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Original research article

EATING DISORDERS AS A FORM OF CONTROL AND SILENT PROTEST

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Abstract

This qualitative study focuses on the subjective experiences of adolescents with eating disorders (ED) and their significance in the context of life. The aim was to understand how young people perceive their disorder, how they live with it, and what function it fulfils in their lives; whether as a way of survival, control over chaos, silent protest against the environment, or expression of inner pain. The research group consisted of twelve adolescents aged 14–18 who were struggling with various forms of ED. The data were obtained through in-depth interviews and analysed using grounded theory. The analysis identified six main categories: the need for control in an environment of uncertainty, the body as a means of expressing pain and non-acceptance, silence as a form of self-protection, contradictory experiences with professional help, family dynamics and paradoxical security embedded in the illness. Here, eating disorders appear as coping tools through which adolescents find order, boundaries and identity where other areas of life are disintegrated or threatening. The findings highlight the importance of relationship-oriented, long-term, and securely anchored care that allows adolescents to rebuild trust and develop more functional coping strategies. The research provides deeper insight into psychodynamics and highlights the importance of an individual approach in which the adolescent is perceived as an active subject of their own story, rather than a passive symptom bearer.

Keywords: *Adolescents; Control; Coping strategies; Eating disorders; Support*

INTRODUCTION

Eating disorders (EDs) in children and adolescents are a serious and complex phenomenon, the aetiology and consequences of which affect physical health, psychological well-being, social relationships and family functioning. Three primary forms of EDs are most commonly reported in the literature: anorexia nervosa, bulimia nervosa, and binge eating disorder. The latter is the most prevalent in children and adolescents, especially among girls (Campbell and Peebles, 2014; López-Gil et al., 2023; Ram and Shelke, 2023). According to a meta-analysis by López-Gil et al. (2023), up to 22% of children and adolescents show signs of eating disorders, with a higher incidence in girls. The interaction of a wide range of biological, psychological, and sociocultural factors conditions the development of EDs. Significant risk factors include negative body image, low self-esteem, dietary tendencies, depression and anxiety disorders, and obesity (Jebeile et al., 2021; McClelland et al., 2020; Stabouli et al., 2021). Furthermore, EDs often have a chronic course and are associated with an increased risk of comorbidities such as anxiety disorders, self-harm, and suicidal behaviour, which require early and targeted intervention (Tanner, 2023; Wever et al., 2024).

In terms of the impacts of ED, there is not only a significant deterioration in the quality of life, but also growth disruption, hormonal dysregulation, and neurological changes (Wu et al., 2019). Children with ED often experi-

ence feelings of shame, isolation, guilt, and misunderstanding, which contribute to their psychological distress and withdrawal from their surroundings (Coelho et al., 2021; Phillipou et al., 2025). In addition, these emotional factors complicate the diagnosis and treatment process; children have difficulty confiding, minimising their difficulties, or resisting the treatment process. Effective treatment of ED in childhood requires a multidisciplinary approach that connects the work of doctors, psychologists, nutritional therapists, and educational staff. Family-based treatment is considered the gold standard, actively involving parents in the treatment process and strengthening their role as key actors in recovery (Couturier et al., 2020; Datta et al., 2022; Lock, 2015). In cases of severe forms of the disease, hospitalisation or using day care centres is necessary. This has proven to be an effective tool for weight restoration and symptom reduction (Krishnamoorthy et al., 2022).

A very important factor for the successful management of ED is the continuity of care across the individual levels of the system. Children often perceive transitions between outpatient and inpatient care as stressful, especially if not accompanied by sufficient support and explanation (Coelho et al., 2021). The emphasis is thus placed on the need for continuity and coordination of care that reflects the child's needs and minimises their stress load. The family context also deserves special attention. Eating disorders do not only affect the child, but also significantly affect their loved ones – parents often experience feelings of guilt, helplessness, anxiety, and chronic stress (Coelho et al., 2021). Children's experiences show that pressure to perform, perfectionism, and excessive expectations from the family or environment can play a role in both the onset and maintenance of symptoms (Phillipou et al., 2025). In this sense, it is confirmed that ED is not only a disease of the individual, but a problem of the entire system in which the child grows up.

MATERIALS AND METHODS

The research was conducted within a qualitative paradigm, specifically through the grounded theory methodology. The aim was to understand the subjective experiences of adolescents with eating disorders (EDs) and analyse how EDs are experienced as a tool for control, self-regulation, and silent protest against external pressures. This approach allows for the capture of the deep meaning of the experience, which is not always reflected in behavioural manifestations or clinical diagnosis.

Purposive sampling with elements of theoretical sampling was used. Clinical psychologists recommended potential participants, and we also approached non-profit organisations and self-help groups working with adolescents with mental health problems. The analysis included 12 individual interviews with adolescents aged 14–18 years (11 girls, 1 boy) selected from a larger sample of 33 children and adolescents with mental health problems. Participants with subjectively experienced difficulties in food intake (e.g., restrictions, binge eating, purging behaviour) and experience with professional help were included. The 45–70-minute interviews were conducted in person or online, according to the participants' preferences. All interviews were recorded, transcribed verbatim, anonymised, and validated. The emphasis was on a non-invasive, non-judgmental approach, and a safe, confidential environment.

Data analysis was conducted in accordance with grounded theory procedures in three phases:

1. Open coding – transcripts were divided into meaningful units, which were marked with codes describing their content (e.g., "feeling of failure after eating", "fear of treatment", "need for control").
2. Axial coding – codes were grouped into higher categories, and relationships between conditions, context, action strategy, and consequences were identified, in accordance with the paradigmatic model.
3. Selective coding – a core category was identified that unifies the others: *"Eating disorder as a survival strategy in an environment where it is not safe to speak or be."*

During the analysis, constant comparison, theoretical sampling within the data, and memo writing were the methods used to capture analytical reflections. The research was carried out in accordance with the ethical

principles for working with minors and sensitive topics. All participants were informed in detail about the purpose of the research, the anonymity of data processing, the voluntary nature of participation, and the possibility of ending the interview at any time without any consequences. In the case of minor informants, informed consent was obtained. All interviews were anonymised, and any identifying data was removed from the records. All procedures were approved by the Ethics Committee of the Faculty of Health and Social Sciences, University of South Bohemia in České Budějovice (No. 018/2023).

RESULTS

The analysis of 12 interviews with adolescents who had proven to suffer from eating disorders identified key dimensions of experience that capture the internal dynamics of ED as a strategy for survival and coping with emotional and relational stress. The results were divided into six thematic areas, which show that ED is not just a medical complication, but a complex psychosocial phenomenon that connects identity, relationships, and the need for control. The central motive of the statements was the desire for acceptance and respect for one's autonomy, which was repeatedly violated by pressure, devaluation, or lack of support. ED thus appears as a silent form of protest and an escape into a safe internal structure that adolescents create when external support fails.

1. Control as the only available source of power

Most informants associated the beginning of ED with a desire to gain control in an environment they perceived as chaotic, rejecting, or overwhelming. Food and the body became the only "space" to exercise will, rules, and order.

"When I was on a diet, I had at least some control. It wasn't working at school or at home."

"Food was the only thing I could decide for myself."

This motive was present in all informants with restrictive forms of PPP (anorexia, orthorexia) and was often accompanied by remorse when "breaking" one's own rules. Control served as compensation for the lost sense of security.

2. The body as a target, tongue and shield

Physicality played an ambivalent role in the experience of ED – as a target of criticism, a language of pain, and a shield against the environment. Informants spoke of hatred for their bodies, but also of "erasing" them as a self-defence strategy.

"I wanted to be invisible. When I lost weight, no one noticed me – and that was good."

"When I had a headache from hunger, at least it drowned out everything else."

Particular attention was paid to the relationship to the body after hospitalisation – some perceived it as an "object of surveillance", not as a part of themselves.

3. Silence as survival – the inability or impossibility of sharing

A significant number of informants described the experience of unsuccessful attempts to share difficulties, which were belittled or ignored by adults. Silence and isolation became a survival strategy.

"I told my mom I wasn't eating, and she just laughed. So I stopped talking."

"I was afraid to say anything at school because I would be called a poser."

A significant barrier was the stigmatisation of ED and fears of distrust or ridicule. Many felt "seen" only when in contact with a peer with a similar experience.

4. Help as an ambivalent experience

The experience of assistance was quite ambivalent, from traumatising hospital stays to individual therapy sessions. Children often encountered a mechanical, disrespectful approach that led to losing trust in the system.

"They just forced me to eat in the hospital. No one asked why I wasn't eating."

"The psychologist interrupted me when I finally decided to say something."

Informants positively evaluated a continuous and human-based therapeutic relationship. It is beneficial when the help is perceived as support rather than control.

5. Family as a trigger, but also a source of change

Family was mentioned by most informants as a key factor in the development of ED, whether through its emotional absence, pressure,

or unprocessed patterns (e.g., diet culture in the family). At the same time, some described that a change in family communication led to relief.

"Mom tried to lose weight with me, saying we'd be pretty. And then she was surprised I didn't eat."

"Dad started talking more when I almost collapsed. And he hugged me for the first time."

Family therapy or joint education were seen as potential for healing, provided there was respect and openness.

6. Disorder as paradoxical safety

Although ED caused considerable suffering, some informants described it as the only stability they had in their lives. The disorder was a "familiar enemy" that provided structure and a sense of identity.

"Without anorexia, I didn't know who I was."

"It was like a ritual – when I couldn't cry, I counted calories."

Change became possible only when a safer alternative was created, i.e., a relationship, a space, or a new form of expression (e.g., art, contact with animals).

Table 1 – A paradigmatic model of children's experience with ED

Model element	Content based on research data
Phenomenon	*Eating disorders as a form of control and silent protest against misunderstanding, inner chaos, and broken relationships*
Causal conditions	• Trauma (bullying, neglect, rigid upbringing) • Social media influence and pressure on body ideals • Internal perfectionism and self-criticism • Lack of emotional support
Context	• Lack of acceptance in the family • Superficial or failing school support • Fragmentation of the professional system • Stigmatisation of mental disorders
Intervening conditions	• Sensitive therapeutic approach • Emotional support from a loved one • Possibility of expression without fear • Creative venting of emotions (writing, animals, art)
Actor strategies	• Body and food control as survival • Concealment of difficulties • Self-harm as emotional regulation • Seeking anonymous help • Resistance to the directive approach of professionals
Consequences	• Deterioration of health, isolation, relapses • Establishment of a therapeutic relationship, partial self-acceptance, activation of resources

Eating disorders are not just an eating disorder, they are a relational protest and body language of children who had no other way to express pain, fear, or loss of control. In an environment where understanding, safety, and emotional resonance are lacking, the child creates survival strategies that help them to regulate chaos – and the body becomes a means of expressing the incommunicable. The testimonies show that effective help must be non-instrumental, relational, and safe. Professional intervention fails without respect and time. Children do not refuse help; they refuse a devaluing approach. Recovery is possible where a space is created for sharing without fear and where the professional perceives the person before the disorder.

DISCUSSION

The findings underscore that eating disorders are a complex psychosocial phenomenon extending far beyond mere problems with food and body image. Informants did not primarily perceive EDs as an effort to achieve an ideal of

beauty, but as a survival strategy in an environment where they feel emotionally threatened, unseen, or disrespected.

The dominant theme was the desire for control in situations where adolescents perceived the surrounding world as chaotic and ungraspable. This motif also aligns with previous research, which indicates that EDs frequently serve as a compensatory mechanism in the context of emotional deprivation and relationship disappointment (e.g., Coelho et al., 2021; Phillipou et al., 2025). In our sample, food control was described as the only area of autonomy that adolescents controlled. This concept has long been emphasised in the Czech environment by clinical literature and practice, which highlight the need for psychotherapeutic approaches aimed at managing affects and relationship problems, not only weight and food (Theiner, 2011). Another significant finding is the role of the body as a means of communication. Adolescents described the body as the target of their own anger, but also as the language they "spoke" with when the verbal path failed. PPPs function here as a silent protest and at the same time a shield against further injury. Experiences with professional help were quite ambivalent in our group. On the one hand, the mechanical, directive approach was perceived as hurtful and alienating. On the other hand, continuity and relational security allowed for gradual opening and building of trust. These findings align with the conclusions of Datta et al. (2022) and Lock (2015), who emphasise the importance of an individualised and long-term therapeutic approach in treating adolescents with PPP. The family played an important role, both in a negative sense (pressure, diet, emotional coldness) and as a potential source of change – if there was a shift in communication and increased empathy. This confirms the importance of family therapy, which was also recommended in international guidelines (Couturier et al., 2020). Clinical workplaces in the Czech Republic have long recommended family-oriented approaches, including multi-family programs (First Faculty of Medicine, Charles University, ©2025). A final key theme is the paradoxical safety of illness – ED has often been seen as a stable part of life, providing a framework, identity, and ritual. This phenomenon should be viewed as a signal of insufficient alternative support, rather than evidence of resistance to change. Overall, research shows that PPP is not an isolated disorder but a reaction to a dysfunctional environment. Effective intervention must therefore be not only therapeutic, but also systemic, relational, and emotionally intelligent. Adolescence is a period of searching for a voice and a place in the world – if this is not possible through healthy paths, young people seek their own, albeit destructive, forms of expression.

CONCLUSION

This study shows that eating disorders in adolescents cannot solely be understood as manifestations of a pathological relationship with food or the body, but as deeply rooted coping strategies in an environment of emotional insecurity, relationship injury, and lack of support. For adolescents, ED often represents the only available way to regain control, express pain, or create structure in a world that seems chaotic or threatening to them. The testimonies demonstrate that the quality of the relationship environment plays a crucial role in prevention and treatment, both within the family, in schools, and in the therapeutic context. Adolescence is a period of increased sensitivity to acceptance, respect, and autonomy. Help that lacks empathy and individualisation can be perceived as threatening and lead to resistance or closure. In contrast, a confidential therapeutic relationship, open family communication, and the possibility of authentic expression create space for change and renewal of identity outside the framework of the illness. Eating disorders should therefore be viewed not only as a clinical diagnosis, but also as a relational and communicative phenomenon that requires sensitive, securely anchored, and long-term intervention. It is essential to recognise and support the individual meaning that the disorder has for the young person – and to offer alternatives that will be equally stable, but healthier and more life-supporting. This study has several limitations. The research sample is relatively small (n = 12) and unbalanced in terms of gender, with a significant predominance of girls. The chosen qualitative method provides deep insight into subjective experiences but does not allow for generalisation of the results. Future

research could include a broader range of informants and combine different methodological approaches for a more comprehensive understanding of the phenomenon.

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Ethical aspects and conflict of interest
The authors have no conflict of interest to declare.

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