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Multiple group identifications and identity compatibility in eating disorder recovery: A mixed methods study

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Abstract

Eating disorder recovery is an identity transition characterised by ambivalence, in which group memberships play an important part. However, our understanding of how memberships of groups with different recovery norms (i.e., supportive vs. unsupportive of recovery) can facilitate or inhibit recovery is limited. To address this gap, this study adopted the Social Identity Model of Recovery to examine how recovery is manifest through the changing composition of an individual's group memberships. We employed a convergent mixed methods design to quantitatively determine whether specific groups (i.e., family, friends, and online groups) are more helpful to eating disorder recovery than others, and to qualitatively explore how group (in)compatibility shapes recovery efforts. There was a high level of convergence across survey ($N = 112$) and interview ($N = 12$) data: groups could have a positive or negative impact according to their recovery norms; different groups provided different forms of support and identity-expression; incompatibility was not always experienced as a problem and could afford strategic benefits. Our findings are amongst the first to attest to the importance of considering identity networks (and their normative content) during eating disorder recovery.

KEYWORDS
eating disorders, identity compatibility, multiple group memberships, recovery, social cure, social identity

1 | INTRODUCTION

Maintaining the change that is critical to eating disorder (ED) recovery can be undermined due to the ego-syntonic nature of EDs (Gregertsen et al., 2017). Moreover, for people with eating disorders (PWED), diagnostic categories often become self-defining (Hastings, McNamara, Allan, & Marriott, 2016). The disorder can inform a positive self-concept and be associated with feelings of accomplishment (Schmidt & Treasure, 2006). Consequently, psychologically disconnecting (or dis-identification; Becker & Tausch, 2014) from the illness identity is an essential, but exceptionally challenging, task (McNamara & Parsons, 2016).

Possessing recovery-supportive social relationships is vital during this time of transition. Family and friends are viewed as important sources of support who help PWED move past their illness to find new meaning and purpose in life (Leonidas & dos Santos, 2014). However, little is known about the social psychological mechanisms through which different groups support recovery. Furthermore, given that groups can also hinder recovery (Kluck, 2010), it remains to be seen which (if any) can be unambiguously classified as recovery supportive.

The current study addresses this gap by adopting a Social Identity Approach to understand the impact of simultaneous group memberships on PWED and their recovery. The Social Identity Approach to Health (SIAH), also known as the "Social Cure," articulates the ways in which our psychological experience of group memberships (i.e., our social identifications) impact individual health and well-being (Haslam, Jetten, Cruwys, Dingle, & Haslam, 2018). Drawing on a well-established literature connecting group memberships with positive (and negative) health outcomes (Brook, Garcia, & Fleming, 2008), the SIAH proposes that multiple, compatible group identifications are essential for maintaining good health, particularly during life transitions (Haslam et al., 2018). This is partly due to the availability of multiple sources of support during times of change (Iyer, Jetten, Tsivrikos, Postmes, & Haslam, 2009). Recent applications of this perspective to addiction (Best et al., 2016) propose that identity compatibility is particularly important to consider for those in recovery. Here, recovery is conceptualised as a process of identity management whereby one leaves groups that are not compatible with one's new recovery identity and joins recovery-supportive groups.

Nonetheless, while social cure research has looked at the benefits of possessing multiple group memberships across many different types of life transition (e.g., retirement, new parenthood, beginning university), few studies have systematically investigated identity content or the ways in which individuals experience identity incompatibility, and whether this indeed acts as a motivator for change. This study explores these questions in greater detail. PWED are an ideal case study given the self-defining nature of the illness, the need for an identity transition for successful recovery, and previous research suggesting the importance of social relationships to this process.

1.1 | A social identity approach to ED recovery

The SIAH (Haslam et al., 2018) posits that a person's social identities shape behaviour such that, when an identity is relevant or "salient," group members will perceive, think and act in terms of that group. Groups have two important health consequences. First, through their norms, groups can impact individuals' performance of health-related behaviours (Tarrant, Haggar, & Farrow, 2012). High identifiers are most likely to adhere to these normative behaviours (e.g., Turner, 1991). Second, groups provide important psychological resources, including social support. These resources are thought to be enhanced by possessing multiple (compatible) group identifications, as the individual is likely to have a richer social landscape in which multiple support-types are available (Haslam et al., 2018).

The Social Identity Model of Recovery (SIMOR; Best et al., 2016) proposes that identifying with a group of "recovery peers" promotes positive health outcomes (Best et al., 2016). However, if one does not also dis-identify from groups that are unsupportive of recovery, then it will be undermined (Dingle, Stark, Cruwys, & Best, 2015). This can be difficult: anti-recovery groups may enable the individual to express important social identities that are central to their self-definition (Quinn & Earnshaw, 2013).

Although SIMOR focuses on addiction recovery, it is likely to be applicable to PWED, for whom the development of a recovery identity might be hindered by their reluctance to relinquish the groups supporting their illness identity. The clinical literature lacks a standardised definition of ED recovery that is acceptable to clinicians, researchers and PWED (McDonald, Williams, Barr, McNamara, & Marriott, 2021). Furthermore, existing definitions tend to focus on assessments of psychological, cognitive, physiological and behavioural symptoms and ignore the role played by social relationships. This is despite the fact that PWED often cite important groups as pivotal to their recovery efforts (Linville, Brown, Sturm, & McDougal, 2012). In this study, we are therefore adopting SIMOR's understanding of recovery as a social process (Best et al., 2016). Using this approach, it is possible to explore the impact of specific group memberships on recovery. Moreover, it is possible to examine PWED's experiences of their social networks, and to explore when and how group (in)compatibility helps or hinders recovery.

1.2 | EDs, group norms and ambivalence

One way in which a social group can impact on eating behaviour (and other health-related behaviours) is through its norms. While some groups espouse norms that are likely to encourage healthy behaviours, others may promote less desirable health practices. In turn, these norms are likely to affect group members' own health behaviours, with those who identify strongly with the group being most likely to adhere (e.g., Turner, 1991). Such adherence has been shown in a variety of health-related behaviours. For instance, Terry and Hogg (1996) found that strongly-identifying Australian university students reported stronger intentions to engage in regular exercise and sun-protective behaviour (both of which are normative to the group) than those who identified less strongly. On the other hand, Livingstone, Young, and Manstead (2011) showed that strongly identifying UK university students reported stronger drinking intentions (again, a normative beahviour for this group). Normative eating behaviours has also been explored: Louis et al. (2007) found that student group norms and student group identification interacted to predict the nature of participants' healthy eating intentions 2 weeks later. Similarly, Åstrøm and Rise (2001) showed that leisure group norms influenced highly identifying young Norwegian adults' healthy eating intentions.

Such observations can be extended to explore norms around disordered eating. For example, when exploring the efficacy of a group-based intervention for ED prevention, Cruwys, Haslam, Fox, and McMahon (2015) found that as the programme progressed, participants were less likely to believe that their fellow group members endorsed thinness- and dieting-related norms. These results highlight the important role played by norms in reducing (and maintaining) disordered eating.

Individual groups and their norms are thus likely to have important impacts upon PWED but untangling these requires further investigation. Dis-identification from the illness identity is challenging if PWED's social networks include groups that are supportive of illness maintenance or possess an appearance-centric culture (Kluck, 2010). Research suggests that the key social groups relevant to PWED are family, friends and ED-related online communities (e.g., Leonidas & dos Santos, 2014; Linville et al., 2012; Rich, 2006). It is likely that these groups are qualitatively different in terms of the dieting-related norms they espouse. In turn, they are likely to have differing impacts on PWED's beliefs about their ability to recover (i.e., recovery self-efficacy; Pinto, Heinberg, Coughlin, Fava, & Guerda, 2008). Indeed, conflicting research evidence pertaining to each of these groups underlines the need to investigate their normative content prior to determining their possible impact on recovery.

Research into online groups highlights the complexity of group norms and their effects. These groups are categorised as either "pro-ED" or "recovery" groups. *Pro-ED groups* are perceived to take an anti-recovery stance

(Rich, 2006). Members share weight-loss tips (Borzekowski, Schenk, Wilson, & Peebles, 2010) and provide affirmation to those restricting food consumption (Csipke & Horne, 2007), which can normalise disordered eating behaviours. However, some have suggested that the dangers posed by these groups need to be balanced against the support they offer to a stigmatised community (e.g., Csipke & Horne, 2007).

In contrast, *recovery groups* promote positive health behaviours, norms, and outcomes for their members. Interactions create a shared recovery identity, facilitate coping strategy development, and encourage illness disclosure (Hastings et al., 2016; McCormack & Coulson, 2009; McNamara & Parsons, 2016). Nonetheless, weight/eating can dominate discourses, creating "anorexogenic" environments (Riley, Rodham, & Gavin, 2009), so, once more, the impact of these groups is likely to be complex and multifaceted.

The evidence is similarly ambiguous in relation to family and friendship groups. Family attitudes concerning body shape and eating behaviours can influence body dissatisfaction and promote disordered eating behaviours (Kluck, 2010). Similarly, experiences of bullying, diet behaviour modelling, and perceptions of friends' dieting can initiate disordered behaviours, which are reinforced by feelings of social acceptance from others (Eisenberg et al., 2005).

In sum, group memberships have important impacts upon PWED. However, these influences depend upon group norms (which are likely to differ in terms of the dieting-related norms they espouse), as well as the ways in which the individual interacts with other members. In order to understand this complexity, and to further explore the effects of multiple simultaneous group memberships, we need to investigate the collection of groups PWED belong to. We did this by employing a mixed-method investigation of four social groups relevant to ED recovery amongst young people (16–25): family, friends, online recovery groups and online pro-ED groups. This age-group is at highest risk of ED onset (Neumark-Sztainer et al., 2006), and is highly active in ED-related online groups (Arseniev-Koehler, Lee, McCormick, & Moreno, 2016). We wished to compare PWED's quantitative perceptions of group norms and identifications with qualitative investigations of the experience of (in)compatibility when seeking support from these groups, in order to determine their varying impacts on recovery and well-being.

Based on previous literature discussed above, our quantitative predictions are: (H1) pro-ED and friendship groups will be perceived as espousing stronger thinness-related norms than family and recovery groups; (H2) identification with family, recovery and friendship groups will positively predict wellbeing, while identification with pro-ED groups will negatively predict wellbeing; (H3) H2 will be moderated by perceived strength of thinness-related norms, with stronger norms weakening the identification/wellbeing relationship, and strengthening the group identification/ill-being relationship.

2 | METHOD

2.1 | Design

We adopted a convergent mixed-methods design, comprising online survey and semi-structured interview studies (Creswell & Plano Clark, 2017). This involved the concurrent collection and subsequent independent analysis of two separate data corpora that were then integrated for interpretation purposes (Henwood et al., 2017). We employed a pragmatist approach and assumed that neither quantitative nor qualitative data alone can fully address the research question (Creswell & Plano Clark, 2017). Furthermore, we employed the SIAH as a conceptual model that informed both quantitative and qualitative data collection, data analysis and our approach to integrating the results of both datasets (Creswell & Plano Clark, 2017).

The online survey study provided an investigation of the norms associated with each of the four groups, participants' identification with them and their relationship with well-being and recovery. The interview study examined the content and meaning of participants' group memberships, their perceptions regarding group (in)compatibility and how such networks are used during the illness-recovery transition. Therefore, although data are collected from

different samples, we ensured that questions in both data collection strands addressed the same theoretical concepts (Creswell & Plano Clark, 2017).

2.2 | Participant recruitment

Ethical approval was granted by the authors' institution. Participants were required to be 16–25 years, and to have experience of online recovery/pro-ED groups. The study was advertised on social media accounts/websites of charities supporting those with mental health issues and/or EDs in the United Kingdom, Ireland, the United States, Canada and Australia. Both data collection strands were advertised simultaneously, and participants were provided with the survey link and contact information to participate in an email interview. We did not link data or ask participants to indicate whether they had participated in both strands. In keeping with our convergent mixed methods design, all participants came from the same population (i.e., those who self-identified as in recovery from an ED) and distinct but complementary data were collected on the same concepts in both data collection strands (Creswell & Plano Clark, 2017).

2.3 | Participants and data collection

2.3.1 | Survey study

Participants

One-hunderd and twelve participants (108 females, 2 males, 2 unknown; $M_{age} = 20.24$ years, $SD = 3.08$, *range* = 16–25) participated; 48% were from Ireland, 44% were from the United Kingdom and 8% were from other locations; 81% had received an official ED diagnosis.[1] The most common diagnosis was anorexia (51%), followed by ED Not Otherwise Specified[2] (15%) and bulimia (14%). Most had received/were receiving treatment (68%).

Measures

Group identification was measured with the four-item Group Identification Scale (GIS; Sani, Madhok, Norbury, Dugard, & Wakefield, 2015; e.g., "I feel a sense of belonging to my [group]") using a 1–7 scale (*strongly disagree* to *strongly agree*) for four groups: family ($\alpha = .91$), friends ($\alpha = .89$), recovery group ($\alpha = .83$) and pro-ED group ($\alpha = .86$). Participants who did not possess a particular group membership were asked to leave the relevant items blank. The mean value was found for each group.

We measured thinness-related *descriptive norms* (how group members behave) for each group using five items from Cruwys et al. (2015). Participants rated their agreement with each item (e.g., "How often do members of your [group] go on a diet?") on a 1–7 scale (*never* to *very frequently*). We found the mean of the items for family ($\alpha = .90$), friends ($\alpha = .94$), recovery group ($\alpha = .81$) and pro-ED group ($\alpha = .90$).

We also measured thinness-related *injunctive norms* (how group members encourage each other to behave) for each group using four items from Cruwys et al. (2015). Participants rated their agreement with each item (e.g., "Members of my [group] think dieting is a good idea") on a 1–7 scale (*strongly disagree* to *strongly agree*). We found the mean of the items for family ($\alpha = .83$), friends ($\alpha = .81$), recovery group ($\alpha = .70$) and pro-ED group ($\alpha = .84$).

Psychological well-being was measured with Diener et al.'s (1985) five-item Satisfaction With Life (SWL) scale (e.g., "If I could live my life over, I would change almost nothing"). Participants rated their agreement on a 1–7 scale (*strongly disagree* to *strongly agree*). The mean of the items was obtained ($\alpha = .87$).

Recovery self-efficacy was measured with the Eating Disorder Recovery Self-Efficacy Questionnaire (EDRSQ; Pinto et al., 2008). Participants rated their agreement with each statement in the 14-item Normative Eating sub-scale (e.g., "I can eat a family meal at a normal rate") and in the 9-item Body Image sub-scale (e.g., "I can feel proud of how I look") on a 1–5 scale (*not at all confident* to *extremely confident*). Means were obtained for *normative eating efficacy* ($\alpha = .95$) and *body image efficacy* ($\alpha = .89$).

2.3.2 | Interview study

Participants

Twelve women aged 16–25 years ($M = 20.25$ years, $SD = 2.70$) who self-identified as "in recovery" participated; 92% were members of both recovery and pro-ED online groups. As illustrated in Table 1, most (58%) had a diagnosis of Anorexia Nervosa and had received/were receiving treatment (67%).

Materials and procedure

A semi-structured interview schedule was developed, which included the following topics: experiences of living with an ED, experiences of being part of an online recovery group, and, if applicable, a pro-ED online group. Asynchronous email interviews were conducted by the third author to reach participants who may prefer to answer anonymously at their convenience in a familiar online setting (Cook, 2012; McCoyd & Kerson, 2006). Transcripts were produced by collating responses from each participant.

2.4 | Data analysis

2.4.1 | Quantitative analytic strategy

Repeated-measures ANOVAs were conducted to compare the strength of the thinness-related norms that participants felt were espoused by each of the four groups, and correlations between key variables were explored. Hierarchical linear regressions were conducted to investigate predictors of recovery/well-being outcomes. Finally, Model 1 in version 3.0 of Hayes' (2017) PROCESS macro was used to examine whether thinness-related norms moderated

TABLE 1 Interview participants' demographic and clinical characteristics.

Pseudonym	Age	Location	Diagnosis	Treatment stage
Lucy	21	London	Anorexia nervosa	Relapsed; receiving further treatment
Jenny	18	Yorkshire	Anorexia nervosa	Receiving treatment
Bella	25	Ireland	Bulimia nervosa	Previously received treatment
Amy	24	Northern Ireland	Binge eating disorder	Not in treatment; relapsed
Olive	22	London	EDNOS	Receiving treatment; relapsing
Amelia	19	Germany	Not specified	Not specified
Samantha	19	South East England	Anorexia nervosa	Relapsed; receiving further treatment
Isabelle	18	South East England	Anorexia nervosa	Relapsed; receiving further treatment
Maggie	18	Yorkshire	Anorexia nervosa	Not specified
Lindsey	22	London	Atypical bulimia nervosa	Not specified
Amanda	16	Yorkshire	Anorexia nervosa	Relapsed; receiving further treatment
Sarah	21	East midlands	Anorexia nervosa	Relapsed; receiving further treatment

the relationship between group identification and well-being (to explore whether the identification/well-being relationship is dependent on the strength of the group's thinness-related norms).

2.4.2 | Qualitative analytic strategy

We identified 259 instances where participants discussed illness/recovery identity, group memberships, and of help-seeking from any of the groups of interest. Data were analysed using reflexive thematic analysis (Braun & Clarke, 2021) employing the SIAH as a guiding conceptual framework. We adopted a "critical realist" epistemological framework (Willig, 2012), viewing accounts as providing an insight into social identity processes at work within participants' networks. The first author conducted the analysis following Braun and Clarke's (2021) rigorous analytic steps, namely, data familiarisation, inclusive coding, grouping codes according to similarity to develop themes, checking themes against the dataset and theme refinement through discussion with the research team.

2.4.3 | Integration procedure

Findings from each dataset are reported in the Results section along with a joint display that represents the integration of both datasets. The integration process involved merging the results from both analyses, comparing these findings, and classifying them as either "convergent" (findings are validated by both methods), "complementary" (quantitative and qualitative findings provide distinct but related insights) and "expansive" (the findings of one method build on an issue identified by the other; Henwood et al., 2017). In this way, a more complete understanding of the phenomena of interest emerges than that provided by the quantitative or qualitative results alone (Creswell & Plano Clark, 2017).

3 | RESULTS

3.1 | Survey study

3.1.1 | Group norms

The main effects of group-type for descriptive norms and injunctive norms were non-significant and significant respectively [$F(2.39, 100.24) = 2.04$, $p = .13$, t, $F(2.49, 109.68) = 6.45$, $p = .001$]. Pairwise comparisons for the latter partially support H1: friends ($M = 4.10$) espouse significantly stronger thinness-related injunctive norms than family ($M = 3.39$, $p = .004$) or recovery groups ($M = 3.10$, $p < .001$), while pro-ED groups ($M = 4.02$) espouse significantly stronger thinness-related injunctive norms than recovery groups ($p = .018$). No other comparisons were significant ($ps > .58$).

3.1.2 | Descriptives and inter-correlations

Table 2 shows the descriptive statistics and inter-correlations. The identification values for all four groups correlated positively ($ps < .013$). Partially supporting H2, SWL correlated positively with family and friend identification ($ps < .001$). Family identification correlated positively with normative eating ($p = .006$) and body image self-efficacy ($p = .014$). Friend identification correlated positively with body-image self-efficacy ($p = .042$). Neither recovery

TABLE 2 Means, standard deviations and alphas (where applicable) for key variables, plus inter-correlations.

	1	2	3	4	5	6	7
1. Family identification: (1–7) ($M = 4.21$, $SD = 1.70$, $\alpha = .91$)	–						
2. Friends identification (1–7) ($M = 4.34$, $SD = 1.55$, $\alpha = .89$)	.53***	–					
3. Recovery identification (1–7) ($M = 4.86$, $SD = 1.32$, $\alpha = .83$)	.34**	.47***	–				
4. ED identification (1–7) ($M = 4.89$, $SD = 1.40$, $\alpha = .86$)	.38**	.31*	.58***	–			
5. Satisfaction with life (1–7) ($M = 2.78$, $SD = 1.38$, $\alpha = .87$)	.42***	.42***	.07	.10	–		
6. Normative eating self-efficacy (1–5) ($M = 1.95$, $SD = 0.93$, $\alpha = .95$)	.26**	.18†	.02	−.16	.35***	–	
7. Body image self-efficacy (1–5) ($M = 1.51$, $SD = 0.61$, $\alpha = .89$)	.23*	.20*	.15	.08	.35***	.67***	–

***$p < .001$; **$p < .01$; *$p < .05$; †$p < .1$.

group identification nor pro-ED group identification correlated with normative eating self-efficacy ($p = .84$, $p = .22$), nor body-image self-efficacy ($p = .21$, $p = .53$). However, pro-ED group identification correlated positively with recovery group identification.

3.1.3 | Hierarchical linear regressions

Before conducting the analyses, we confirmed that the data met the assumptions for regression in terms of tolerance values, multicollinearity and outliers.

Group identification predicting well-being/recovery

As illustrated in Table 3, we entered gender, age and ED diagnosis (yes/no) as control variables at Step 1, while family, friend, recovery group and pro-ED group identification were entered at Step 2. Partially supporting H2, family identification was a significant positive predictor of normative eating self-efficacy ($\beta = .37$, $p = .03$). Pro-ED group identification was a significant negative predictor of normative eating self-efficacy ($\beta = -.38$, $p = .01$).

Norms moderating the relationship between identification and well-being

We included the same control variables as in the previous analyses. The analyses involved 5,000 bootstrapping samples with 95% confidence intervals (LLCI/ULCI), using the percentile method. Values were mean centred for the construction of products.

We observed no moderation effects for friends, family or recovery group identification ($ps > .05$). Partially supporting H3, injunctive thinness-related norms moderated the relationship between pro-ED group identification and eating self-efficacy (*Coeff.* $= -.14$, $SE = .04$, $t = -3.52$, $p = .001$, $LLCI = -.22$, $ULCI = -.06$). Pro-ED group identification predicted lower eating self-efficacy when norms were high, that is, more thinness-related (+1 SD; *Effect* $= -.32$, $SE = .08$, $t = -3.89$, $p = .0003$, $LLCI = -.49$, $ULCI = -.16$), but marginally predicted higher eating self-efficacy when norms were low (−1 SD; *Effect* $= .17$, $SE = .10$, $t = 1.73$, $p = .09$, $LLCI = -.03$, $ULCI = .37$). In effect, pro-ED-group identification only predicted low eating self-efficacy when the group's thinness-related injunctive norms were high.

3.2 | Qualitative analysis

Three themes were identified in the data that captured the ways in which participants' awareness and experience of group incompatibility shaped their support-seeking behaviours. These were: (a) experiencing group memberships

TABLE 3 Results of the hierarchical linear regression analysis for family, friend, recovery group and pro-ED group identification (and control variables) predicting Satisfaction with Life (SWL), Normative Eating Self-Efficacy and Body Image Self-Efficacy.

SWL	B	SE	β
Step 1			
Constant	−.41	1.74	
Gender (0 = male, 1 = female)	1.47	1.00	.20
Age (years)	.07	.06	.16
Diagnosis (0 = no, 1 = yes)	.33	.56	.08
	($R^2 = .06$)		
Step 2			
Constant	−1.92	1.68	
Gender (0 = male, 1 = female)	1.28	.91	.18
Age (years)	.08	.06	.19
Diagnosis (0 = no, 1 = yes)	−.12	.55	−.03
Family identification (1–7)	.26	.14	.32†
Friend identification (1–7)	.19	.14	.23
Recovery identification (1–7)	.04	.18	.04
Pro-ED group identification (1–7)	−.05	.15	−.06
	($R^2 = .30$, $\Delta R^2 = .24$**)		
Normative eating self-efficacy	**B**	**SE**	β
Step 1			
Constant	−.29	.88	
Gender (0 = male, 1 = female)	.10	.51	.03
Age (years)	.08	.03	.33*
Diagnosis (0 = no, 1 = yes)	.36	.29	.16
	($R^2 = .15$)		
Step 2			
Constant	−.24	.88	
Gender (0 = male, 1 = female)	−.08	.48	−.02
Age (years)	.08	.03	.36
Diagnosis (0 = no, 1 = yes)	.11	.29	.05
Family identification (1–7)	.16	.07	.37*
Friend identification (1–7)	.000098	.08	.00
Recovery identification (1–7)	.10	.10	.18
Pro-ED group identification (1–7)	−.20	.08	−.38*
	($R^2 = .33$, $\Delta R^2 = .18$*)		
Body image self-efficacy	**B**	**SE**	β
Step 1			
Constant	.11	.64	
Gender (0 = male, 1 = female)	.23	.37	.08
Age (years)	.04	.02	.23†
Diagnosis (0 = no, 1 = yes)	.36	.21	.23†

(Continues)

TABLE 3 (Continued)

Body image self-efficacy	B	SE	β
	($R^2 = .12$)		
Step 2			
Constant	−.22	.68	
Gender (0 = male, 1 = female)	.16	.37	.06
Age (years)	.04	.02	.26†
Diagnosis (0 = no, 1 = yes)	.21	.23	.13
Family identification (1–7)	.08	.06	.26
Friend identification (1–7)	.02	.06	.06
Recovery identification (1–7)	.05	.07	.11
Pro-ED group identification (1–7)	−.04	.06	−.11
	($R^2 = .22$, $\Delta R^2 = .10$)		

***$p < .001$; **$p < .01$; *$p < .05$; †$p < .10$.

through the lens of a central ED identity, (b) the function of incompatibility within identity networks and (c) the implications of incompatibility for recovery.

3.2.1 | Theme 1: Experiencing group memberships through the lens of a central ED identity

Participants' ED was central to their self-definitions. This identity seemed chronically salient across social contexts, and their interactions were viewed through this lens (Quinn & Earnshaw, 2013), as exemplified by Samantha:

> *I can get really upset or angry at people if they say what seems like a harmless comment to them but I have a lot of insecurities so even things like people saying "you look well"* can make me cry.

Across accounts, participants identified friends'/family's lack of understanding. While these groups were generally perceived as supportive, it was clear that the ED contributed to social distancing between participants and other group members:

> *(My friends) always encourage and support me. They say they understand but they don't understand they just hear what I am saying they don't have the irrational thinking that I have.* (Amy)

Amy suggested that while her friends are supportive, they do not share her "irrational" thinking patterns. Thus, there is a feeling of some acceptance, but a lack of understanding. Filling this gap was an important motivator for joining online groups; allowing participants to express and find support for this important identity (Rich, 2006). In contrast to Amy's feelings about her friendship group, Lucy's online group "get the weird thoughts behind some of my actions that my family might not get and understand the fear of letting go."

Participants articulated that norms associated with the two online group-types were distinct and separate from each other (and other groups) in a way that was not as consistently expressed in relation to family and friendship groups. As expected, recovery groups were described as focusing on supporting movement away from the ED identity. As Jenny recounted: "if one of us is struggling we can ask for help and others try and support us, giving us helpful comments and reminding us why we need to do this." Typically, recovery groups did not allow discussions of

specific behaviours or weight, so as to maintain a safe environment. In contrast, participants described pro-ED group interactions as supportive of disordered behaviours, such as sharing weight-loss tips. Both group-types allowed participants to express their central identity. Amy characterised online groups as providing "freedom" from those outside the group who viewed her behaviours as indicating a need for immediate intervention:

> *If I were to of voiced my thoughts to the real human people I'd of ended up in hospital or in a psych ward—which did happen numerous times, though in the online world I had the freedom to say how I felt without any strings attached, I was free.* (Amy)

In effect, Amy articulates her experience of being in groups with incompatible norms and reports the need to tailor her interactions according to the group's norms.

3.2.2 | Theme 2: The function of incompatibility within identity networks

Participants saw group incompatibility as serving a purpose, rather than as problematic. It was evident that each group fulfilled specific identity needs. The norms associated with different groups shaped individuals' perceptions of the form of support they could expect to draw from each group. As Bella explained, her friendship group was one that she could turn to when she faced certain challenges:

> *Superficially, I can talk to my friends, complain about exercising not working and when I eat poorly. They relate and they also reassure me because they don't see the problem. They listen but I only say what I think passes for normal. If the thoughts get too persistent, that I need a structure, I use pro-ana forums to be with likeminded people.* (Bella)

In the extract above, Bella described the psychological benefits associated with being in a group context that matched her "state" of illness/recovery. The setting allowed for the expression of that important identity, and she was supported in that identity.

From our participants' accounts, it was evident that they felt restricted in terms of what they could discuss in online recovery groups (similar to the restrictions they felt were placed on them by family/friends). This was experienced as particularly difficult during crises. As Lindsey noted, "you cannot share all the experiences you wish to. It definitely silences you more." However, Amy described the benefits of possessing both forms of online group memberships: "I love having the choice to use either groups—both of them are a safety net for when I need advice or support that I can access right at home." In this way, group incompatibility was reported to facilitate access to timely, effective support.

3.2.3 | Theme 3: The implications of incompatibility for recovery

While participants used incompatibility to their advantage, it was also clear that there were costs. This was predominantly the case for online group memberships. Participants mentioned regulating their contact with online groups (both recovery and pro-ED) to avoid feeling distressed (Hastings et al., 2016). One strategy was to limit occasions in which group activity might serve to undermine identity:

> *I've had people say I'm fat and disgusting via Instagram so it's a bit of a tricky one as it can be so helpful but also very triggering. I've also found this with Facebook groups like the big anorexia/eating disorder recovery page so I do find them great from time to time but i wouldn't get too involved with them because it can be very tough to keep levelheaded.* (Samantha)

There were also group-based regulation strategies (Hastings et al., 2016). While recovery group norms could be experienced as restrictive, they were experienced as helpful when participants were actively working towards recovery. Participants talked about adhering to a "community expectation" in their interactions. It was clear that for recovery groups to be helpful, all members should be seeking recovery:

> *Support between people with ED's [is] very hard. I think unless all the people involved are *trying* to recover to the exact same degree and are motivated encouraging […] support groups can often be more negative than positive.* (Amelia)

A final management strategy was network change, whereby individuals shifted towards engaging only with online recovery groups. This appeared to be more important to those who were further along in recovery:

> *it was very difficult to figure out which [groups] were unhelpful for me—though now it's rather easy—and as a result I was sucked into potentially unhelpful conversations. I wouldn't say it made me worse, but it did give my eating disorder tools, I learnt ways to restrict "better," that sort of thing. When I committed to recovery it took a while to accept that I couldn't help these people too. But once I accepted this, and realised staying in unhelpful groups would only do me harm it was fairly easy to walk around.* (Maggie)

As Maggie notes, her increasing "commitment" to recovery highlighted the problem of membership in groups that had incompatible norms, prompting her to leave these "unhelpful" groups. This exemplifies the dynamic nature of social identity networks and indeed, social identities themselves. These are not fixed and will change, for example, in response to the immediate social environment which influences one's perceptions of which social identities are salient and important as well as the degree to which the self is seen as similar to other group members (Frings, Wood, & Albery, 2021; Turner, 1982). In this instance, Maggie realises that recovery implies a need to address network incompatibility by dis-identifying from specific groups that she feels dissimilar from and dissatisfied with (Becker & Tausch, 2014; Best et al., 2016).

3.3 | Integration of results

Using a mixed methods approach, we were able to more fully understand whether some groups were more helpful to recovery than others, and to unpack the ways in which identity (in)compatibility shaped recovery efforts. Table 4 presents the integration of both datasets and classifies findings as "convergent," "complementary" and "expansive" (Henwood et al., 2017). In the Discussion section, we present the interpretation of the integration results organised by two key topics relevant to our theoretical model: (a) the degree to which particular social identities are (un)supportive of recovery and (b) the consequences of social identity (in)compatibility.

4 | DISCUSSION

4.1 | Are some group identifications more helpful for recovery than others?

Some group memberships appeared to support recovery. Consistent with previous research, our quantitative results suggested that family is an important recovery resource (Linville et al., 2012). This group was perceived to espouse recovery-oriented norms, and identification was associated with recovery-related outcomes. As expected, there were negative effects of identifying with a pro-ED group that espoused strong thinness-related norms (Borzekowski et al., 2010). This provides preliminary evidence for the effect of different group norms on recovery. The qualitative

TABLE 4 Data Integration.

Quantitative findings	Qualitative findings	Merged outcome
Friends espoused stronger thinness-related norms than family and recovery groups. Pro-ED groups espoused stronger thinness-related norms than recovery groups.	Participants recognised that norms varied between the two types of online groups.	Convergent
	Participants joined online groups to meet specific identity needs and address problem of lack of understanding	Complementary
While identification was a non-significant predictor of the recovery outcomes in many cases, family identification may be more supportive of recovery than pro-ED group identification.	The norms associated with different groups in their network shaped participants' perceptions of the form of support they could expect to draw from each group.	Complementary
Pro-ED group identification was a significant negative predictor of eating self-efficacy when ED thinness-related injunctive norms were high (i.e., more thinness-related)	PWED associated different outcomes with disclosure of ED thoughts/behaviours. For instance, real-world groups would insist on hospitalisation, but online pro-ED groups would facilitate discussion, and endorse performance, of disordered behaviours.	Convergent
	A network with groups that were not recovery-oriented (including recovery groups where not everyone is trying to recover) fuels ambivalence about recovery and undermines recovery efforts. Increasing "commitment" to recovery made clear the need for network change.	Expansive
There was an absence of recovery benefits associated with identifying with a recovery group.	Discussions in an online recovery group were experienced as distressing if there was a mismatch between the individual's understanding of group norms and group members' behaviours.	Expansive

evidence complemented these findings, showing that individuals strategically selected which group to interact with (according to group norms), and engaged in selective disclosure to different groups, avoiding talk of dieting behaviours with family but not with pro-ED groups (Borzekowski et al., 2010). This was in recognition of the fact that such behaviour was permitted in pro-ED groups but could result in forced hospitalisation in other group contexts. Moreover, by showing that PWED may use their group memberships strategically to gain the specific support they need in the current context. These results support Vignoles' Motivated Identity Construction Theory (e.g., Vignoles, Regalia, Manzi, Golledge, & Scabini, 2006), which argues that people join groups to strategically develop/enhance feelings of belongingness and efficacy.

It may be that possessing multiple identifications provides access to multiple types of support, but that these are not always compatible with recovery. Our qualitative findings expanded upon this. Within networks, PWED actively sought out group contexts in which to obtain identity-relevant support, acceptance/belonging (Baumeister & Leary, 1995) and the ability to express valued ED-related identities (Rich, 2006). As suggested by Yom-Tov, Brunstein-Klomek, Hadas, Tamir, and Fennig (2016), PWED visited either recovery or pro-ED groups depending on their conflicting perceptions of self (Higbed & Fox, 2010). In effect, possessing multiple identifications might satisfy a greater range of needs, but these may not all accord with recovery.

While selective engagement with groups may fulfil psychological needs, as suggested above, it is also possible that adopting one identity (vs. another) may have an impact on subsequent behaviour. For example, people's

response to a relapse may depend on their stage of recovery. In early recovery, a relapse may make high ED identities salient, which may encourage disordered behaviours. At a later stage of recovery, a response to a relapse might be increased identification with recovery as an ego reparative strategy and corresponding engagement in recovery-oriented behaviours (e.g., normative eating, treatment engagement, etc.). Exploring the links between needs management, identification and behaviour is an important next step in this area.

Our findings also highlighted the complexities inherent in peer support. Quantitative analysis failed to provide any evidence of well-being/recovery benefits associated with recovery group identification. Our qualitative analysis expanded on this to suggest that not all members of recovery groups were perceived as "in recovery" (Hastings et al., 2016) and recovery-focussed forums on pro-ED groups could be particularly problematic (Borzekowski et al., 2010). It has been suggested that recovery groups do not resonate with members in the same way that pro-ED groups do (Peebles et al., 2012) and that the recovery group identity is far less coherent than the pro-ED group identity (Amianto, Northoff, Daga, Fassino, & Tasca, 2016) possibly due to factors including the "unimaginability" of recovery (Hannon, Eunson, & Munro, 2017), the different goals PWED have and their disunity with the medical discourse (Dawson, Rhodes, & Touyz, 2014).

4.2 | The benefits and costs of identity incompatibility

Both our studies suggested that incompatibility manifested itself as distinct injunctive norms relating to thinness/dieting. On average, stronger thinness-related norms were espoused by friendship groups compared with family groups and recovery groups, and by pro-ED groups compared with recovery groups. The qualitative findings complemented these results by illustrating that participants seek out groups with specific norms (e.g., online groups) to find acceptance, a sense of belonging, and understanding. However, possessing all these groups meant that PWED created identity networks comprising groups with incompatible norms. Quite high proportions of both our samples had membership of both types of online groups, supporting previous ED research noting this trend (Wilson, Peebles, Hardy, & Litt, 2006). We also found that high levels of ED group identification were linked to high levels of recovery group identification. Similar patterns of identification with apparently contradictory groups have been observed in the addiction literature, namely between being in recovery and an active addict (e.g., Bathish et al., 2017; Buckingham, Frings, & Albery, 2013). In that case, it was suggested that rather than developing distinct user and recovery identities as proposed by SIMOR, individuals were developing a single identity, namely, "recovering addict"—a construct linked to participation in 12-step programmes (Bathish et al., 2017; Buckingham et al., 2013). This accords with findings of McNamara and Parsons (2016) whereby members of an online ED recovery group indicated that they perceived EDs to be chronic illnesses and the emerging recovery identity developed within the group appeared to contain "residual aspects" (p. 672) of the illness identity whereby participants felt that recovery involved the potentially indefinite management of disordered thoughts and behaviours.

For our participants, there was virtually no overlap in membership across each of the groups. This facilitated the positive experience of identity incompatibility, namely that participants maintain existing group memberships by adhering to that specific group's norms, knowing that they possess group memberships that facilitate expression of both ED and recovery identities (Haslam et al., 2018)—something that may drive feelings of ambivalence towards recovery. Group incompatibility allowed participants to strategically interact with a group that would provide the understanding and support they needed during times of stress (whether that support was pro-ED or pro-recovery; Higbed & Fox, 2010).

Participants recognised this incompatibility, but only perceived it as problematic in two instances. First, it was distressing for participants to perceive a mismatch between their salient identity (and its associated norms) and the group context in which they found themselves. Second, it was only those further along in recovery that recognised the detrimental effects of network incompatibility. This fits well with the SIMOR approach, which highlights that successful recovery will be reflected in transition from illness to recovery groups. However, it does draw attention to

recovery's complex and often non-linear trajectory (Hannon et al., 2017), in which the abandonment of illness-related groups may be piecemeal and irregular. Our results suggest that this is due to the context-dependent nature of identity-based interactions, whereby individuals will continue to engage with a variety of groups to navigate the day-to-day challenges they face. From this perspective, successful transition may be better conceptualised as reflecting the ability to address ongoing identity-needs in recovery groups, rather than in pro-ED groups.

5 | CONCLUSIONS

Our work is the first to employ a mixed methods approach to examine multiple identifications, group norms, identity (in)compatibility and their impacts on well-being and recovery. Our findings suggest that the identity content of specific groups is an important consideration. However, we do note our relatively small sample size and the need to confirm our quantitative results in a larger sample. Nonetheless, our participants demonstrated characteristics that are typical of the wider population of PWED, such as a reasonably large proportion not being in treatment and a large minority experiencing relapse.

Moreover, we suggest that the "stress" of incompatibility is not likely to motivate or support early recovery efforts. Indeed, for some participants, identity incompatibility was not experienced as stressful until after they had formed a clear commitment to recovery (and perhaps a more coherent recovery identity). Future research should examine how groups can facilitate or promote the initial motivation to change that is an important first step towards recovery (e.g., Nordbø et al., 2012).

Finally, this study provides further support for the recommendation to consider social identity processes during treatment. We recommend that clinicians discuss with clients the nature of their group memberships and employ techniques (such as social identity mapping; see Cruwys et al., 2016) that would facilitate such discussions as a way of addressing identity incompatibility and promoting recovery.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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ENDNOTES

[1] The small number of participants without a diagnosis meant we could not compare diagnosed and non-diagnosed participants, but future research should explore this.

[2] This study was conducted before changes in DSM diagnostic categories were published.

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