one thing I like doing and that is talking about food with people." Amanita (2335-2338)
		(2c) Therapeutic.		"It's just like going to therapy. Life changing. It's like going to a priest to confess." Wendell (1556-1561)
	(3) Strategically eating, talking about food, and	(3a) To appear "normal."		"They wouldn't know I'm in EDR, because I try to keep it normal." Chuck (2137)

	talking about EDR to conceal being in EDR.	(3b) To avoid feelings of shame and embarrassment.		“I’m very picky eating foods. ...Yeah, because I’m trying to avoid the shame that comes about in purging in public places.” Robin (1702-1709)
		(3c) To avoid being treated poorly or differently.		“They would then, everything that I do, like anything that I eat, they would kind of look at like ‘Oh, is she slipping?’ They would. They’d look at me at a restaurant differently or something.” Meadow (336-341)
		(3d) To protect younger siblings.		“I didn’t want him to worry about me because I’m supposed to be worrying about him. He’s my little brother.” Ilana (2795-2800)
	(4) Setting boundaries around food.			“I would say I would request small amounts. And then healthy foods, if they can’t provide that. I’d rather have a fruit and water.” Benny (460-463)
Relational Layer	(1) Impact of sharing meals on relational closeness and vice versa.	(1a) Sharing meals facilitates relational closeness.		“So, I don’t even worry about anything. It’s just like, you know, eating food that somebody cares about you made.” Juniper (1360-1367)
		(1b) Relational closeness facilitates enactment of EDR during meals.		“I don’t have to be afraid of what I eat around her.” Ilana (2827)
	(2) Feeling supported by loved ones who have changed how they eat,	(2a) Loved ones changed their diets to mirror the participant’s.		“Because if they had a choice, they’d eat those foods. But because they don’t want to hurt my feelings or make me feel bad about what I eat, they just eat what I eat

	cook, and talk about food.			so that I may not feel so bad about it." Penelope (584-586)
		(2b) Loved ones changed where they eat.		"I get to choose where we eat and she will work with anything." Ilana (3067-3070)
		(2c) Loved ones changed how they talk about food.		"I think they have started kind of improving how they communicate about food with me." Kurt (3607)
		(2d) Loved ones changed how they prepare food.		"And then they would prepare food that's best suited for me. They won't give me food they know very well will bring up the disorder or something that would be against the recovery process." Mortimer (707-709)
	(3) Inability to share meals strains relationships.			"Which is really depressing when everyone is just eating and having a good time. You're just sitting there." Ilana (2664-2666)
	(4) Loved ones fitting themselves into someone else's recovery.	(4a) Doing so is helpful.	(4aa) By offering encouragement.	"They know what I'm going through, and I get encouragement to maybe eat more." Merle (3204-3206)
			(4ab) By holding participants accountable to their EDR goals.	"I have some friends that actually keep me in check. Like when we are together and we're eating something, they help me to not overeat." Wendell (1419-1421)
			(4ac) Seeking out food for participants.	"And my grandmother, who is very supportive, she actually packs some extra foods from the market for me." Wendell (1553-1555)
			(4ad) Mutual support between loved ones and participants.	"We had a good system going where after the meetings we'd both go and get food together, so that we'd eat that day." Kurt (3492)

	(5) Participants feel like their boundaries around food are respected and defended.			“And it’s normally one of their wives or girlfriends will just be like ‘Shut the fuck up. That’s what she asked in nice words. To shut the fuck up.” Ilana (2716)
	(6) Participants feel like their boundaries around food are misunderstood and disregarded.			“I reduced the amount of times I would go and engage in activities with my friends outside, related to food. At some point people thought I was rather avoiding them.” Martin (472)
Communal Layer	(1) Other people in EDR can offer instrumental and emotional support around food in ways that people who haven’t experienced EDR cannot.			“Because they’re all in the same boat. We have deeper conversations because they get it.” Meadow (370)
	(2) Comparing personal experience of EDR to other peoples’ experience of EDR and other mental health disorders.	(2a) Identifying with people who’ve experienced other mental health disorders.		“It’s just like an alcohol addiction. We’re all addicted to something.” Meadow (276)
		(2b) Disidentifying with people who’ve experienced other mental health disorders.		“What I think is disturbing is the way people find out you are trying to recover from something. They think you are depressed or something.” Charlie (888)
		(2c) Struggling to identify with other people with EDs.		“And before I could cut her off, I think the damage was done. But I kind of got in my head that everyone with an active ED is like her. And it’s not ideal.

				Because like, I am that, too!" Kurt (3454-3456)
	(3) Feeling misunderstood or stigmatized because of EDR.			"Their reaction of not being able to understand or being like, 'It's just food. Just put food in your body. It's not that big of a deal,' was so invalidating." Aspen (3757)