"Everyone here wants everyone else to get better": The role of social identity in eating disorder recovery

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Abstract

Retention of a positively valued illness identity contributes to poor outcomes for individuals with eating disorders. Consequently, dis-identification from the illness identity and the adoption of a recovery identity is vital for successful recovery. While social identity processes have been shown to influence eating disorder maintenance, their role in recovery is rarely considered. This study explores how a sense of shared identity helps individuals with eating disorders manage their condition and promotes recovery. Transcripts from 18 online support sessions involving 75 participants were thematically analysed. Our findings suggest that the illness identity initially operates as a social identity that forms the basis for connections with similar others. For those wishing to recover, identity-based support is then perceived to be more effective than that found outside the group. Online interactions also facilitate construction of a new shared recovery identity which promotes a shift from the illness identity as a primary source of definition and endorses group norms of illness disclosure and treatment engagement. While in the clinical literature, eating disorder identity is seen as problematic and interventions are targeted at challenging an individual's self-concept, we suggest that interventions could instead harness identity resources to support a transition to a recovery identity.

While research in the Social Cure paradigm (Jetten, Haslam & Haslam, 2011) has explored

unhealthy eating behaviour (see Balaam & Haslam, 1998; Cruwys et al., 2012; Guendelman,

Cheryan, & Monin, 2011; Oyserman, Fryberg, & Yoder, 2007), the role played by social identity

in eating disorder (ED) recovery has yet to be considered (Giles, 2006; Ison & Kent, 2010). EDs

are debilitating conditions with few effective treatments (Marzola, Abbate-Daga, Gramaglia,

Amianto, & Fassino, 2015) and high relapse rates (Abbate-Daga, Amianto, Delsedime, De-Bacco

& Fassino, 2013; McCormack & Coulson, 2009). Retention of a positively valued illness identity

contributes to these poor outcomes (Abbate-Daga et al., 2013; Espíndola & Blay, 2009; Giles,

2006; Nordbø, Espeset, Gulliksen, Skårderud, & Holte, 2006). Recovery is possible to the extent

that the individual successfully relinquishes the illness identity and develops a new, but equally

meaningful, recovery-oriented identity (Espíndola & Blay, 2009; Federici & Kaplan, 2008). Like

many other diagnostic labels, while the ED identity is predominantly conceptualised in terms of

personal identity, it also functions as a social identity (Cruwys & Gunaseelan, 2016; Read,

Morton, & Ryan, 2015). This forms the basis for making identity-relevant connections (Read et

al., 2015). To date, most research in the ED literature has focused on how these connections act

to maintain eating disorders to the detriment of examining their role in promoting recovery

(Riley, Rodham, & Gavin, 2009). It is this gap that the current study addresses.

The role of identity factors in eating disorder development and maintenance

EDs are conceptualised as the result of impaired development of the self (Abbate-Daga et

al., 2013; Stein, Corte, Chen, Nuliyalu, & Wing, 2013). Recently, there has been increased focus

on the psychological (rather than physiological) factors that act to maintain these disorders. In

their maintenance model of Anorexia Nervosa (AN)[1], Schmitt and Treasure (2006) propose that these psychological factors operate at both an intrapersonal and interpersonal level.

At the intrapersonal level, EDs develop and are maintained through the individual's beliefs about the advantages associated with the disorder (Schmitt & Treasure, 2006). Instead of describing eating disordered behaviour as a means of maintaining the ideal body weight (Espíndola & Blay, 2009), it is characterised as fulfilling social psychological needs such as conquering feelings of worthlessness (Marzola et al., 2015), cultivating feelings of success (Jenkins & Ogden, 2012), and achieving positive distinctiveness from others (Marzola et al., 2015). Thus, the disorder is a source of self-definition which functions as a meaning-making framework that guides behaviour (Espíndola & Blay, 2009; Ison & Kent, 2010; Jenkins & Ogden 2012; Marzola et al., 2015; Nordbø et al., 2006). This identity becomes entrenched over time as disordered behaviours are reinforced through an initial improvement in mood and the development of beliefs linking the disorder to improved coping abilities (Schmidt & Treasure, 2006).

At the interpersonal level, EDs are maintained through the responses of significant others. In the beginning, the disordered behaviours are viewed as a means of gaining social acceptance (Nordbø et al., 2006) and reducing feelings of isolation (Marzola et al., 2013). For example, for those with Anorexia Nervosa, early weight loss elicits positive comments from others which reinforce restricting behaviours by associating them with feelings of attractiveness and confidence (Schmidt & Treasure, 2006). Over time, concern on the part of close others leads to sustained efforts to provide care and support to the individual affected. However, such interactions and relationships can degenerate if the support offered is rejected by the recipient

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[1] While the model was developed based primarily on evidence from individuals with AN, Schmidt & Treasure (2006) acknowledge that similar processes are likely to be present in other ED subtypes and addictions.

(Schmidt & Treasure, 2006; Linville, Brown, Sturm & McDougal, 2012). A perceived lack of understanding on the part of others, alongside the stigma attached to eating disorders, motivates the individual to seek out alternative social environments in which to obtain support (Linville et al., 2012; Ransom, LaGuardia, Woody & Boyd, 2010; Williams & Riley, 2013). Such connections, for example, participation in online pro-ED communities, can maintain disordered behaviours through identity-based support and mutual social influence (Brotsky & Giles, 2007; Giles, 2006; Haas, Irr, Jennings & Wagner, 2011; Mulveen & Hepworth, 2006, Norris, Boydell, Pinhas, & Katzman, 2006; Ransom et al., 2010; Rich, 2006; Rodgers, Showron, & Chabrol, 2012; Williams & Riley, 2013).

In sum, the eating disorder illness identity is an important lens through which the individual experiences and responds to the social world and can be maintained through valued identity-based relationships. Recovery requires a re-evaluation of beliefs and values and the abandonment of maladaptive eating behaviours (Abbate-Daga et al., 2013; Bowlby, Anderson, Hall, & Willingham, 2015). At the centre of this lies identity change (Bowlby et al., 2015; Espíndola & Blay, 2009; Federici & Kaplan, 2008; Jenkins & Ogden, 2012).

Recovery as a social process and the role of social identity relationships

Including identity change as a key element of ED recovery has the potential to address high relapse rates (Bowlby et al., 2015) and broadens an almost exclusive focus on physiological recovery (Bardone-Cone et al., 2010). In the clinical literature the ED illness identity is primarily conceptualised at the individual level as an element of personal identity. Change is proposed to occur at the intrapersonal level via the relationship between therapist and client through the latter assisting in the development of a "more mature personality" (Abbate-Daga et al., 2013, p.307) or through identity interventions designed to build positive self-schemas in the individual (Stein et al., 2013). This neglects the social context of identity change and ignores the role of group

5

memberships (and the social identities derived from them) in promoting recovery. There are two issues potentially explaining this dominant view of illness and recovery. First, there is a tendency to locate the aetiology of EDs within the individual (Malson, Bailey, Clarke, Treasure, Anderson, & Kohn, 2011). Second, ED-related identity connections are believed to promote maladaptive rather than recovery behaviours and so these tend to be discouraged (Vandereycken, 2011; Williams & Riley, 2013).

However, such identity-based connections are not inevitably associated with disorder maintenance. In a clinical setting, ED recovery is assisted by the support and understanding of similar others (Ison & Kent, 2010). Such identity connections have also been shown to promote recovery behaviours in an online setting (Ransom et al., 2010). The extent to which social identities contribute to resilience or vulnerability depends on the norms and values associated with the specific group membership (i.e. the social identity content) (Cruwys & Gunaseelan, 2016; Dingle, Stark, Cruwys, & Best, 2015). In research on individuals with depression, identification with a depression illness identity was associated with reduced well-being only for those who showed greater conformity towards group norms which characterised individuals in terms of depression symptomatology (Cruwys & Gunaseelan, 2016). However, those with depression who identified with recovery-oriented groups displayed an improvement in well-being and depression symptoms (Cruwys et al., 2014). This illustrates the importance of considering identity content when determining the health outcomes of group membership. It also suggests a clear need for further examination of the social identity factors that promote eating disorder recovery.

Eating disorder recovery as social identity transition

Social identities have an important role to play in adjusting to change (Haslam, Holme, Haslam, Iyer, Jetten, & Williams, 2008; Iyer, Jetten, Tsivrikos, Postmes, & Haslam, 2009; Jetten

& Pachana, 2011; Jones, Williams, Jetten, Haslam, Harris, & Gleibs, 2012). They influence the way we experience the world (Haslam, 2004; Tajfel, 1982), have important associations with both physical and psychological health and well-being (Haslam, Jetten, Postmes, & Haslam, 2009; Jetten et al., 2011; Jetten, Haslam, Haslam, Dingle, & Jones, 2014), and guide health behaviours (Oyserman et al., 2007; Tarrant & Butler, 2011).

A positive response to psychologically exiting a valued group is to adopt a new, but equally meaningful and supportive, social identity (Iyer et al., 2009). Recent research investigating the role of social identity in addiction recovery proposes that identification with a recovery-based group alongside dis-identification with a group oriented towards addictive behaviours can promote recovery and positive health outcomes (Best et al., 2015; Dingle, Stark, et al., 2015). The key to successful recovery is the internalisation of a recovery-oriented identity whose norms (or identity content) encourage health enhancing behaviours (Best et al., 2015). This new identity provides an alternative meaning-making framework that guides subsequent behaviour, which in turn reinforces the new identity (Best et al., 2015). Although research in this area is in its infancy, recent studies have illustrated that identification with addiction recovery-oriented groups was associated with lower relapse rates (Buckingham, Frings, & Albery, 2013), treatment engagement (Beckwith, Best, Dingle, Perryman, & Lubman, 2015), and greater duration of abstinence (Tomber, Shahab, Brown, Notley, & West, 2015).

Support groups are one possible source of recovery identities (Best et al., 2015; Read et al., 2015; Vangeli & West, 2012). Identification and active engagement with such groups maintains recovery by facilitating access to psychological resources that protect well-being (Best et al., 2015; Dingle, Cruwys & Frings, 2015; Haslam et al., 2009; Jetten et al., 2011). First, a sense of shared identity makes social support possible (Dingle, Cruwys, et al., 2015; Read et al., 2015). Identity-based support is more likely to be given, accepted in the spirit in which it was

intended, and has greater impact than that received from outgroup members (Haslam, Jetten, O'Brien, & Jacobs, 2004; Haslam, O'Brien, Jetten, Vormedal, & Penna, 2005; Haslam, Reicher, & Levine, 2011). Second, such groups can become sources of stigma resistance, helping individuals cope with the additional burden of possessing a stigmatised identity (Crabtree, Haslam, Postmes, & Haslam, 2010; Read et al., 2015). Finally, construction of a recovery identity occurs through interactions between group members (Best et al., 2015; Dingle, Stark, et al., 2015). However, the role played by support groups in this process requires further exploration (Best et al., 2015; Dingle, Stark, et al., 2015).

In summary, eating disorder recovery requires an identity transition. Social identities play an important role in facilitating this transition with identity content a key feature of determining the health-related consequences of identification. There are three gaps that remain to be explored in this area. First, there is very little research on how social relationships promote recovery from an ED (Leonidas & dos Santos, 2014; Linville et al., 2012). While social identity processes are believed to maintain eating disorders, there is no consideration of how they might support recovery. Second, there is very limited exploration of recovery identities in general in the social cure tradition with the exception of the developing literature on addiction recovery (see Beckwith et al., 2015; Best et al, 2015; Dingle, Stark, et al., 2015). Finally, social cure research remains primarily quantitative (Crabtree et al., 2010; Dingle, Cruwys, et al., 2015) and has yet to examine in detail group dynamics *in situ*. We propose that such an examination will facilitate an understanding of how interactions between group members can promote ED recovery.

Participants

Participants in this study are members of an online eating disorder support group. Moderated 90 minute sessions are conducted weekly in a secure chat room, accessible by participants from their own homes. Participants discuss the emotions associated with their experiences rather than specific disordered behaviours and are not permitted to share personally identifiable information.

Registered members of the online group at the time the study took place were overwhelmingly female (95%) and over 25 years of age (56%). The most commonly reported eating disorder type was Binge Eating Disorder (32%) followed by Bulimia (28%) and Anorexia (20%). The remaining 20% identified as combination Anorexia/Bulimia.

Data collection

The research was reviewed and approved by an institutional board. Transcripts of 18 group sessions involving 75 individuals held between June 2012 and January 2013 formed the data corpus for this study. An average of seven participants attended each session. Mean overall attendance was 1.79 sessions (SD=1.26). 29 individuals attended multiple sessions (M=3.03, SD= 1.24). Study information was emailed to all registered group members and was posted on the participating organisation's website. Permission to record the sessions was obtained at the beginning of each session from all participants in that session.

Analytic approach and procedures

A theoretically-guided thematic analysis (Braun & Clarke, 2006) was conducted on the transcripts. We made a concerted effort to discuss data which did not fit with our theoretical framework. A realist epistemological approach (Willig, 2012) was adopted in this study which

involved viewing participants' accounts as representing reality and as providing an insight into the social identity processes occurring within the online group.

Transcripts were read repeatedly for data familiarisation purposes. All data relevant to the research question were coded, being as inclusive as possible. Similar codes were grouped to form themes which articulated the most salient patterns occurring across the dataset. Deviant case analysis (Silverman, 2001) was used to further develop the thematic structure. Specifically, identified instances that did not fit with our thematic structure were used to revise it so that it could account for the data in its entirety. Once the thematic structure was finalised, all extracts relating to each theme were collated.

Four broad themes were identified in light of the theoretical perspective adopted here: (1) getting the 'right' support for recovery, (2) shared identity fosters positive support experiences, (3) recovery is not a return to normal, and (4) recovery means reaching out to others. Extracts are provided to illustrate identified themes. The nature of the online chat is such that a number of conversations can be seen on-screen at any one time. In the interests of clarity, only relevant conversations taken verbatim from on-screen chats have been included as extracts. We have clearly identified in extracts where portions not referring to the conversation of interest have been removed using three dots within square brackets ([…]). All names are pseudonyms.

Findings

Theme One: Getting the 'right' support for recovery

Participants' discussions across the sessions suggested a strong feeling of 'otherness' characterised their daily lives and their interactions with friends and family. There was a clear indication that they perceived themselves as different from those with 'normal' attitudes to food – a group that they expressed a desire to be part of, but felt alienated from. This sense of alienation

was fuelled by what they saw as the pervasive stigmatisation of individuals with eating disorders (Rich, 2006). Participants felt that others viewed them as attention-seeking, as being in some way personally responsible for their situation, and as having a greater degree of control over their recovery than was the case (Linville et al., 2012):

Extract 1

Session 10

Cassidy says:20:55:19	*Nobody seems to understand the hold it has over u, they seem to think you are choosing to have the ED*
Jessie says:20:55:45	*[…] i agree [Cassidy] like its a choice we make but its not - who wud want this*

Session 11

Jessie says:20:41:23	*and I've actually said to my partner that if Id a broken leg that you could actually SEE, you would grasp it better*
Maddison says:20:41:51	*that's because people think we choose this*

As illustrated above, participants strongly resisted the stereotype that their disorder was "a choice we make." The expectation of being negatively treated by others on the basis of their illness identity when seeking support often hindered help-seeking (Read et al., 2015; Stevenson, McNamara & Muldoon, 2014).

While many participants did reveal that friends and family were willing to help them during recovery, some felt there was a limit to how effective this support could be (Linville et al., 2012; Rich, 2006). However, it was not just a fear of stigmatisation but a perception that those who are not part of the social category of "people with EDs" lacked the understanding needed to provide appropriate support (Bowlby et al., 2015; Espíndola & Blay, 2009; Linville et al., 2012).

Extract 2: Session 1

11

Isabel says:20:24:55   *I try be open with people but I guess it's in my nature to keep things*

                                 to myself. I just feel guilty because I've put people through enough

                                 and I don't want to burst their bubble and tell them I'm not okay.

                                 But either way they won't understand, they can't.

Sam says:20:26:02   *I think that if you haven't gone through it you will never fully*

                                 understand it.

In Extract 2, Isabel suggests that even if she were to ask for help from those close to her, they

could not provide her with the support she needs because they "won't understand." In response,

Sam maintains that it is *only* those who have experienced the disorder and recovery process that

have that understanding. This sentiment was expressed across sessions and seemed to fuel

participants' desire to join the online group. Group members' mutual understanding both of

eating disorders and of the associated stigma formed the basis for a sense of empathy for fellow

sufferers and a desire for positive outcomes for all. These elements are recognisably indicative of

a shared social identity which underlies the expectation of positive support interactions in

contrast to well-intentioned but inadequate support experiences with those outside the group

(Dingle, Cruwys, et al., 2015; Haslam et al., 2004; Haslam et al., 2005; Haslam et al., 2011; Read

et al., 2015):

Extract 3: Session 11

Hayley says:20:36:49   *ed's are those awful illnesses that whilst people think they*

                                 understand, in real life, dealing with real people affected by them,

                                 they actually have no idea

Jessie says:20:37:07   *ur right Hayley*

Quinn says:20:37:08   *seriously though, everyone here wants everyone else to get better,*

                                 we all understand what everyone is going through and know how

difficult it is to talk about it. I think anyone in need of support is in

the right place

Theme 2: Shared identity fosters positive support experiences

While possessing an illness identity alongside a burgeoning desire to recover may have been the

catalyst for joining the online group (Best et al., 2015), the group must build a shared recovery

identity among its members in order for mutual support to have its desired effects (Haslam et al.,

2011). The online sessions were attended by individuals with a range of ED subtypes, reflecting

the heterogeneity of this illness group. Research exploring online pro-ED groups suggests that

tensions between ED subgroups often interfere with the aim of mutual support purported to be

the *raison d'être* of these communities (Giles, 2006). The norms of the recovery group outlined

in the 'group rules' discourage such distinctions:

Extract 4: Session 3

Facilitator says:20:05:29   *[…]We try to keep the atmosphere informal and supportive. We*

also avoid talking about the specifics of food and weight and

instead concentrate on the feelings around them. This helps to

include everyone, as we at [name of organisation] believe that the

emotions surrounding eating disorders are the same regardless of

which particular eating disorder it is. We try not to isolate anyone.

These group norms were stated at the beginning of each session (and each time a participant

joined the session after it had commenced). Prohibiting the discussion of the "specifics of food

and weight" ensured the psychological safety of the group (as these might act as behavioural

triggers) as well as ensuring that group discussions were centred on health-enhancing behaviours

commensurate with a recovery-oriented identity. This approach was broadly successful. Members

rarely differentiated each other on the basis of ED subtype and typically indicated they were on a shared recovery journey:

Extract 5: Session 2

Casey says:20:45:56   *guys it can be done. May take a few admissions but I know so many people who have recovered 100%. We can't give up hope. Guys don't give up.*

To the extent that identity was perceived as shared, group members could derive reassurance and support from others. Participating in sessions and interacting with other group members often resulted in feelings of emotional relief, a reduction in feelings of isolation and a desire to continue to work on their recovery (Barak, Boniel-Nissim, & Suler, 2008; McCormack & Coulson, 2009):

Extract 6

Session 10

Bailey says:20:37:35   *im feeling less alone thats what I like about coming on here*

Ellie says:20:38:18   *im feeling pretty much depressed but wasnt sure what would happen coming on but you do feel less alone and not as crazy haha*

Sarah says:20:38:59   *I feel more informed.. which I appreciate - thanks everyone*

Session 11

Maria says:20:52:00   *It's been great being here and being able to talk about this again, I've just been so overwhelmed with everything lately, it's been difficult, I really want to start working on this again though😊 I think I really needed to come here tonight*

Session 12

Karen says:20:40:00   *Thanks for your help [Lara], and [Jay], being able to identify with*

other people helps. And I think this meeting will be a good start for

me.

Session 17

Frankie says:20:39:37   *thanks for showing me that we are not struggling alone guys*

There were two exceptions to this broader pattern. In both instances, participants were first-time attendees and both expressed uncertainty as to whether the group was right for them. These sentiments were expressed when their experiences or feelings appeared to be at odds with shared experiences of fellow group members:

Extract 7: Session 6

Facilitator says:19:53:47   *So guilt is the thing you're struggling with. Is that it?*

Ruth says:19:54:12   *yep!*

Facilitator says:19:54:31   *Can anyone else identify with that*

Brooke says:19:56:58   *Guilt, bane of my life, guilty for eating/not eating, even feel guilty*

for not feeling guilty, i cant seem to win

Chloe says:19:59:28   *I didnt feel guilt, i just binged cuz I couldnt deal with whatever was*

going on in my life

Ruth says:19:59:40   *I am the same its just seems like such a hard thing to break. The*

constant thoght of what you should have to eat is crazy. I started

counselling 5 weeks ago so praying this will get to the bottom of it.

See i binge Chloe cause of things in my life but then feel so guilty

after it. you try to not think about the guilt but then your thinking

about not thinking about it. How do you feel after a binge Chloe?

Chloe says:20:05:40   *just felt like shit really and i wanted the food out of my system as*

fast as possible. When I purged I felt great - id accomplished

something. Im actually in recovery Ruth, counselling will help you.

Im just testing this forum tonight, but maybe its not the right group

for me.

In Extract 7 above, group members Ruth and Brooke, both of whom are in the early stages of recovery, discuss their shared experiences of feeling guilty – an experience which Chloe does not relate to. She speaks of her 'purging' behaviours using the past tense to clearly indicate that she is "actually" in recovery. The fact that Ruth characterises her 'bingeing' behaviours as on-going signals to Chloe that she is not similar to others in the group, thus generating the uncertainty she expresses as to whether it is the "right group" for her. Thus it would appear that to the extent that identity was not shared, group support was not perceived as helpful. It also suggested that violating the group rules regarding discussing specific on-going behaviours could indeed prevent a sense of a shared recovery identity developing within the group.

Theme 3: Recovery is not a return to normal

Another function of the group was to construct a shared understanding of recovery and a shared belief that it was possible. While group members had a strong desire to recover, recovery was often linked with negative feelings such as anxiety and guilt. This led many to articulate a feeling of ambivalence towards recovery and in some instances, a clear fear of recovery (Abbate-Daga et al., 2013; Marzola et al., 2015).

Extract 8: Session 18:

Brooke says:20:18:39	*Its funny that we can know the benefits of recovery and what we need to be doing even to get there but then ED for me will always end finding hundred and one reasons why i shouldn't recover.*
Pat says:20:22:45	*yes, and of course my no 1 excuse is that I really don't need to put on any weight at all - because I actually don't... I find that I get a certain distance and then the voice tells me that this is wrong and that I'll get really fat. I know that this is normal and that I should fight it. I know the pathway is never straightforward and that I should continue to fight, but it feels so desparately unsafe. i realise that it's all about fear of losing identity etc but when you put the issues of getting fatter on top of that it makes is all so much harder..*

Pat suggests that her "fear of losing identity" contributes to the distress she experiences when contemplating recovery (Abbate-Daga et al., 2013). Across participants, it was apparent that a significant barrier to recovery was an inability to imagine oneself as recovered (Malson et al., 2011). This was primarily the case when recovery was defined as a return to being "normal" (i.e., joining the 'outgroup' described in theme 1).

Extract 9

Session 13

Linda says:20:44:33	*Even if I finally get past the physical side of the illness ... I, hand on my heart, can't imagine ever getting to a point where I don't think about it. That's actually a really depressing thought.....*

Session 17

17

Sam says:20:41:09   *Wouldn't be so amazing to wake up and be free from it, always*

                             wish I could just be normal and be like everyone else.

[....]

Facilitator says:20:43:40 *Thanks all, at [organisation] we firmly believe that people can and*

                             do recover from EDs..but recovery takes time as everyone has been

                             speaking about tonight..

Discussing the idea that complete recovery may be unattainable could be quite de-motivating for

group members. It was often at this point that facilitators, as exemplified above, stepped in to

emphasise the group's normative belief that recovery was possible. In addition, those further

along in recovery responded to others' concerns of not ever being "normal" by engaging in a re-

imagining of recovery:

Extract 10: Session 7

Sadie says:20:42:42   *I have had my ED for over 20 yrs, with years of complete recovery*

                             along the way. I have found that no..........it doesnt go away. You

                             just manage it a bit better. If you are happier in yourself, gaining a

                             pound while I still find difficult, I can cope with. I too ask the

                             question, does recovery mean that one day I will be 'normal' with

                             normal eating habits, but I now dont believe it will happen. Not to

                             dishearten anyone.......what I mean is, stop searching for the time

                             when everything will be perfect, and then being hard on yourself

                             for not reaching that perfection. For me anyhow, I have accepted

                             that I have an ED, I will always have it. I do believe complete

                             recovery is possible, and living a normal life is possible. But the

	underlying association with food, I think will always be there. So just to accept that, and try to live with that in the most healthy and positive way possible.
Ruth says:20:44:47	*That's a good way of thinking Sadie suppose it is all about caring for youself*
Becky says:20:45:37	*and yeah they are very wise insightful words realistic too...*

In Extract 10, recovery is re-appraised as something that is difficult but manageable and is defined as learning to manage maladaptive behaviours and intrusive thoughts. Thus, for group members, recovery does not mean being "normal" but rather not having the illness identity as the primary source of self-definition (Best et al., 2015; Bowlby et al., 2015; Jenkins & Ogden, 2012). It suggests that a recovery identity for group members retains residual aspects of who they used to be which might preserve a sense of identity continuity (Iyer et al., 2009).

Theme 4: Recovery means reaching out to others

The identity content of a recovery group should be oriented towards promoting health-enhancing behaviours (Best et al., 2015). In our data, the online group promoted disclosure of illness and engagement with health services. Reaching out to others was a key element of recovery and an important action for group members (Bowlby et al., 2015; Federici & Kaplan, 2008):

Extract 11

Session 18

Brooke says:20:54:48	*Recovery is a very long process with lots of up's and down's, you can recover with perseverance and with HELP, I don't advocate going it alone on recovery at all*

Session 10

Sarah says:20:00:59	*yea - I guess I should really do that. Its just my big secret you know.. Id be so ashamed to tell anyone... I cant even think how Id bring myself to get the words out*
Kathy says:20:03:13	*We are all like that [Sarah], I am not in a position to offer you advice but one think I will say is once you you confide in someone it will make a big difference to you*

This contrasts sharply from the norms associated with the ED identity which encourage secrecy and concealment of the disorder (Norris et al., 2006; Riley et al., 2009).

In the recovery group, there appeared to be different levels of disclosure. For many, "speaking" to the online group was the first time that they had disclosed their ED to anyone and revealing this elicited praise from fellow group members:

Extract 12: Session 12

Mary says:20:37:23	*[….]you've made a great first step by just talking about it. Its upsetting to think how ashamed people feel, we are all doing a really good thing just by talking😇well done*

As noted in Extract 12, speaking to the online group was a "great first step" but this needed to be followed up with engagement with formal health services and treatment. At times group members, particularly those new to the group, revealed that they were avoiding disclosing to a health professional. In response to such accounts group members went to some lengths to recommend service engagement with interactions often resulting in the individual group member agreeing to contact their GP.

Extract 13: Session 4

Tracey says:20:40:35   *all i got from my gp was this web site*

[....]

Casey says:20:41:10   *[Tracey], go back to the gp and say you need more support, they*

                               should be able to guide you to services.

Logan says:20:41:28   *Well GO BACK and demand a referal! if you don't talk to your GP*

                               then in my opinion you can't recover.

[....]

Tracey says:20:41:47   *i will do* 😉

Moving from a position of wishing to avoid health service engagement to one of being

open to it is illustrative of the effect of the social influence exerted by the group (Haslam et al.,

2004; Turner & Oakes, 1986). This also was seen to influence engagement with professionally

recommended treatments. As exemplified below, identity-based advice from fellow group

members could be privileged above advice from those outside the group (Barak et al., 2008;

Haslam et al., 2004):

Extract 14: Session 17

Pat says:20:46:00   *This may be not an allowed question but if anyone is willing to say*

                            it, I'd love to know if anyone has been on medication for associated

                            depression with an ED and whether it has helped? [...]

Miriam says:20:46:47   *Pat Im over work for a few months with depression and Im on alot*

                               of medication for it. It has helped

Pat says:20:51:28   *....Miriam, I'm really glad that medication has helped. My GP is*

          pretty keen for me to be on it but so far I have said no, but maybe I

          should rethink that....

In this extract, receiving information from Miriam about the merits of taking medication has had somewhat more of an impact on Pat's willingness to consider taking medication than the GP's recommendation.

Discussion

The aim of this paper was to explore how a sense of shared identity promotes recovery in individuals with eating disorders. Our findings suggest that the illness identity initially operates as a social identity that forms the basis for connections with similar others. For those wishing to recover, online group support is perceived to be more effective than that found outside the group but is only beneficial to the extent to which it is based on a shared recovery identity. Online interactions facilitate construction of a recovery identity which promotes a shift away from the illness identity as a primary source of definition and endorses alternative group norms of illness disclosure and treatment engagement.

Converting the Social Curse to Social Cure

The stigma attached to eating disorders may act as a social curse (Kellezi & Reicher, 2011; Stevenson et al., 2014) by forming a barrier to developing and maintaining the supportive relationships needed for recovery (Linville et al., 2012; Rich, 2006; Williams & Riley, 2012). Forming a shared recovery identity with similar others seems to facilitate the social identity change needed for recovery. However, this is only true to the extent that the recovery identity content reflects norms conducive to positive health and well-being (Cruwys & Gunaseelan, 2016; Dingle, Stark, et al., 2015), including promoting disclosure and service engagement.

As our data suggest, the norms and practices of the recovery group differed from those operating in pro-ED groups (Giles, 2006; Mulveen & Hepworth, 2006; Williams & Riley, 2012). First, differentiating between ED subgroups was discouraged in order to construct and promote a shared recovery identity. This shared identity ensured participants could benefit from online group membership, regardless of ED subtype.

Second, concealment of disordered behaviours was strongly discouraged in the recovery group. A concern relating to joining an online group is that the group could become a replacement for other "real-world" relationships needed for successful recovery (Jetten, Haslam, Haslam, & Branscombe, 2009). Nonetheless, the fact that this group endorsed norms of illness disclosure and treatment engagement suggests that identification with the group, which is assumed to increase motivation for performance of identity-congruent behaviours (Best et al., 2015; Oyserman et al., 2007; Tarrant & Butler, 2011), could go some way towards building the supportive relationships outside the group necessary for recovery (Federici & Kaplan, 2008; Jenkins & Ogden, 2012). To this end, we argue that replacing a stigmatised illness identity which endorses norms of concealment (Rich, 2006; Williams & Riley, 2013) with a recovery identity that promotes disclosure and healthcare engagement is preferable to replacing a "positive" eating disorder identity with a "negative" one (Ison & Kent, 2010). The latter strategy might be more likely to be act as a social curse rather than a social cure.

Following on from this, Best et al. (2015) propose that dis-identification with an illness identity and identification with a recovery identity should coincide with social network changes. In the current context, this would involve individuals reducing and eventually eliminating contact with pro-ED groups. Our data, however, did not permit us to investigate such connections among our participants. To this end, we suggest that future research investigate whether contact (and identification) with online pro-ED groups reduces alongside greater contact (and identification)

23

with online recovery groups and whether this is associated with positive health outcomes. Pro-ED sites often have subsections dedicated to recovery (Giles, 2006; Mulveen & Hepworth, 2006; Williams & Riley, 2013). This is typically used to suggest that the primary function of such sites is mutual support rather than the maintenance of disordered behaviours (Giles, 2006). However, we argue that visiting such sites (even if only for participation in the recovery forums) is unlikely to assist in building a successful recovery identity involving complete dis-identification with the illness identity.

Finally, interactions with group members facilitated the construction of a shared understanding of recovery. In our data, the recovery identity appeared to contain residual elements of the illness identity rather than representing a return to "normal." The latter view of recovery which involves complete rejection of the illness identity (Jenkins & Ogden, 2012) appeared to overwhelm group members. This does not negate the possibility of the eventual emergence of a *complete* recovery identity. Social identity research in the area of smoking cessation suggests that identities developed in support group settings might act as a *transitional* identity on the path towards a full recovery identity (Vangeli & West, 2012). In this field, transition to an "ex-smoker" rather than a "non-smoker" identity can facilitate recovery in those with longer histories of smoking (and more established "smoker" identities) as it represents an element of identity continuity (Vangeli & West, 2012) which is itself thought to be predictive of successful identity transitions (Iyer et al., 2009). However, promoting identification with non-ED related groups might be beneficial in maintaining long-term recovery (Federici & Kaplan, 2008) and avoiding entrenchment in a self-definition, even in part, based on mental illness (Tew, Ramon, Slade, Bird, Melton, & Le Boutillier, 2012).

Strengths and limitations of the current study

There are a number of strengths of the present study. First, there is a dearth of research in the ED literature on the role that social relationships outside the therapeutic *milieu* play in recovery (Leonidas & dos Santos, 2014; Linville et al., 2012). This study illustrates that a sense of shared identity with others in ED recovery, although usually discouraged in the clinical literature due to its associations with disorder maintenance (Vandereycken, 2011), can in fact promote recovery. We suggest here that our data supports proposals for considering the importance of assessing identity content prior to determining the consequences of identification for health (Cruwys & Gunaseelan, 2016).

Second, our findings suggest that social cure processes are seen in online as well as face-to-face groups, supporting recent findings by Pendry and Salvatore (2015). In this study, however, it might be important to consider the effect that the nature of the group had on the effectiveness of the processes described. First, the fact that this group does not meet face-to-face might in this recovery context prove advantageous. For individuals with eating disorders, online groups minimise appearance anxiety and appearance-related triggers (McCormack & Coulson, 2009; Vandereycken, 2011). In addition, normative influence is especially strong in online contexts (Postmes, Spears & Lea, 2000). Second, this online group, while having repeat attenders, does not have a stable membership and it is unclear what form the processes described in this study might take or how their effectiveness would be influenced in a continuous support environment. It is worth noting however, that the beneficial effects of group membership depend on psychological identification with the group rather than frequency of contact with the group (Cruwys et al., 2014). Thus, we would suggest that whether support is continuous or not is not the key issue affecting health outcomes but rather relates to whether the identity has been internalised (Best et al., 2015). However, as internalisation of the recovery identity is a gradual

process (Best et al., 2015), it is unlikely that those who only attend the group once will have the opportunity to fully transform their illness identity.

A second strength of the study is that it adds to the emerging literature concerning the role that social identity plays in illness recovery. It addresses issues of identity content, explores the nature of recovery identities, and uses qualitative methods, all of which are areas meriting further development in this field. The use of a novel method facilitates exploration of how group interactions facilitate the construction of a recovery identity. This addresses a gap in the social cure literature identified by Dingle, Stark, et al. (2015). Furthermore, these processes were observed in a naturalistic setting (Giles, 2006) with individuals currently in recovery, rather than emerging from retrospective accounts from recovered individuals.

Finally, it is likely that the social identity processes outlined here are not specific to ED recovery and could be applied to investigations of other areas in which the support of similar others is essential in facilitating health-related identity transitions. This could include recovery from other forms of mental illness (Tew et al., 2012), physical injury (Jones et al., 2012), or recovering from traumatic environments such as military personnel re-entering civilian life after deployment (Pietrzak et al., 2010).

However, the study also has some limitations. Due to the confidential nature of data collection there was not an opportunity to collect participant demographics (although an overview of user characteristics was provided). While we noted a number of intentions to act (i.e. engage in treatment, disclose to others) in discussions we are not in a position to determine whether these intentions subsequently translated into action. Nor are we clear on how long reported improved feelings of well-being persisted for. We propose that further research is needed to provide additional empirical support for the relationships suggested here.

Finally, our analysis examined the data through a social identity lens. However, investigating other aspects of the data, using different methods would reveal additional insights. First, examining the interactions using a discursive approach would illustrate how understandings of recovery identities emerge in dialogue between participants and provide insight into how such communities function (Williams & Riley, 2013). Second, individual variability within the data would lend itself to a phenomenological approach to investigate individual recovery experiences. Chronic conditions are constructed as part of individuals' personal identities (alongside their social identities) and the sense of oneself as a unique individual informs support seeking strategies (Read et al., 2015). As recovery from mental illness is often conceptualised as a personal journey (Topor, Borg, Di Girolamo, & Davidson, 2011), examining our data from this perspective could complement the insights provided in the current paper. Finally, the social identity approach to addiction recovery incorporates elements of social network analysis in its investigations (e.g., Beckwith et al., 2015). Adopting this technique could reveal relationships between individuals within the group that might be particularly important for individual recovery as well as providing greater insight into group structure (Maloney-Krichmar & Preece, 2005).

Nonetheless, we believe that this study represents an important addition to the social cure literature. The aim of the research was to explore how a sense of shared identity promotes ED recovery. Our findings illustrated that such identities provide the psychological resources necessary for facilitating the identity transition necessary for recovery. In the clinical literature, an ED illness identity is seen as problematic and interventions are targeted at challenging an individual's self-concept (as well as the groups they might belong to). Here we offer an alternative conceptualisation of ED recovery as a social process and suggest interventions could instead harness identity resources to support a transition to a recovery identity.

REFERENCES

Abbate-Daga, G., Amianto, F., Delsedime, N., De-Bacco, C., & Fassino, S. (2013). Resistance to treatment and change in anorexia nervosa: A clinical overview. *BMC Psychiatry*, *13*, 294-311. doi: 10.1186/1471-244-13-294.

Balaam, B.J., & Haslam, S.A. (1998). A closer look at the role of social influence in the development of attitudes to eating. *Journal of Community & Applied Social Psychology*, *8*(3), 195-212. doi: 10.1002/(SICI)1099-1298.

Barak, A., Boniel-Nissim, M., Suler, J. (2008). Fostering empowerment in online support groups. *Computers in Human Behaviour*, *24*, 1867-1883. doi: 10.1016/j.chb.2008.02.004.

Bardone-Cone, A.M., Harney, M.B., Maldonado, C.R., Lawson, M.A., Robinson, D.P., Smith, R., & Tosh, A. (2010). Defining recovery from an eating disorder: Conceptualisation, validation, and examination of psychosocial functioning and psychiatric comorbidity. *Behaviour Research & Therapy*, *48*(3), 194-202. doi: 10.1016/j.brat.2009.11.001.

Beckwith, M., Best, D., Dingle, G., Perryman, C., & Lubman, D. (2015). Predictors of flexibility in social identity among people entering a therapeutic community for substance abuse. *Alcoholism Treatment Quarterly*, *33*(1), 93-104. doi: 10.1080-07347324.2015.982.465.

Best, D., Beckwith, M., Haslam, C., Haslam, S.A., Jetten, J., Mawson, E., & Lubman, D.I. (2015). Overcoming alcohol and other drug addiction as a process of social identity transition: The social identity model of recovery (SIMOR). *Addiction Research & Theory*. Advance online publication. doi: 10.3109/16066359.2015.1075980.

Bowlby, C.G., Anderson, T.L., Hall., M.E.L., & Willingham, M.M. (2015). Recovered professionals exploring eating disorder recovery: A qualitative investigation of meaning. *Clinical Social Work Journal*, *43*, 1-10. doi: 10.1007/S10615-012-0423-0.

Braun, V, & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. doi: 10.1191/1478088706qp063oa.

Brotsky, S.R., & Giles, D. (2007). Inside the "Pro-Ana" community: A covert online participant observation. *Eating Disorders: The Journal of Treatment & Prevention*, *15*(2), 93-109. doi: 10.1080/10640260701190600.

Buckingham, S.A., Frings, D., & Albery, I.P. (2013). Group membership and social identity in addiction recovery. *Psychology of Addictive Behaviours*, *27*(4), 1132-1140. doi: 10.1037/a0032480.

Crabtree, J.W., Haslam, S.A., Postmes, T., & Haslam, C. (2010). Mental health support groups, stigma, and self-esteem: Positive and negative implications of group identification. *Journal of Social Issues*, *66*(3), 553-569. doi: 10.1111/j.1540-4560.2010.01662.x.

Cruwys, T., Platow, M.J., Angullia, S.A., Chang, J.M., Diler, S.E., Kirchner, J.L., … Wadley, A.L. (2012). Modelling of food intake is moderated by salient psychological group membership. *Appetite*, *58*(2), 754-757. doi:10.1016/j.appet.2011.12.002.

Cruwys, T., Haslam, S.A., Dingle, G.A., Jetten, J., Hornsey, M.A., Chong, E.M.D., & Pei, T.P.S. (2014). Feeling connected again: Interventions that increase social identification reduce depression symptoms in community and clinical settings. *Journal of Affective Disorders*, *159*, 139-146. doi: 10.1016/j.jad.2014.02.019.

Cruwys, T., & Gunaseelan, S. (2016). "Depression is who I am": Mental illness identity, stigma, and well-being. *Journal of Affective Disorders*, *189*, 36-42. doi: 10.1016/j.jad.2015.09.012.

Dingle, G.A., Stark, C., Cruwys, T., & Best, D. (2015). Breaking good: Breaking ties with social groups may be good for recovery from substance misuse. *British Journal of Social Psychology*, *54*(2), 236-254. doi: 10.1111/bjso.12081.

Espíndola, C.R., & Blay, S.L. (2009). Anorexia nervosa's meaning to patients: A qualitative synthesis. *Psychopathology*, *42*, 69-80. doi: 10.1159/000203339.

Federici, A., & Kaplan, A.S. (2008). The patient's account of relapse and recovery in anorexia nervosa: A qualitative study. *European Eating Disorders Review*, *16*(1), 1-10. doi: 10.1002/erv.813.

Giles, D. (2006). Constructing identities in cyberspace: The case of eating disorders. *British Journal of Social Psychology*, *45*(3), 463-477. doi: 10.1348/014466605X53596.

Guendelman, M.D., Cheryan, S., & Monin, B. (2011). Fitting in but getting fat: Identity threat and dietary choices among U.S. immigrant groups. *Psychological Science*, *22*(7), 959-967. doi: 10.1177/0956797611411585.

Haas, S.M., Irr, M.E., Jennings, N.A., & Wagner, L.M. (2011). Communicating thin: A grounded model of online negative enabling support groups in the pro-anorexia movement. *New Media & Society*, *13*(1), 40-57. doi: 10.1177/1461444810363910.

Haslam, C., Holme, A., Haslam, S.A., Iyer, A., Jetten, J., & Williams, W.H. (2008). Maintaining group memberships: Social identity continuity predicts well-being after stroke. *Neuropsychological Rehabilitation*, *18*, 671-691. doi: 10.1080/09602010701643449.

Haslam, S.A. (2004). *Psychology in organisations: The social identity approach*. London: Sage.

Haslam, S.A., Jetten, J., O'Brien, A., & Jacobs, E. (2004). Social identity, social influence and reactions to potentially stressful tasks: Support for the self-categorization model of stress. *Stress & Health*, *20*, 3-9. doi: 10.1002/smi.995.

Haslam, S.A., O'Brien, A., Jetten, J., Vormedal, K., & Penna, S. (2005). Taking the strain: Social identity, social support and the experience of stress. *British Journal of Social Psychology*, *44*(3), 355-370. doi: 10.1348/014466605X37468.

Haslam, S.A., Jetten, J., Postmes, T., & Haslam, C. (2009). Social identity, health and well-being: An emerging agenda for applied psychology. *Applied Psychology: An International Review*, *58*(1), 1-23. doi: 10.1111/j.1464-0597.2008.00379.x

Haslam, S.A., Reicher, S.D., & Levine, M. (2011). When other people are heaven, when other people are hell: How social identity determines the nature and impact of social support. In J. Jetten, C. Haslam & S.A. Haslam. (Eds.), *The social cure: Identity, health and well-being* (pp. 157-174). New York: Psychology Press.

Ison, J., & Kent, S. (2010). Social identity in eating disorders. *European Eating Disorders Review*, *18*(6), 475-485. doi: 10.1002/erv.1001.

Iyer, A., Jetten, J., Tsivrikos. D., Postmes, T., & Haslam, S.A. (2009). The more (and the more compatible) the merrier: Multiple group memberships and identity compatibility as predictors of adjustment after life transitions. *British Journal of Social Psychology*, *48*, 707-733. doi: 10.1348/014466608X397628.

Jenkins, J., & Ogden, J. (2012). Becoming "whole" again: A qualitative study of women's views of recovering from anorexia nervosa. *European Eating Disorders Review*, *20*(1), e23-e31. doi: 10.1002/erv.1085.

Jetten, J., Haslam, C., & Haslam, S.A. (Eds.). (2011). *The social cure: Identity, health and well-being*. New York: Psychology Press.

Jetten, J., & Pachana, N.A. (2011). Not wanting to grow old: A social identity model of identity change (SIMC) analysis of driving cessation among older adults. In J. Jetten, C. Haslam & S.A. Haslam. (Eds.), *The social cure: Identity, health and well-being* (pp. 97-113). New York: Psychology Press.

Jetten, J., Haslam, C., Haslam, S.A., & Branscombe, N.R. (2009). The social cure. *Scientific American Mind*, *20*, 26-33. doi: 10.1038/scientificamericanmind0909-26.

Jetten, J., Haslam, C., Haslam, S.A., Dingle, G., & Jones, J.M. (2014). How groups affect our health and well-being: The path from theory to policy. *Social Issues & Policy Review*, *8*(1), 103-130. doi: 10.1111/sipr.12003.

Jones, J.M., Williams, W.H., Jetten, J., Haslam, S.A., Harris, A., & Gleibs, I.H. (2012). The role of psychological symptoms and social group memberships in the development of post-traumatic stress after traumatic brain injury. *British Journal of Health Psychology*, *17*, 798-811. doi: 10.1111/j.2044-8287.2012.02074.x.

Kellezi, B., & Reicher, S. (2011). Social cure or social curse? The psychological impact of extreme events during the Kosovo conflict. In J. Jetten, C. Haslam & S.A. Haslam. (Eds.), *The social cure: Identity, health and well-being* (pp. 217-234). New York: Psychology Press.

Leonidas, C., & dos Santos, M.A. (2014). Social support networks and eating disorders: An integrative review of the literature. *Neuropsychiatric Disease & Treatment*, *10*, 915-927. doi: 10.2147/NDT.560735.

Linville, D., Brown, T., Sturm, K., & McDougal, T. (2012). Eating disorders and social support: Perspectives of recovered individuals. *Eating Disorders*, *20*, 216-231. doi: 10.1080/10640266.2012.668480.

Maloney-Krichmar, D., & Preece, J. (2005). A multilevel analysis of sociability, usability, and community dynamics in an online health community. *ACM Transactions on Computer-Human Interaction*, *12*(2). doi: 10.1145/1067860.1067864.

Malson, H., Bailey, L., Clarke, S., Treasure, J., Anderson, G., & Kohn, M. (2011). Un/imaginable future selves: A discourse analysis of in-patients' talk about recovery from an 'eating disorder.' *European Eating Disorders Review*, *19*, 25-36. doi: 10.1002/erv.1011.

Marzola, E., Abbate-Daga, G., Gramaglia, C., Amianto, F., & Fassino, S. (2015). A qualitative

investigation into anorexia nervosa: The inner perspective. *Cogent Psychology*. doi:

10.1080/23311908.2015.1032493.

McCormack, A., & Coulson, N.S. (2009). Individuals with eating disorders and the use of online

support groups as a source of social support. *Cyberpsychology*, *3*(2). Retrieved from

http://cyberpsychology.eu/view.php?cisloclanku=2009112402&article=1

Mulveen, R., & Hepworth, J. (2006). An interpretative phenomenological analysis of

participation in a pro-anorexia internet site and its relationship with disordered eating.

Journal of Health Psychology, *11*(2), 283-296. doi: 10.1177/1359105306061187.

Nordbø, R.H., Espeset, E.M., Gulliksen, K.S., Skårderud, F., & Holte, A. (2006). The meaning of

self-starvation: Qualitative study of patients' perceptions of anorexia nervosa.

International Journal of Eating Disorders, *39*, 556-564. doi: 10.1002/eat.20276.

Norris, M.L., Boydell, K.M., Pinhas, L., & Katzman, D.K. (2006). Ana and the internet: A

review of pro-anorexia websites. *International Journal of Eating Disorders*, *39*(6), 443-

447. doi: 10.1002/eat.20305.

Oyserman, D., Fryberg, S.A., & Yoder, N. (2007). Identity-based motivation and health. *Journal

of Personality & Social Psychology*, *93*(6), 1011-1027. doi: 10.1037/0022-3514.91.1.188.

Pendry, L.F., & Salvatore, J. (2015). Individual and social benefits of online discussion forums.

Computers in Human Behaviour, *50*, 211-220. doi: 10.1016/j.chb.2015.03.067.

Pietrzak, R.H., Johnson, D.C., Goldstein, M.B., Malley, J.C., Riners, A.J., Morgan, C.A., &

Southwick, S.M. (2010). Psychosocial buffers of traumatic stress, depressive symptoms,

and psychosocial difficulties in veterans of Operations Enduring Freedom and Iraqi

Freedom: The role of resilience, unit support, and post deployment social support.

Journal of Affective Disorders, *120*, 188-192. doi: 10.1016/j.jad.2009.04015.

Postmes, T., Spears, R., & Lea, M. (2000). The formation of group norms in computer-mediated communication. *Human Communications Research*, *26*(3), 341-371.

Ransom, D.C., La Guardia, J.G., Woody, E.Z. & Boyd, J.L. (2010). Interpersonal interactions on online forums addressing eating concerns. *International Journal of Eating Disorders*, *43*(2), 161-170. doi: 10.1002/eat.20629.

Read, S.A., Morton, T.A., & Ryan, M.K. (2015). Negotiating identity: A qualitative analysis of stigma and support seeking for individuals with cerebral palsy. *Disability & Rehabilitation*, *37*(13), 1162-1169. doi: 10.3109/09638288.2014.956814.

Rich, E. (2006). Anorexic (dis)connection: Managing anorexia as an illness and as an identity. *Sociology of Health & Illness*, *28*(3), 284-305.

Riley, S., Rodham, K., & Gavin, J. (2009). Doing weight: pro-ana and recovery identities in cyberspace. *Journal of Community & Applied Social Psychology*, *19*(5), 348-359. doi: 10.1002/casp.1022.

Rodgers, R.F., Skowron, S., & Chabrol, H. (2012). Disordered eating and group membership among members of a pro-anorexic online community. *European Eating Disorders Review*, *20*, 9-12. doi: 10.1002/erv.1096.

Schmidt, U., & Treasure, J. (2006). Anorexia nervosa: Valued and visible. A cognitive-interpersonal maintenance model and its implications for research and practice. *British Journal of Clinical Psychology*, 45, 343-366. doi: 10.1348/014466505X53902.

Silverman, D. (2001). *Interpreting qualitative data: Methods for analysing talk, text and interaction.* London: Sage.

Stevenson, C., McNamara, N., & Muldoon, O. (2014). Stigmatized identity and service usage in disadvantaged communities: Residents' community workers' and service providers'

perspectives. *Journal of Community & Applied Social Psychology*, *24*(6), 453-466. doi: 10.1002/casp.2184.

Stein, K.F., Corte, C., Chen, D.G., Nuliyalu, U., & Wing, J. (2013). A randomised controlled clinical trial of an identity intervention programme for women with eating disorders. *European Eating Disorders Review*, *21*(2), 130-142. doi: 10.1002/erv.2195.

Tajfel, H. (1982). Social psychology of intergroup relations. *Annual Review of Psychology*, *33*, 1-39. doi:10.1146/annurev.ps.33.020182.000245.

Tarrant, M., & Butler, K. (2011). Effects of self-categorisation on orientation towards health. *British Journal of Social Psychology*, *50*(1), 121-139. doi: 10.1348/014466610X51164J.

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: A review of the evidence. *British Journal of Social Work*, *42*(3), 443-460. doi: 10.1093/bjsw/bcr076.

Tomber, I., Shahab, L., Brown, J., Notley, C., & West, R. (2015). Does non-smoker identity following quitting predict long-term abstinence? Evidence from a population survey in England. *Addictive Behaviours*, *45*, 99-103. doi: 10.1016/j.addbeh.2015.01.026.

Topor, A., Borg, M., Di Girolamo, S., & Davidson, L. (2011). Not just an individual journey: Social aspects of recovery. *International Journal of Social Psychiatry*, *57*(1), 90-99. doi: 10.1177/0020764010345062.

Turner, J.C., & Oakes, P.J. (1986). The significance of the social identity concept for social psychology with reference to individualism, interactionism and social influence. *British Journal of Social Psychology*, *25*, 237-252. doi: 10.1111/j.2044-8309.1986.tb00732.x.

Vandereycken, W. (2011). Can eating disorders become 'contagious' in group therapy and specialised inpatient care? *European Eating Disorders Review*, *19*, 289-295. doi: 10.1002/erv.1011.

Vangeli, E., & West, R. (2012). Transition towards a 'non-smoker' identity following smoking cessation: An interpretative phenomenological analysis. *British Journal of Health Psychology*, *17*, 171-184. doi:10.1111/j.2044-8287.2011.02031.X.

Williams, C., & Riley, S. (2013). Finding support and negotiating identity. An analysis of the structure and content of newbie posts and their elicited replies on five pro-eating disorder websites. *RESET*, *2*. doi: 10.4000/reset.117.

Willig, C. (2012). *Qualitative interpretation and analysis in psychology*. New York: McGraw-Hill Education.