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Reclaiming the Body: Identity Reconstruction in Women Recovering from Eating Disorders

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A B S T R A C T

Objective: This study aimed to explore the lived experiences of identity reconstruction among women in recovery from eating disorders, with a particular focus on how they reclaim embodied selfhood and reshape their sense of self.

Methods and Materials: Using a qualitative phenomenological approach, this study involved semi-structured interviews with 25 women residing in Canada who self-identified as being in recovery from clinically diagnosed eating disorders. Participants were recruited through online mental health communities and support forums, with inclusion based on self-reported recovery and age range between 21 and 43 years. Data collection continued until theoretical saturation was achieved. Each interview lasted 60 to 90 minutes and was audio-recorded, transcribed verbatim, and analyzed using thematic analysis within NVivo software. The analysis followed Braun and Clarke's six-step approach, with attention to reflexivity, participant validation, and thematic coherence.

Findings: Four overarching themes emerged from the data: (1) Disconnection from the Body, highlighting alienation, shame, and loss of bodily autonomy; (2) Reconstructing Self-Identity, encompassing narrative transformation, emotional integration, and a shift in personal values; (3) Relational Healing and Social Reintegration, describing the repair of familial and intimate relationships and navigation of social stigma; and (4) Empowerment Through Recovery Practices, including the use of mindfulness, creative expression, self-compassion, and autonomy in recovery decisions. Participants described recovery not merely as behavioral change, but as a transformative process involving embodied awareness, emotional reconciliation, and the development of a resilient, post-disorder identity.

Conclusion: Effective recovery support should move beyond symptom reduction and prioritize narrative, emotional, and bodily reintegration through holistic, person-centered approaches.

Keywords: *Eating disorders, recovery, identity reconstruction, embodiment, women.*

1. Introduction

Eating disorders represent a complex interplay of psychological, sociocultural, and bodily distress that deeply alters a person's sense of self, identity, and embodied experience. For many women, recovery from eating disorders is not merely a matter of symptom reduction but a profoundly existential process involving the reconstruction of identity and the reclamation of the body as an integrated part of the self. Across diverse cultural contexts, the female body has been positioned as a battleground for ideals, control, and social worth, rendering it especially vulnerable to fragmentation and disconnection during disordered eating (Nguyen et al., 2024; Palmeroni et al., 2020). While there is a growing body of research on the epidemiology and symptomatology of eating disorders, less attention has been paid to the lived experiences of women in recovery—specifically how they navigate identity reconstruction in the aftermath of bodily alienation and disordered eating behaviors (Gupta & Kapur, 2019; Lee et al., 2023).

The sociocultural construction of femininity has long been implicated in the development and maintenance of eating disorders. Across both Western and non-Western contexts, thinness has been idealized as a marker of self-discipline, attractiveness, and social success (Jankauskienė & Bacevičienė, 2022; Salleh et al., 2024). For many women, internalizing these appearance-based standards contributes to body dissatisfaction and the perception that the body must be disciplined and controlled to be socially acceptable. Studies show that such internalization can mediate the relationship between media exposure and disordered eating behaviors (Jankauskienė & Bacevičienė, 2022; Zhou et al., 2022). These standards are further complicated by intersecting identities, such as gender identity, race, or sexual orientation, which may intensify body surveillance and exacerbate eating pathology (Barnhart et al., 2023; Nagata et al., 2020). Transgender and gender-diverse individuals, for instance, face distinct body image struggles and sociocultural pressures, often resulting in heightened disordered eating as a means to align external appearance with gender identity (Barnhart et al., 2023; Rasmussen et al., 2024).

The onset of an eating disorder often marks the beginning of a profound disconnection from the body. Rather than being experienced as an integrated self, the body becomes an object to be managed, scrutinized, or punished. This detachment can foster a form of dissociation, in which emotional and sensory awareness are dulled in favor of external appearance management (McCurdy-McKinnon & Feusner, 2017; Zaitsoff et al., 2020). In this context, eating disorders serve not only as mechanisms of control but also as a defense against psychological pain and identity confusion. Many women describe their eating disorder as both a source of suffering and a structured, albeit harmful, identity—a narrative supported by longitudinal and clinical findings on the role of body checking, weight preoccupation, and ritualistic behaviors in shaping self-perception (Trolio & Racine, 2023; Zaitsoff et al., 2020).

Emerging adulthood, a period marked by identity formation and individuation, is often when eating disorders intensify or emerge (Devrim-Lanpir et al., 2018; Palmeroni et al., 2020). The transition from adolescence to adulthood brings increasing social and relational pressures, especially for women expected to meet narrow appearance norms while also establishing academic, social, or professional identities. This convergence of developmental and sociocultural stressors creates a perfect storm for body dissatisfaction and disordered eating (Gupta & Kapur, 2019; Tuan Nor Atiqah Syafiqah Tuan Abd & Shukri, 2019). Studies among university populations indicate high levels of body dissatisfaction and distorted body image, particularly among women with elevated risk for disordered eating (Essa et al., 2020; Natarijadi & Hadiati, 2021). For some, eating pathology becomes a means of asserting control in an otherwise uncertain life stage.

The identity-altering nature of eating disorders also impacts interpersonal relationships. Disordered eating often isolates individuals, distorts communication patterns, and alters the dynamics of romantic and familial relationships (Birmingham et al., 2019; O'Connor et al., 2019). Partners and family members may inadvertently enable or misunderstand the disorder, while individuals may conceal behaviors to maintain control or avoid confrontation. This relational rupture further reinforces the internalized shame and secrecy that often accompany eating disorders (Birmingham et al., 2019; O'Connor et al., 2019). At the same time, social support can serve as a crucial element of recovery. Studies have shown that individuals who perceive greater understanding and validation from others are more likely to seek help, engage in treatment, and experience sustained recovery (Nguyen et al., 2024; Taylor et al., 2018).

Recovery from an eating disorder is not a singular event but a nonlinear and often protracted journey. It involves not only the cessation of symptoms but also the reconstruction of personal identity, emotional integration, and embodied self-awareness (Duarte et al., 2017; Palmeroni et al., 2020).

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Central to this process is the experience of reclaiming the body as part of the self, rather than as a project to be perfected or controlled. This shift requires a reconfiguration of beliefs, values, and emotional relationships with the body. For many women, recovery entails developing a compassionate and mindful relationship with their physical selves, challenging internalized ideals, and navigating vulnerability as part of their emerging identity (Kulshreshtha et al., 2020; Lee et al., 2023). Mindfulness-based and intuitive eating interventions have shown promise in supporting this embodied awareness, leading to improvements in both psychological well-being and physiological functioning (Essa et al., 2020; Lee et al., 2023).

Despite increased clinical and academic attention to recovery processes, the subjective experiences of identity reconstruction remain underexplored in qualitative research. Most existing studies focus on symptom remission, diagnostic transitions, or behavioral change rather than the existential and relational dimensions of recovery. Yet, qualitative accounts from individuals in recovery suggest that these aspects—emotional growth, self-compassion, and relational repair—are often more meaningful and lasting than weight restoration or behavioral control alone (O'Connor et al., 2019; Palmeroni et al., 2020). Moreover, recovery is deeply contextual, shaped by cultural values, gender roles, and available support systems. Cross-cultural studies highlight that what constitutes "healthy embodiment" can vary, and so too do the pathways toward recovery (Salleh et al., 2024; Zhou et al., 2022).

In this context, qualitative research becomes particularly valuable. It allows for the exploration of nuanced and individualized experiences that resist reduction to diagnostic categories or quantitative measures. In-depth interviews and narrative inquiry have proven effective in capturing the complexities of post-disorder identity, including how individuals reestablish self-worth, reframe past traumas, and renegotiate their place within interpersonal and social spheres (Duarte et al., 2017; Nguyen et al., 2024). Through rich qualitative data, researchers can begin to trace the contours of healing and growth—how women, in particular, move from disembodiment to presence, from shame to self-acceptance, and from isolation to reconnection.

The present study seeks to contribute to this growing body of knowledge by exploring how women reconstruct their sense of identity after recovering from eating disorders.

2. Methods and Materials

2.1. Study design and Participant

This qualitative study employed a phenomenological approach to explore the process of identity reconstruction in women recovering from eating disorders. The research aimed to capture the lived experiences of individuals who had undergone a transformative journey from disordered eating toward a reclaimed sense of self. Participants were selected using purposive sampling to ensure relevance to the research question, with inclusion criteria focusing on women who self-identified as being in recovery from a clinically diagnosed eating disorder. A total of 25 women, aged between 21 and 43, residing across various provinces in Canada, participated in the study. Recruitment was conducted through online support groups, recovery forums, and mental health organizations. The sample size was determined based on the principle of theoretical saturation, which was reached when no new themes or insights emerged from additional interviews.

2.2. Measures

2.2.1. Semi-Structured Interview

Data were collected through in-depth semi-structured interviews, allowing participants to reflect on and articulate their experiences in reconstructing identity post-recovery. Each interview lasted between 60 and 90 minutes and was conducted either in person or via secure video conferencing, depending on participants' location and preference. The interview guide included open-ended questions focused on participants' personal narratives, body image, emotional healing, social relationships, and evolving self-concepts. Interviews were audio-recorded with consent and subsequently transcribed verbatim for analysis. Field notes were also taken to capture non-verbal cues and contextual observations where applicable.

2.3. Data Analysis

Data analysis was conducted using thematic analysis, guided by Braun and Clarke's six-step framework. NVivo software was utilized to organize, manage, and code the qualitative data systematically. The analysis began with familiarization through repeated readings of transcripts, followed by initial coding to identify meaningful units of text. Codes were then grouped into broader categories, which were refined into emergent themes that encapsulated the essence of participants' experiences. Reflexivity was maintained throughout the research process by engaging in

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ongoing self-reflection and peer debriefing to minimize bias and enhance credibility. Thematic saturation was achieved after the 22nd interview, but three additional interviews were conducted to confirm the stability of the themes. Trustworthiness was ensured through triangulation of data sources, member checks with selected participants, and maintaining a detailed audit trail throughout the analytic process.

3. Findings and Results

The study sample consisted of 25 women residing in various provinces across Canada who self-identified as being in recovery from a clinically diagnosed eating disorder. Participants ranged in age from 21 to 43 years, with a mean age of 29.6 years (SD = 5.4). In terms of diagnostic history, 10 participants (40%) had a history of anorexia nervosa, 8 participants (32%) had experienced bulimia nervosa, and 7 participants (28%) reported recovering from binge eating disorder. The majority of participants (n = 17, 68%) identified as white, while the remainder identified as Black (n = 2, 8%), South Asian (n = 2, 8%), East Asian (n = 2, 8%), and Indigenous (n = 2, 8%). Most participants held at least an undergraduate degree (n = 15, 60%), while the rest had completed either some post-secondary education (n = 7, 28%) or a high school diploma (n = 3, 12%). At the time of the interviews, 14 participants (56%) were employed full-time, 6 (24%) were students, and 5 (20%) were engaged in part-time work or volunteering. All participants reported being in recovery for a minimum of one year, with recovery durations ranging from 1 to 8 years (M = 3.7 years, SD = 1.9).

Table 1

Main categories, subcategories, and related concepts (open codes) derived from participant interviews

Categories	Subcategories	Concepts (Open Codes)
Disconnection from the Body	Alienation from bodily sensations	Feeling numb, Ignoring hunger cues, Describing body as "not mine," Dissociation
	Shame and disgust	Avoiding mirrors, Describing body as "ugly," Self-loathing, Fear of being seen
	Control through restriction	Rigid eating rules, Caloric counting, Exercise compulsion, Food avoidance
	Fragmented body image	Seeing self as parts, Conflicting weight perception, Emotional detachment
	Medical objectification	Feeling like a diagnosis, Treated as a number, Clinical gaze, Dismissed by providers
	Loss of bodily autonomy	Disempowerment during treatment, Not consulted on care decisions, Bodily compliance
Reconstructing Self-Identity	Reclaiming bodily awareness	Listening to internal cues, Gentle movement, Recognizing hunger, Body-mind reconnection
	Rewriting personal narratives	Letting go of labels, Constructing new self, Language shift, Journaling transformation
	Shifting values and goals	Prioritizing relationships, Moving from aesthetics to health, Seeking authenticity
	Embracing emotional complexity	Accepting sadness, Naming emotions, Feeling whole, Tolerating vulnerability
	Moving beyond diagnosis	"I am more than my disorder," Embracing diversity, Reclaiming personhood
Relational Healing and Social Reintegration	Repairing family dynamics	Open conversations, Re-negotiating roles, Rebuilding trust, Boundary setting
	Peer support and shared experiences	Group therapy, Online forums, Recovery communities, Feeling seen and understood
	Navigating social stigma	Fear of judgment, Concealing past, Encountering stereotypes, Shame in social settings
	Re-establishing intimacy	Physical touch discomfort, Trusting partners, Expressing needs, Being emotionally open
	Role of therapists and allies	Feeling heard, Validated by professionals, Safe therapeutic space, Collaborative care
	Social re-engagement	Returning to work/school, Reconnecting with friends, Social risk-taking
Empowerment Through Recovery Practices	Mindfulness and body connection	Breathing exercises, Body scans, Yoga, Present-moment awareness
	Creative expression and meaning-making	Art therapy, Dance, Writing poetry, Symbolic rituals
	Self-compassion practices	Speaking kindly to self, Inner child work, Forgiving the body, Guided meditations

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	Autonomy in recovery decisions	Choosing treatment plans, Setting boundaries, Saying no, Building internal authority
	Celebrating progress	Marking milestones, Creating recovery r

Disconnection from the Body emerged as a central theme in participants' early recovery experiences. Many described an enduring alienation from bodily sensations, with reports of feeling numb, ignoring hunger cues, and perceiving their bodies as foreign. One participant shared, "I didn't even know when I was hungry or full anymore—it was like my body didn't belong to me." This detachment often coexisted with emotional distancing from the body's needs. Alongside this, participants expressed profound shame and disgust, describing their bodies as "repulsive" or "something to hide." As one woman recalled, "Looking in the mirror made me feel physically sick. I couldn't even recognize myself." These internalized emotions often fueled a pattern of control through restriction, where rigid eating rules, calorie monitoring, and compulsive exercise became mechanisms for asserting dominance over the body. One interviewee explained, "As long as I controlled what I ate, I felt like I had control over everything else—even if it was fake." Participants also reported experiencing a fragmented body image, in which they viewed themselves not as whole beings, but as isolated body parts under scrutiny. This disjointed self-perception led to emotional detachment and identity confusion. Compounding these experiences was a feeling of medical objectification, as many participants recounted being reduced to numbers, diagnoses, or weight charts during treatment. A participant lamented, "All they saw was the number on the scale. No one asked how I was actually feeling." This dehumanization contributed to a further loss of bodily autonomy, with some describing experiences of disempowerment in treatment settings where they were not involved in decisions about their own care.

Reconstructing Self-Identity was another prominent theme, reflecting a complex and ongoing process of healing. Participants described beginning to reclaim bodily awareness by tuning into hunger cues, practicing gentle movement, and developing a mindful relationship with their physical selves. As one woman reflected, "I started asking my body what it needed, instead of punishing it." Many women also engaged in rewriting personal narratives, often challenging the labels they had carried and reshaping their identities beyond the disorder. Journaling and storytelling emerged as tools for re-authoring their sense of self. One participant noted, "I stopped seeing myself as broken. My story is still mine, but now I get to tell it differently." This shift was accompanied by changing values and goals, with women prioritizing authenticity, emotional fulfillment, and connection over appearance or thinness. Several participants described a transition from perfectionistic ideals to values centered on self-care and meaning. In parallel, they began embracing emotional complexity, learning to tolerate and name difficult emotions rather than suppress them. As one woman put it, "Feeling sad or angry didn't mean I was failing anymore—it just meant I was human." A crucial subtheme involved moving beyond diagnosis, where participants deliberately distanced themselves from being defined by their eating disorder. One shared, "I'm more than a patient or a diagnosis. I'm a whole person with a future." This reclaiming of selfhood marked a turning point in their recovery journey.

The third major theme, Relational Healing and Social Reintegration, highlighted the importance of interpersonal dynamics in identity reconstruction. Participants discussed repairing family dynamics by renegotiating roles, setting boundaries, and engaging in open communication. One woman shared, "My mom used to walk on eggshells around me. Now we talk, really talk, and it's healing us both." Peer-based connections, including support from others in recovery, played a vital role. Many described online forums, group therapy, and recovery communities as spaces of validation. A participant explained, "In those groups, I didn't have to explain myself. They just got it." At the same time, participants struggled with navigating social stigma, expressing fears of being judged or misunderstood. Some chose to conceal their recovery status to avoid stereotypes, with one stating, "People think eating disorders are just about vanity. It's exhausting to correct them." Reconnecting intimately also presented challenges, particularly in re-establishing intimacy, as many participants reported difficulty trusting partners, being physically vulnerable, or expressing emotional needs. One woman reflected, "It took me a long time to believe that someone could love me, body and all." The role of therapists and allies was crucial, with participants identifying key relationships that provided safety, validation, and consistent support. One participant emphasized, "My therapist saw me when I couldn't see myself. She reminded me I was still in there." Finally, the process of social re-engagement—such as returning to school, work, or social activities—was seen as both empowering and anxiety-provoking, but essential to reclaiming a place in the world.

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The final theme, Empowerment Through Recovery Practices, captured the agency participants developed through intentional healing strategies. Many described using mindfulness and body connection practices such as yoga, body scans, and breathing techniques to develop a compassionate relationship with their bodies. One woman explained, "When I do yoga, I'm not trying to change my body—I'm trying to listen to it." Creative expression and meaning-making through art, dance, and writing allowed participants to externalize their inner experiences. As one participant stated, "Painting became my voice when I couldn't find the words." A strong subtheme was self-compassion practices, where participants cultivated forgiveness, inner kindness, and self-nurturing. One woman shared, "I started talking to myself like I would to a friend. It changed everything." Autonomy in recovery decisions was also central, with participants asserting control over their treatment paths, setting personal boundaries, and resisting external pressures. As a participant described, "For once, I was calling the shots—not the disorder, not the doctors, me." Finally, many celebrated their recovery milestones in symbolic ways, pointing to celebrating progress as a vital source of motivation and pride. Whether through journaling, ceremonies, or sharing stories, these acts helped consolidate their sense of growth. One participant summarized, "Recovery isn't linear, but every step forward is worth marking."

4. Discussion and Conclusion

This study explored the identity reconstruction processes among women recovering from eating disorders, focusing on how they reconnected with their bodies and redefined their sense of self through emotional, relational, and embodied practices. The analysis yielded four primary themes: disconnection from the body, reconstructing self-identity, relational healing and social reintegration, and empowerment through recovery practices. These themes collectively reflect the nonlinear and deeply personal nature of recovery, emphasizing that identity reconstruction is central to healing from disordered eating.

The first theme, disconnection from the body, highlighted the alienation and dissociation participants experienced during the peak of their disorders. This fragmentation often manifested as bodily numbness, shame, and an overwhelming desire for control. Such findings are consistent with earlier research showing that individuals with eating disorders frequently experience their bodies as foreign objects, subjected to intense scrutiny and punishment (McCurdy-McKinnon & Feusner, 2017; Zaitsoff et al., 2020). Participants' accounts of avoiding mirrors, suppressing hunger cues, and feeling like their bodies were not their own mirror the bodily dissociation and body-checking behaviors identified in longitudinal studies (Zaitsoff et al., 2020). The reported sense of medical objectification and loss of autonomy within clinical environments also aligns with research highlighting how clinical interactions can reinforce depersonalization when treatment is overly focused on physical markers like weight (O'Connor et al., 2019; Taylor et al., 2018). These findings suggest that disembodiment during illness is not solely internal but often compounded by systemic and relational dynamics.

The second theme, reconstructing self-identity, reflected participants' efforts to shift from being defined by their diagnosis to developing a new, holistic sense of self. Participants described processes such as reclaiming bodily awareness, reshaping personal narratives, and shifting internal values—transitions that echo the developmental significance of identity formation during recovery (Palmeroni et al., 2020). The importance of identity work has been emphasized in prior research, which suggests that unresolved identity confusion can perpetuate disordered eating behaviors, particularly during adolescence and early adulthood (Devrim-Lanpir et al., 2018; Gupta & Kapur, 2019). Participants' accounts of rewriting their stories through journaling and self-reflection also support narrative-based approaches to eating disorder recovery, which emphasize meaning-making and the reconstruction of self beyond pathology (Duarte et al., 2017). Moreover, the shift toward embracing emotional complexity and moving beyond diagnostic labels reflects the role of self-compassion in facilitating psychological flexibility and reducing the internalized stigma often associated with eating disorders (Essa et al., 2020; Lee et al., 2023). These findings point to the importance of recovery models that prioritize emotional integration and identity expansion, rather than symptom elimination alone.

The third theme, relational healing and social reintegration, emphasized how recovery unfolded within the context of interpersonal relationships. Participants spoke about repairing family dynamics, re-establishing intimacy, and navigating the stigma associated with their past. These relational processes are well-documented in the literature, which underscores the role of social support in recovery and the negative impact of isolation on maintaining disordered

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eating (Birmingham et al., 2019; Nguyen et al., 2024). For instance, O'Connor et al. (2019) found that partners of individuals with eating disorders often struggle to understand the disorder, contributing to relational strain and emotional distance (O'Connor et al., 2019). Participants in the present study echoed this challenge but also described healing through open communication and boundary-setting—strategies that have been shown to improve relational dynamics during recovery (Birmingham et al., 2019). In addition, peer support and online communities were frequently cited as pivotal, consistent with findings that recovery-oriented groups offer spaces of validation and connection, especially for individuals reluctant to engage in formal treatment (Tuan Nor Atiqah Syafiqah Tuan Abd & Shukri, 2019). The stigma experienced by participants further reflects existing research indicating that eating disorders are often misunderstood and trivialized, leading to concealment and shame (Salleh et al., 2024; Zhou et al., 2022). Importantly, the re-engagement with social and professional environments was seen as a form of reclaiming normalcy, which aligns with models emphasizing functional reintegration as a critical outcome of recovery (Nguyen et al., 2024).

The final theme, empowerment through recovery practices, captured how participants actively reclaimed their agency through practices such as mindfulness, creative expression, and autonomy in treatment decisions. These strategies contributed to increased body trust, emotional regulation, and resilience. Prior studies support the therapeutic role of mindfulness and intuitive eating in reducing body dissatisfaction and fostering adaptive coping (Essa et al., 2020; Lee et al., 2023). The use of creative outlets, such as dance or art, to process emotions and embody healing has also been observed among women in recovery (Kulshreshtha et al., 2020; Palmeroni et al., 2020). Moreover, the emphasis on autonomy and self-directed decision-making in treatment echoes findings that individuals are more likely to maintain recovery when they have control over their therapeutic path and are treated as collaborators rather than passive recipients (O'Connor et al., 2019; Rasmussen et al., 2024). Participants' narratives of celebrating recovery milestones reflect a shift from perfectionism toward self-affirmation, suggesting that rituals of success can play a motivational role in sustaining progress. These findings collectively underscore the importance of holistic, person-centered approaches that support not only behavioral change but also empowerment, creativity, and meaning-making in recovery.

This study also complements research addressing the intersection of gender identity and eating disorders. While the sample in this study focused on cisgender women, the experiences of identity reconstruction and body reclamation described by participants parallel those found among transgender and gender-diverse individuals navigating body incongruence and sociocultural pressures (Barnhart et al., 2023; Rasmussen et al., 2024). In both populations, recovery involves navigating external ideals and internal self-definition. This intersectional lens highlights the need for inclusive models of recovery that are sensitive to gender, cultural background, and lived experience.

Furthermore, the findings echo growing recognition of the sociocultural roots of disordered eating. Participants' narratives of pressure, perfectionism, and idealized beauty align with research indicating that body dissatisfaction is often socially constructed and reinforced by media and peer influences (Jankauskienė & Bacevičienė, 2022; Zhou et al., 2022). These pressures begin early and can persist into adulthood, shaping both the development of disordered eating and the challenges of recovery (Salleh et al., 2024; Trolio & Racine, 2023). For medical and psychological professionals, understanding these broader contextual factors is essential for fostering empathy and designing effective interventions.

5. Limitations and Suggestions

While this study provides rich insight into the lived experience of identity reconstruction among women recovering from eating disorders, several limitations must be acknowledged. First, the sample consisted exclusively of women from Canada, which limits the cultural generalizability of the findings. Cultural perceptions of body, selfhood, and recovery vary significantly across contexts, and future studies may uncover different processes in non-Western or more diverse samples. Second, the study relied on retrospective self-reporting, which may introduce memory bias or selective interpretation of past experiences. Although this is a common feature in phenomenological research, it limits the capacity to assess causal relationships or temporality. Third, the use of semi-structured interviews, while effective for in-depth exploration, may have constrained some participants from fully articulating experiences outside the scope of the interview prompts.

Future research should aim to explore identity reconstruction across different populations, including men, non-binary individuals, and culturally diverse groups.

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Comparative studies could illuminate how gender identity, race, and cultural values intersect with body image and recovery trajectories. Longitudinal designs would also be valuable in tracing how identity shifts unfold over time, particularly from the acute treatment phase to long-term recovery. Furthermore, incorporating mixed methods—combining narrative interviews with psychological assessments—could offer a more comprehensive picture of the recovery process. Finally, future studies might investigate how digital platforms and online communities support or complicate identity work in recovery, given the increasing role of virtual support spaces.

Clinicians and support professionals should recognize that recovery involves more than the cessation of disordered eating behaviors—it is a holistic transformation that includes emotional, relational, and identity-based growth. Therapeutic approaches should center the client's agency and narrative, allowing space for meaning-making and self-definition. Practices that foster bodily awareness, such as mindfulness and creative expression, should be integrated into treatment plans. Recovery support should also extend to relational contexts, helping clients repair and navigate interpersonal relationships. Lastly, practitioners should be mindful of the potential for medical objectification and ensure that clients are treated as whole persons, not defined solely by diagnosis or weight. A strengths-based, person-centered framework can empower clients to reclaim their bodies and reconstruct identities rooted in compassion, resilience, and authenticity.

Authors' Contributions

Authors contributed equally to this article.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

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Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

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