How We Experience Eating Disorders:

An Interpretive Phenomenological Analysis

by

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Dedication

I dedicate this thesis to the women I met at Renfrew Center for Eating Disorders with very special gratitude to the women who chose to be involved in this research.

Acknowledgments

I would like to express my gratitude to Jill McCracken. I have had many roadblocks along the way in this research, and Jill was always there with a helping hand. She never let me give up on my research. Without her support throughout my academic journey, I would not be in graduate school. Jill truly dedicates her life to helping others and is an admirable mentor.

A special mention to Morgan Gresham for always helping me to find the necessary resources needed for this study. Discussing mental illness was very hard for me when I started this research and now, I can speak freely about my experience, feel like an expert and even help others.

A very special thank you to my best friend, Rachel, who has been the biggest support in my life throughout the past five years. Rachel is the perfect complement.

A distinct kind of gratitude goes out to my pseudo mom, Debbie. She is the definition of resilience.

Last, but certainly not least, I would like to thank my mom for always picking up the phone.

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Abstract

There is very little existing qualitative research about the lived experience of individuals with eating disorders (ED) from the lens of a researcher who also identifies as a member of that community. To that end, this project asks: "What is the lived experience of having an ED? And how does my perspective as someone who identifies as having an ED inform my research process and findings?" In this thesis, I draw on feminist practices that recognize participants as collaborators and co-researchers, and I conduct open-ended interviews with four women who were diagnosed with, and sought treatment for, an ED. I then analyze the transcripts using Interpretive Phenomenological Analysis (IPA). The results, supported by existing research, indicate that this phenomenon emerges from one's internalization of a false self-concept, which then leads to poor self-esteem and the emergence of ED behaviors to support this identity. Further, within communities where ED behavior is part of group identity, participants adapt their behavior to meet the expectations of others. This process of utilizing participants as experts on the ED experience can form a richer understanding of this phenomenon and therefore contribute to more effective treatment modalities. Knowledge of how an ED emerges and is maintained invites change and can help researchers better respond to individuals living with an ED. My research also reveals a need for more qualitative studies that speculate on the connection between "self" and EDs in order to examine how social environments impact the creation of identity. Likewise, additional studies that take place after inpatient treatment of an ED are needed to explore further the change in ED behaviors created through the shared identity of the recovery community.

Introduction

Rationale for Study

The National ED Association (NEDA) states that “in the United States, more than 20 million women and 10 million men suffer from a clinically significant eating disorder [1] at some time in their life” (Choudhury, 44). Not only do EDs disproportionately affect women, but they also cause disability and death due to their devastating consequences. The American Psychological Association (APA) reports that “eating disorders rank among the ten leading causes of disability among young women” (qtd. in Nunn, 43). The problem is so severe that “every 62 seconds someone dies of an eating disorder” (Smirk, 10), giving EDs the `highest mortality rate of any mental illness (Choudhury). Clinicians argue that due to poor understanding of eating-disorder etiology (Nunn, Shimer, Oluyori, Ried, Stein, Smethurst*)* and lack of resources to combat ED, its treatment continues to have poor outcomes (Shimer, Striegel-Moore et al.). These studies reveal that gaining an understanding of meaning and experience could provide further insights into the causes of EDs.

Much quantitative research has attempted to make sense of ED pathology, giving rise to the success of modern medicine as a treatment and contributed immensely to

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[1] Eating Disorders: are considered a persistent overconcern with body size and shape indicated by behavior such as prolonged fasting, strenuous exercise, and self-induced vomiting aimed at decreasing body weight and fat (Garner & Myerholtz, 592).

understanding EDs. However, these approaches are closely tied to positivism, or the search for “objective truth,” and seek to explain behavior rather than meaning (Oluyori). Nunn argues that a qualitative approach may contribute more to an understanding of the processes between self and ED due to a focus on the thinking and experience of the participants. This knowledge is only obtained by collecting and analyzing the narratives of those who experience life with an ED. In my study, I collect the narratives of four women who were in treatment for an ED, and I utilize Interpretive Phenomenological Analysis (IPA) as an idiographic qualitative inquiry whereby the researcher investigates the experience of living with ED as described by the participants (Smith and Osborn). This process of utilizing participants as experts on the ED experience can form a richer understanding of this phenomenon and therefore contribute to more effective treatment modalities. Knowledge of how an ED emerges and is maintained invites change and can help researchers better respond to individuals living with an ED.

Although there have been a few studies that utilize IPA in relationship to EDs, Nunn argues that qualitative studies “remain relatively few in number compared to the volume of quantitative studies” (105). Studies that are qualitative focus their inclusion data on exclusively those with anorexia (Fox; Beattie; Wykertowicz; Strauss; Svenaues); emotions, treatment effectiveness, the process of recovery (Beattie, Millstein,Oulyori, Shimer; Pardi) and the role that online weblogs known as “Pro-Anorexia” sites have on the identity of someone with an ED (Mchee-Vincent; Smethhurst, et al). None, however, explore the lived experience of having an ED from the position of a researcher who has an ED.

Therefore, the goal of this study is to provide insights into the lived experience of having an ED from the point of view of a female patient who has been in treatment for ED. Further, this study serves to further feminist research to understand "better practices" for women with EDs who seek treatment. Utilizing feminist interviewing methods that aim to break down the hierarchy between researcher and participant, this methodology centers women with EDs as experts in their field who attempt to provide an accurate understanding of what it is like to live with an ED. Lastly, this research attempts to continue to fill the existing gap between researcher and participant through the reflexive nature of my positionality as a member of the community.

Positionality

I am a 28-year-old, white, feminist, college graduate student. I first developed bulimia at the age of 13, which transitioned into anorexia ten years later. I did not receive treatment for my ED until age 24, primarily because I did not have insurance that would cover my treatment. Even after I obtained insurance through Veterans Affairs (VA), I fought relentlessly to receive treatment for my ED. Because ED treatment is considered "specialized care," it is often not covered by insurance. I have been in therapy at the VA for seven years for Post-Traumatic Stress Disorder, Major Depressive Disorder and Generalized Anxiety Disorder; however, I received specialized care for my ED for only one month in 2017.

I received residential treatment for Anorexia Nervosa (AN) in an inpatient treatment center at Renfrew Center for EDs after fighting with my insurance for two years to pay the $40,000 price tag for one month of residential treatment. By the time my psychiatrist and I persuaded the insurance to approve my stay, I had reached what the VA considered a “critical” level of care. My heart rate was a steady 30 beats per minute, and I was near death from my anorexia[2]. During my treatment, I met three of the collaborators in this study, and we have continued our close relationships after treatment. Because I was able to create rapport with them and gain their trust while we were in treatment together, each collaborator expressed interest in being interviewed about their experience after I explained my initial course project (conducted in 2017). Therefore, these close relationships served to create a strong foundation upon which to conduct this research because the women involved truly wanted to share their experience.

As a member of the ED community, I bring my own perspective and experience to this study. I anchor myself in this place because most research has been developed by researchers who either do not identify or disclose their own ED status. Not only am I able to bring my own experience to this analysis, but I am able to build rapport with participants because we share many of the same experiences. This connection impacts the research and our findings because we discuss, together, how we understand these complex issues.

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[2] I am no longer in treatment for my ED though I have asked for a specialist many times since 2017. My insurance will only cover costs if I am considered at risk enough to be in residential care.

Anorexia Nervosa and Bulimia Nervosa: Background

This study examines the narratives of collaborators who have been clinically diagnosed with Anorexia Nervosa (AN)[3] or Bulimia Nervosa (BN)[4] and attended a treatment center in 2017. Both AN and BN have many commonalities, and there is much debate on whether the two are separate diagnoses. Herman and Polivy argue that "the core symptoms (e.g., body dissatisfaction; preoccupation with food, weight, and shape; certain ego deficits) do not necessarily separate AN from BN patients, even if the diagnostic criteria for the two EDs differ" (188). The only clinical criteria that separate AN from BN is that the patient must be below 85% of ideal body weight.

Further, since AN purge type also includes criteria for binging, it is widely debated whether purge type AN should be considered BN. For this reason, many women, myself included, are originally diagnosed with BN until enough weight is lost to be considered AN. Both disorders require that an individual engages in ED behaviors twice a day for at least three months (Shimer), and many women experience an ED in private. In fact, Choudhury argues that "only1 in 10 individuals with anorexia receive treatment" (43) leaving 90% of those who are battling an ED to battle it alone.

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[3] Anorexia Nervosa (AN): a "refusal to maintain body weight at or above a minimally normal level for one's age and height; an intense fear of gaining weight or fatness; disturbed experience of body weight or shape; and amenorrhea for at least three consecutive menstrual cycles (Nunn 9). AN is subdivided into those who restrict calories and those who do not.

Bulimia Nervosa: "binge eating followed by compensatory behavior to prevent weight gain" (qtd. in Nunn 9). A binge is an episode of lack of control of one's eating, which leads to eating a large amount of food in a short amount of time.

[4]

Because many individuals are reluctant to reveal they have an ED, the precise prevalence and incidence of EDs are unknown and much debated. According to a study conducted in 2002, “AN prevalence estimates tend to range from about 3% to 10% of at-risk females (those between 15 and 29 years of age) with BN patients outnumbering AN at least 2 to 1” (Polivy and Herman). Further, it is almost impossible to know if someone has BN because most patients binge and purge in private and appear to be of healthy weight, which makes the disorder even harder to detect. Herman and Polivy state that BN “patients are likely to present themselves for treatment because the binge-purge cycle is often profoundly disturbing to them” (189). Consequently, they must accept that they have a condition that requires treatment, whereas patients with AN are likely to deny that they have a condition and only present themselves for treatment because family members have concerns for their lives. Given that patients with an AN diagnosis have to meet criteria for being underweight, it is likely that people who are close to them will notice weight loss and other associated health problems. It is important to note that many patients with AN arrive at inpatient treatment after medical stabilization leading to involuntary inpatient treatment (Westmoreland, et al)[5].

Even when those with ED do seek treatment, there are poor treatment outcomes (Bardone-Clay, Fox, Garner, Millstein, Nunn, Oldershaw, Ouloyori, Polivy, and Herman,

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[5] The success of treatment based on individual knowing or not yet knowing one needs treatment is outside the scope of this study see (Gresham; Fox 2004).

Shimer) and interventions do not result in enduring rates of remission (Polivy and Herman). In fact, “it is thought that a third of patients continue to meet diagnostic criteria more than 5 years after initial treatment” (Nunn 9) which demonstrates how difficult it can be to stop ED behaviors.

Research suggests that inpatient and residential treatments are beneficial (Frisch, Twohig, Vandereycken). Twohig claims that, “statistically, residential treatment affects ED severity, reduces depression and anxiety, and improves quality of life” (236). Though residential treatment options from AN and BN are becoming increasingly more available, treatment programs are often for profit and nonregulated (Frisch). In fact, “Kaye et al. found that managed care companies often limit coverage for the treatment of EDs, leaving individuals responsible for the cost of more intensive rehabilitation after medical stabilization” (qtd. in Frisch, 435). This intensive care comes at a high price, often out of reach for those who need it. According to Frisch, the average length of stay is 83 days and costs $79,348. As noted previously, the decision to place someone with AN or BN in an inpatient setting is due to life threatening situations, leaving those who need the care most, often without.

EDs are complex and multi-determined by a combination of different factors (Fox, Nunn, McGhee-Vincent, Shimer, Oulouyi). Nunn states that “while there has been a long debate about nature vs. nurture in science, research has shown that ED etiology is not an either/or debate, but rather an interplay of both biological and psychosocial factors” (5). This interdisciplinary approach to the condition is called the biopsychosocial model and represents psychological issues, social issues, and genetics. Family studies have shown that females are more likely to suffer from an ED if a close family member has been diagnosed (Nunn; Shimer). However, it is unclear if their ED is due to family culture (social factors) or purely genetics (biological factors), which is why an interdisciplinary approach to risk factors is vital to understanding the phenomenon. Narrative analysis allows for a full examination of the biological, psychological and social aspects of the disorder. Further, this analysis is the only model that more closely captures the entirety of the experience, especially given the importance of society in the emergence of the "self-concept."

"Self" Concepts

Carl Ransom Rogers defines the self-concept as "the organized, consistent set of perceptions and beliefs about oneself" (Mcleod, 1). In other words, the self-concept is the collection of individual perceptions one holds about themselves. The self-concept answers the question, "Who am I?" and it includes self-schemas (the beliefs one holds) and self-knowledge and self-esteem (the way one feels about herself). According to his theory of self-actualization, McLeod argues all people are good and creative and are meant to reach their full potential. He claims that people only "become destructive when a poor self-concept or external constraints override the valuing process" (1). According to Cooley, this value system comes from primary groups or those in their immediate environment. Within this study, I argue participants create their self-concept based on their primary groups because individuals share ideas in the group and accept these ideas from community members. Further, this study examines destructive ED behaviors that emerge from a poor self-concept.

In Cooley’s social-self theory, he argues that everything we learn in life comes from social transmission and emulation of our environment. He claims that the “I” or “self” is rooted in social conditioning and therefore is not separate from the environment. In other words, everyone is a product of their environment. Within these primary groups, “primary social ' sentiments and attitudes, including consciousness of one's self in relation to others, love of approbation, resentment of censure, emulation, and a sense of social right and wrong formed by the standards of a group” (32), are formed. Cooley argues that when a person is a “degenerate,” it is based on a judgment of ‘good’ or ‘bad’ behavior from the primary group, and this judgment can influence and potentially change the behavior of an individual. Therefore, “human nature” is a social construct that argues how one should behave in particular groups, and therefore if the group changes, so do one's actions or human nature (Cooley). For example, Cooley would argue that the women involved in this study picture an ideal body shape they can obtain through the “social” part of the biopsychosocial model. For example, media portrays thin women as happy and successful. Further, ideas of Western beauty are internalized and maintained in primary groups where behavior is normalized. For instance, one collaborator expresses that on her dance team, everyone had an ED, “and everyone got weighed, it was totally normal” (Brittny). In this primary group, Brittny internalizes this thin beauty ideal as a self-concept, which then led to ED behaviors being her status quo. However, in other primary groups, that is not always the case. For example, in this study, the collaborators are all in the “ED recovery” primary group through their shared experience of residential treatment. In this group, the standard behaviors include abstaining from ED behaviors like restricting calories to meet a thin beauty ideal. Therefore, the participants change their behavior to meet this status quo.

Epstein theorizes that changes in behavior come from a lack of self-esteem. Self-esteem answers the question, “how do I feel about myself?” and is the backbone of the self-system. Epstein states, “there is a basic need for self-esteem which relates to all aspects of the self-system, and, in comparison to which, almost all other needs are subordinate” (qtd in Nunn, 32). According to Epstein’s self-theory,

> the self-concept has two basic functions. First, it organizes the data of experience, particularly experiences involving social interaction, into predictable sequences of action and reaction. Second, the self-concept facilitates attempts to fulfill a need while avoiding disapproval and anxiety. (qtd. in Nunn, 32)

Therefore, when the self-concept is in danger, the individual “experiences anxiety and attempts to defend himself against the threat” (qtd in Nunn, 32). For example, returning to the example of the ED recovery group, Epstein would argue that the change in behavior comes from a place of disapproval. In this group, if a participant engaged in ED behaviors, she would be met with disapproval. Therefore, social anxiety produced by disapproval causes the participant to adapt her behavior to meet that of the group. The relationship between social anxiety and bulimia has also been examined critically (Rodin, et al).

In a study published in the *Journal of Abnormal Psychology and Sociology*, findings “strongly support the hypothesized link of social-self concerns to body dissatisfaction and bulimia nervosa" (Rodin, et al. 297). This study found that perceived self-fraudulence and public self-consciousness relate to body dissatisfaction, social anxiety, and bulimia. They argue that because women's bodies are constantly under scrutiny, feeling inadequate in physical appearance leads to social anxiety, which they argue has long been linked to having a comorbid, or simultaneous, relationship with bulimia. The authors state,

> Social anxiety disorder (SAD) and EDs are highly comorbid (Godart et al., 2000, Pallister, Rodin et al., and Waller). The lifetime prevalence of SAD has been reported as 33.9% among individuals with anorexia nervosa (AN) (Halmi, Eckert, Marchi, & Sampugnaro, 1991) and as 17% among individuals with bulimia nervosa (BN). (Brewerton, Lydiard, Herzog, & Brotman, 1995) (Rodin,et al. 1)

Social anxiety, paired with an ED, leaves sufferers struggling to construct an "adequate self" (Rodin, et al). The study claims that those with ED "seem exquisitely tuned to the evaluation others make of them, and the expectations others hold for them" (Rodin, et al. 297), which creates an overdeveloped "false self" that leads to the absence of a "true self." This concept is known to be false because no one can know what others think of them. The women then "become hypervigilant about public face and social attitude" (297). The collaborators in this study create a false self-concept based in their lack of self-esteem. The participants alter their self-concept based on poor self-esteem, which then leads them to engage in ED behaviors. The following literature is some examines the concept of self and Interpretive Phenomenological Analysis.

IPA and the "Self"

Two other studies examine the "self" as it relates to EDs (Nunn; Kent and Ison). In the first, Amanda Louise Nunn focuses on how women see themselves, why they see themselves this way, and whether "there is a link between their view of themselves and their ED" (Nuun, 79). Her data, much like my own, includes four women who were diagnosed with, or have undergone treatment for, an ED. Based on her interviews, she finds her participants "experience a fragile sense of self" or, in other words, a lack of certainty in self or constantly question "who am I?" She describes her second theme, "the influences of others on self-perception," as "the negative assumptions that they [participants] made about the thinking of others, feeling worse about themselves due to the way others treated them, and also feeling better about themselves in response to positive feedback" (Nunn, 124). She finds the theme "strategies employed to manage the sense of self" as the coping mechanisms (commonly ED behaviors) that participants manage the perceptions they hold of themselves. And finally, she notes "the enduring influence of early experiences on self," which explores the relationship that childhood experiences continue to have on the construction of one's identity.

The second study utilizes semi-structured interviews with eight females who have an ED diagnosis to "allow an exploration of the social identity with people diagnosed with an ED" (475). The study utilizes Tajifel's social identity theory, as 'that part of the individual's self-concept which derives from their knowledge of the membership of a social group (or groups) together with the value and emotional significance attached to that membership" (qtd. in Kent, et al. 475). Their study's primary focus was to explore the complex social identity of being “eating disordered.” They found three superordinate themes that emerged from participants’ accounts: “(1) Shifts in social identity; (2) Outgroup perceptions and influences and (3) EDs as an ingroup” (475). Their study argues that a person’s social identity can change while having an ED, and they propose an interaction between one’s social identity and a person’s recovery from an ED (Ison, et al). This interaction between social identity and recovery will be further explored in my study.

Methods

This study seeks to find the essence of an individual's lived experience of an ED through Interpretive Phenomenological Analysis. I am utilizing feminist interviewing methods that aim to break down the hierarchy between researcher and participant; this study gains insight from interviews with four women who have been in treatment.

Participants

This project includes interviews with four women between the ages of 18 and 40 who attended an ED treatment center in 2017. Three of the four participants attended Renfrew Center for EDs, which means they had a clinical diagnosis of an ED. I met the fifth participant at work. She also attended a residential treatment center in 2017. All the participants included in this study experience other comorbid mental health problems.

After I discussed my study and its goals with the participants, they all chose to join the project. Each of our interviews began with the question: "What is your experience with having an ED?" Each participant was given a pseudonym to maintain their anonymity.

Feminist Interviewing

In *Feminist Research Practice,* Sharlene Nagy Hesse-Bibler states, "feminist researchers are particularly interested in issues of social justice and social change for women and other oppressed groups" (147). According to Hesse-Bibler, feminist interviewing "is mindful of the researcher-researched relationship and the power and authority imbued in the researcher's role" (117). Feminist research is not just concerned with women or oppressed groups and social change, but also with reducing the hierarchies that play out in more traditional research methods. To that end, I utilize feminist research methods to gain a perspective on the lives of women in the ED community. Being mindful of this power hierarchy means paying close attention to the nature of the researcher's relationship with research participants to understand personal standpoints and what role they play in the interview process (Hesse-Bibler). In order to be aware of personal standpoints, the feminist researcher must practice reflexivity throughout the process. Reflexivity is "the process through which a researcher recognizes, examines, and understands how his or her own social background and assumptions can intervene in the research process" (Hesse-Bibler, 129). Within my study, I address the hierarchies typically at play in the interview process with a positionality journal.

My reflexivity process included writing in a positionality journal to "memo" throughout every step of the process, asking myself, "Who am I?" and "How do I relate to the research?" In practicing this reflexivity, I was able to address my positionality in the community within the research. The following is a sample from a journal entry in which I discuss my research:

> Whatever may come from this research, I hope it is beneficial for everyone involved. I remember back in October when they [my therapist] asked me to "tell

> my story" about my ED, and it was a really impactful exercise for me. And, it really helped me afterwards to read it a few times over.

In this journal entry, it is clear that I am part of the ED community and that I have an interest in this research which will never allow me to be objective. However, Feminist Standpoint Theory (Harding) argues that perspectives of marginalized communities are better understood and represented by those who belong to the group. She argues that no one can ever be objective, as everything that we do is considered in the social context. For example, in this study, I have insider knowledge about my community which includes shared ideas, identities and even shared language. In her theory, Harding argues that creating a space for bracketing assumptions and biases throughout research, creates "strong-objectivity." This process argues that a researcher will never be without bias and yet they can provide valid data. The research is subjective because the analysis is written by a researcher who is also a community member; the research can be replicated and is not generally based in the researcher's opinion. My status as an "insider" in this community also breaks down the existing hierarchy between researcher and participant—which is vital to feminist interviewing.

I shared my own stories and experiences with the participants I interviewed, which further increased reciprocity and rapport. Because I also spent 30 days in inpatient treatment with most of the participants, I was able to share my own "biography" with them. Ann Oakley, an early feminist researcher, calls this choice the "participatory model" which stresses the importance of the researcher sharing his or her biography with the researched (qtd. in Hesse-Bibler, 128). This open dialogue created a sense of understanding or “shared knowledge” between us, which encouraged participants to share openly with me and to offer perspectives that might be unavailable to an outside researcher.

The researcher can also break down notions of power and authority more fully. Hesse-Bibler states that when the researcher treats the interview participant as a “co-constructor” of meaning, it creates a further reduction in the hierarchy. When the researcher is considered an “insider” of the community (Hesse-Bibler), this creates an equal hierarchy. Boylorn discusses the importance of this co-creation of knowledge by approaching interview participants as co-researchers and collaborators. The process “validates and privileges the experiences of participants, making them experts and therefore co-researchers and collaborators in the process of gathering and interpreting data” (601). Because I am an insider in this community, and I utilize feminist research methods, when I refer to participants in this study, I use the terms collaborators, co-researchers, and participants interchangeably.

Hesse-Bibler argues that a way to further empower the participant as a co-creator is to share the research findings and interpretations with them, which can then push the co-researcher to resolve any disagreements in interpretations of their interview. This sharing also creates an increased investment in the success of the project. For all these reasons, I chose to share recorded interviews, transcripts, and findings with the co-researchers. Working with a small sample size of four, I focused on what Hesse-Bibler calls the “process,” or the “meanings” individuals attribute to their given social situation. The interview guide is brief and open-ended to capture participants’ lived experiences without directing participants to specific narratives about their diagnoses or experiences. The procedure involves studying a small number of subjects through extensive engagement to develop patterns and relationships of meaning (Moustakas). To capture the lived experience of having and receiving treatment for an ED, I then utilize a qualitative method of analysis called “Interpretive Phenomenological Analysis.”

Interpretive Phenomenological Analysis (IPA)

Phenomenological research is a qualitative inquiry in which the researcher investigates the meaning of a lived experience to identify its essence as described by the research participants (Smith and Osborn). IPA aims “to explore in detail how participants are making sense of their personal and social world...and the meanings particular experiences, events, or states hold for participants’ lives” (Smith, 54). Ried et al state, “IPA’s increasing popularity within health psychology may well stem from its ability to contribute to biopsychosocial perspectives” (4), which is necessary to grasp the full experience of an ED. This method does not make generalized statements or theories about an entire population, and due to the fact that qualitative analysis is inevitably a personal process, the term *essence* is understood as a meaning rather than an absolute truth.

In IPA, there is not one, but a variety of ways to analyze verbatim transcripts to find the essence. Explaining the analysis, Reid, at al. states that “researchers reduce the complexity of experiential data through rigorous and systematic analysis which relies on the process of people making sense of the world and their experiences, firstly for the participant, and secondly for the analyst" (6). For this reason, I utilize coding for the analysis.

IPA offers the researcher the chance to engage with a research question at an idiographic (particular) level. The first step is bracketing, or a way of "noticing, becoming aware, without imposing our prejudgment on what we see, think, imagine or feel. It is a way of genuine looking that precedes reflectiveness, making judgments, for reaching conclusions (111). Bracketing means looking ``inward" to reflect "on one's own lived reality and experiences" (Hesse-Bibler, 129). To attempt this process, I utilized bracketing in a positionality journal.

I attempted to write a memo at every point in the research process. The following is a sample journal memo that explores my relationship with the participants before beginning the interview process:

> Each participant is a friend of mine. Three of the participants attended treatment in Renfrew while I did. I was fighting for my own recovery during this time. My heart rate was around 30bpm when I arrived at Renfrew, and I spent the first five days crying through most groups and at the table while everyone else ate their food. Being all locked in the same place, with little to no contact from the outside world, we got to know each other very well. For me, discussing my traumatic past life events and sharing my struggles with my ED at that period created a sense of belonging with the women I am collaborating with. I feel that Catherine, who did not attend treatment with me, will still be open and honest with her experiences. Although maybe not as open as the other participants. We met each other while

> modeling before attending treatment. Since this meeting, four years ago, I have spoken with her at least once every six months about where I am in my recovery process—even when she is halfway across the world. Her perception of my struggle, however, will be different than the others because she has only known me when I've fought for recovery and never in my suffering.

This journal entry is another example of how I examined my positionality within the research. In this entry, I make two assumptions: First, the women in the study would share freely; and second, that Catherine may not be as open about her experience due to not being in residential treatment at the same time and place, and therefore, not seeing my struggle with my ED first hand.

Having this journal allowed me to become more aware of my intent and to check back periodically and ask myself, "Who am I?" and "How am I related to the research?" To ensure I was properly tracking my process, I create a space to reflect on each interview, each participant, and each step of the research process. After I bracketed my assumptions and biases, I continued onward to the textual analysis.

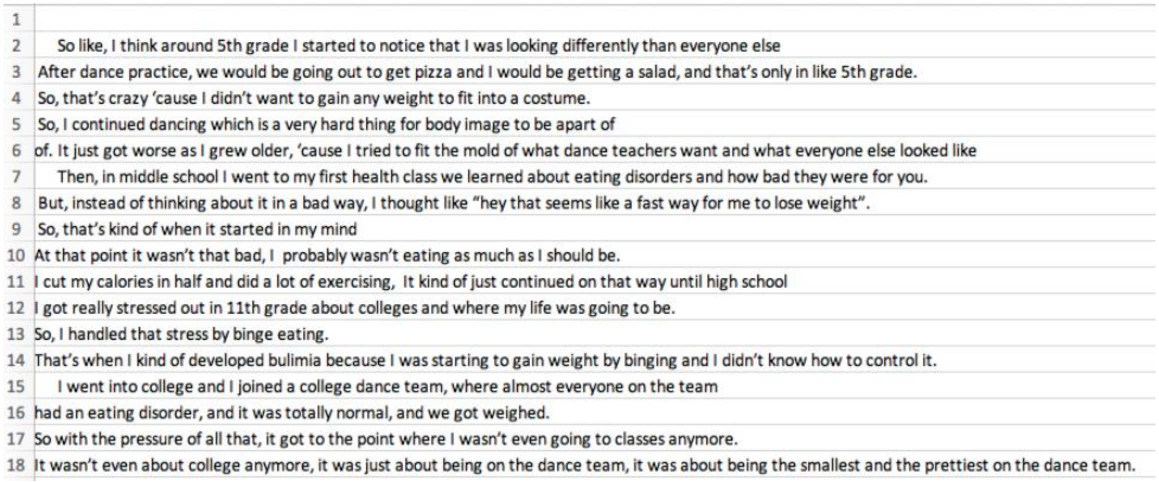
Mixed Methods

To separate my own experience from the narratives, I employed a mixed-methods analysis. I transcribed all of the interviews as Microsoft Word documents and converted them into rich text format. I then uploaded the text into Microsoft Excel. Once I created a new Microsoft Excel file for each co-researcher, I uploaded my text data in (A1), delimited by tab. This action placed each of the participant's interviews into the spreadsheet row by row, separated by sentence. This process is called horizontalization, and it means each sentence is illustrated as a separate thought, which can help the researcher eliminate assumptions about what idea might come next. This step is essential for examining the data through a new lens. According to Moustakas, the first step is to “suspend everything that interferes with fresh vision” (111). Narratives give us context, and within this background knowledge, they provide an assumption of what will come next. For example, the sentence, “we went down to the river,” tells the reader a few things: that there is more than one person at the location and that there is water. The reader may assume that the next sentence would tell you what actions happened at the river. However, this is only an assumption. Preconceived notions about what is communicated next are mitigated by removing the narrative that surrounds each sentence.

Coding

Once separated into equally-relevant ideas, I utilized inductive coding to reduce information into a discrete set of words. In qualitative data, codes are as important as numbers in quantitative data. Codes are the smallest amount of data used to explain the same meaning (Yi). Inductive coding involves assigning code in the order the person brings up the topic. For example, when Jackie says, “My name is Jackie, and I was 20 years old when my ED started” (Jackie), the first codes would be: name, age, ED.

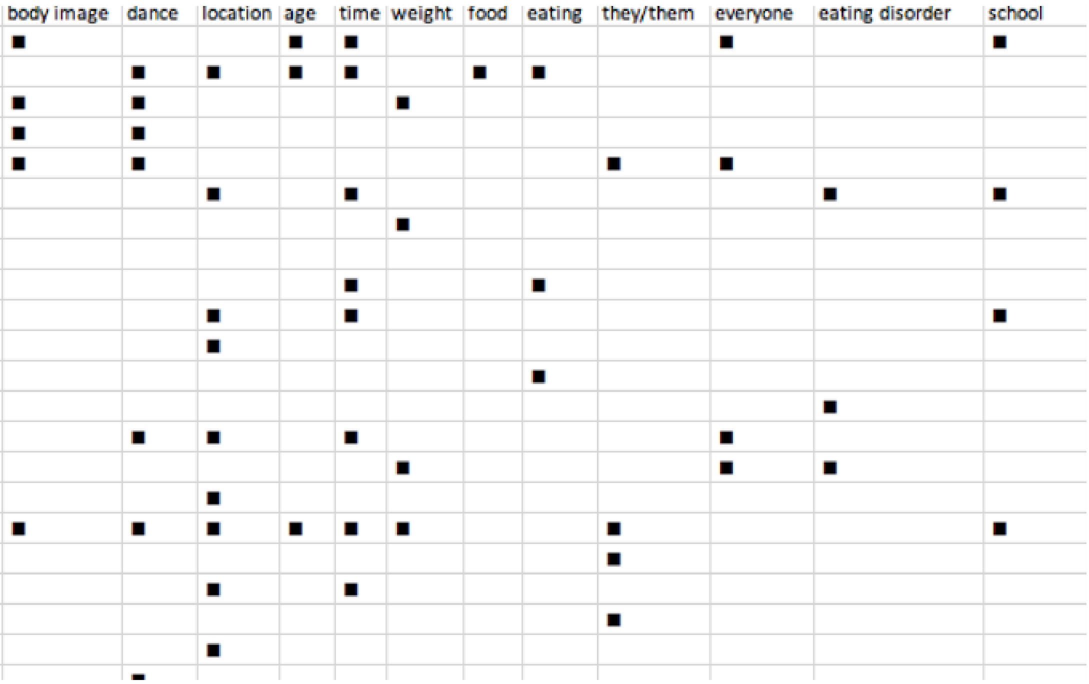
This type of process is essential in IPA because it allows me to be as objective as possible about the information I am analyzing. IPA is a search and analysis for latent meaning, or rather, what is underneath the direct narrative that is used to explain the experience. To start the process, I read line by line horizontally in my Microsoft Excel sheet. Figure 1 shows Brittny's transcript separated line by line.



1	
2	So like, I think around 5th grade I started to notice that I was looking differently than everyone else
3	After dance practice, we would be going out to get pizza and I would be getting a salad, and that's only in like 5th grade.
4	So, that's crazy 'cause I didn't want to gain any weight to fit into a costume.
5	So, I continued dancing which is a very hard thing for body image to be apart of
6	of. It just got worse as I grew older, 'cause I tried to fit the mold of what dance teachers want and what everyone else looked like
7	Then, in middle school I went to my first health class we learned about eating disorders and how bad they were for you.
8	But, instead of thinking about it in a bad way, I thought like "hey that seems like a fast way for me to lose weight".
9	So, that's kind of when it started in my mind
10	At that point it wasn't that bad, I probably wasn't eating as much as I should be.
11	I cut my calories in half and did a lot of exercising, It kind of just continued on that way until high school
12	I got really stressed out in 11th grade about colleges and where my life was going to be.
13	So, I handled that stress by binge eating.
14	That's when I kind of developed bulimia because I was starting to gain weight by binging and I didn't know how to control it.
15	I went into college and I joined a college dance team, where almost everyone on the team
16	had an eating disorder, and it was totally normal, and we got weighed.
17	So with the pressure of all that, it got to the point where I wasn't even going to classes anymore.
18	It wasn't even about college anymore, it was just about being on the dance team, it was about being the smallest and the prettiest on the dance team.

Figure 1: Brittny's transcript separated by Line

Figure 2 shows the codes that emerged from the transcripts.



body image	dance	location	age	time	weight	food	eating	they/them	everyone	eating disorder	school
■			■	■					■		■
	■	■	■	■		■	■				
■	■				■						
■	■										
■	■							■	■		
		■		■						■	■
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Figure 2: Codes from Brittny's transcripts

The following figure shows Brittny’s finished and coded interview. The lines going vertical with the most in the box mean that the topic in that column was presented in the data frequently.

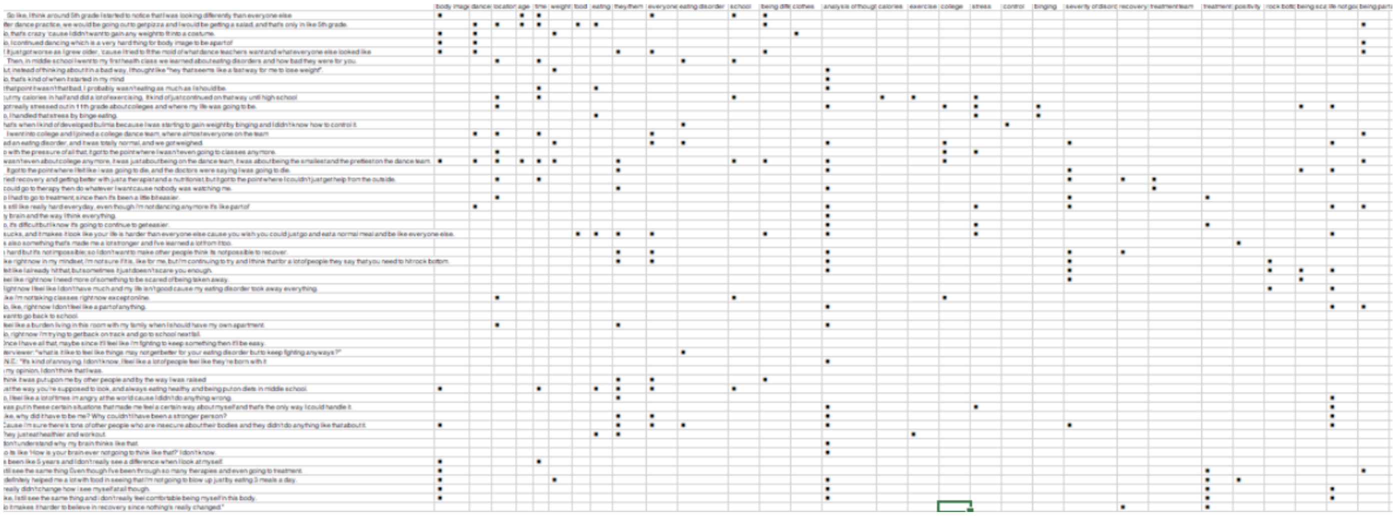


Figure 3: Brittny's coded interview

I started to notice that at least two of my participants had similar codes, for example, “friend, person, eating.” By the fourth interview, I copied and pasted Brittny’s codes onto Jackie’s interview without reading through the interview first. This process is called deductive coding or using a discrete set of codes across multiple data sets. Copying and pasting this set of codes from another interview is the opposite of the inductive coding process because I did not allow the data to provide me with the codes; rather, I made the incorrect assumption that I knew what would be present in the data. I returned to my journal to make a note of the coding process. The following is a journal memo where I discuss my positionality:

> Originally, this research was just part of a class project, so I asked my friends if anyone wanted to share their story and experience with the hopes that the general

> community will see the vastness of experience in EDs and maybe this would aid in lessening the stigma of having an ED. I also had hopes that if someone struggling read their story and related, they would realize treatment is out there, and have hope for recovery. All the women involved shared my interest in these goals. Three of the participants saw this experience in telling their stories as vital to their recovery process. I see that one of the hurdles in going into this research is going to be that I have an assumption that all my interviews will at least discuss the recovery process, and maybe this is a limitation in what is shared through the interviews.

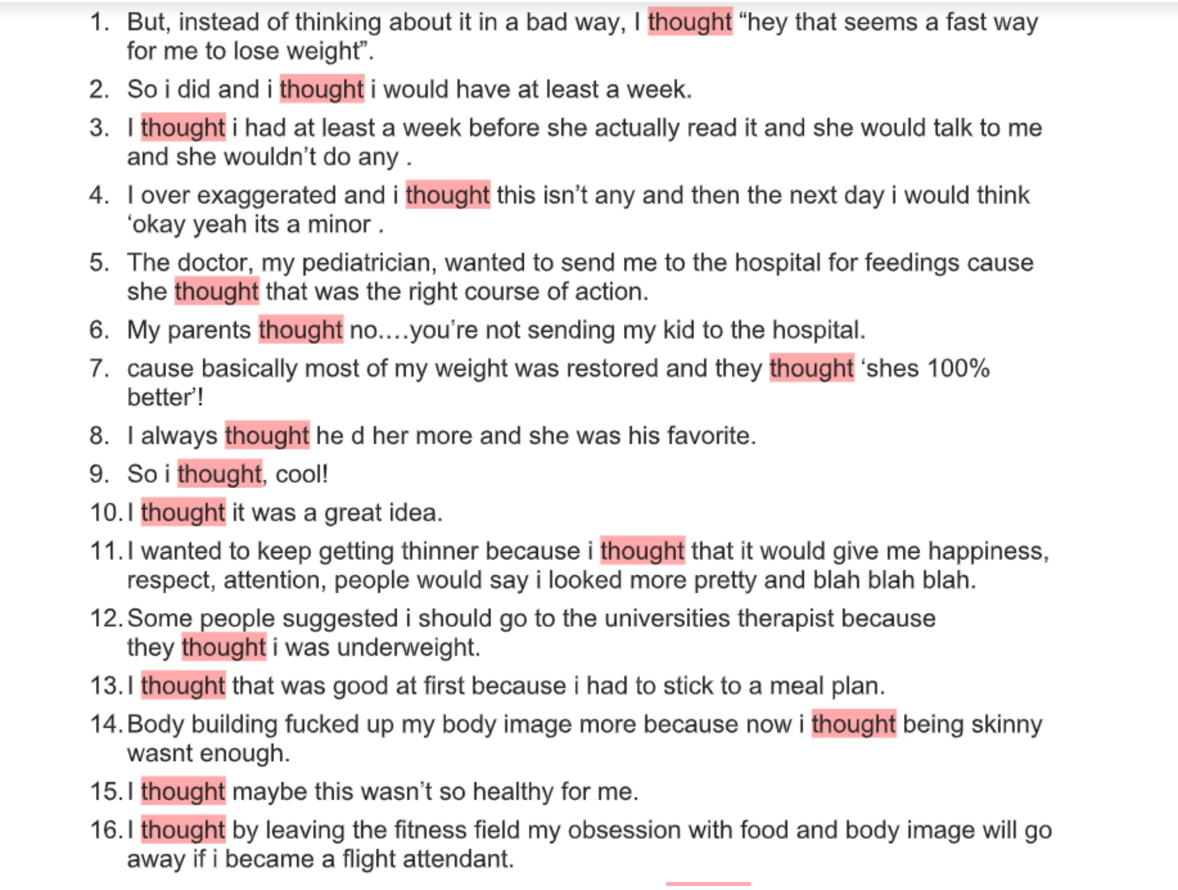
In this journal entry, I discuss my assumptions before going into inductive coding. Though I made attempts to bracket the assumption that all participants would discuss recovery before coding, I still let the assumption affect the analysis. Due to this assumption that all participants would discuss similar topics, I was not able to separate myself from the raw data to conduct inductive coding properly. I was coming from a place of opinion, assumption and bias, or subjectivity.

In order to maintain strong objectivity, or Sandra Harding's theory that researchers can never truly be neutral and unbiased, I returned to my journal and asked the question "Who am I?" and "How am I related to the research?" I realized that I needed to utilize a new way of visualizing the data because I was still making assumptions based on shared knowledge of each participant as well as the experience. I then used Word Clouds to separate ideas from sentences, narratives and even other words. To do this, all transcriptions were entered in Microsoft Word and then into

WordSift.com. Figure 4 creates a visual of the top 50 words used in all of the interview as they are arranged on the webpage.

Figure 4: The 50 most used words across all transcriptions

In Figure 4, larger words are used more often. Clicking on one of the words in this WordSift.com word cloud brings up all the separate sentences in which each word was used. Figure 5 provides an example of one of these lists.



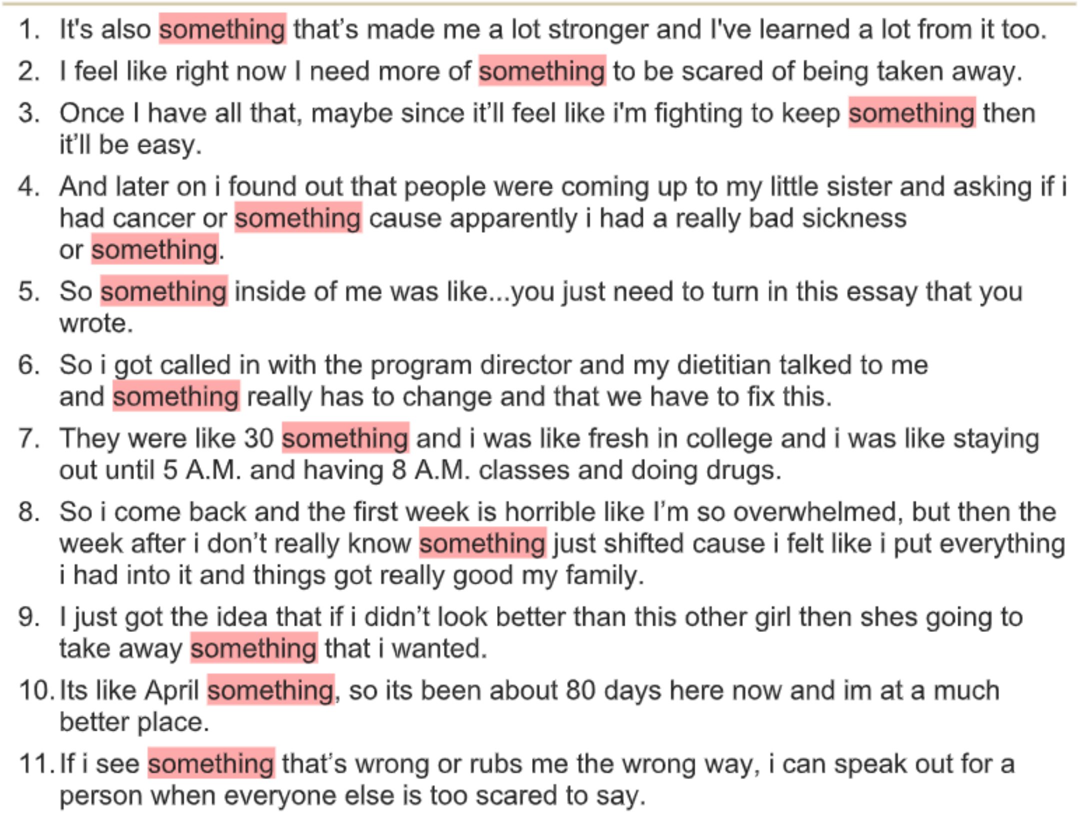
1. But, instead of thinking about it in a bad way, I thought “hey that seems a fast way for me to lose weight”.
2. So i did and i thought i would have at least a week.
3. I thought i had at least a week before she actually read it and she would talk to me and she wouldn’t do any .
4. I over exaggerated and i thought this isn’t any and then the next day i would think ‘okay yeah its a minor .
5. The doctor, my pediatrician, wanted to send me to the hospital for feedings cause she thought that was the right course of action.
6. My parents thought no….you’re not sending my kid to the hospital.
7. cause basically most of my weight was restored and they thought ‘shes 100% better’!
8. I always thought he d her more and she was his favorite.
9. So i thought, cool!
10. I thought it was a great idea.
11. I wanted to keep getting thinner because i thought that it would give me happiness, respect, attention, people would say i looked more pretty and blah blah blah.
12. Some people suggested i should go to the universities therapist because they thought i was underweight.
13. I thought that was good at first because i had to stick to a meal plan.
14. Body building fucked up my body image more because now i thought being skinny wasnt enough.
15. I thought maybe this wasn’t so healthy for me.
16. I thought by leaving the fitness field my obsession with food and body image will go away if i became a flight attendant.

Figure 5: Participants’ use of the word *thought* in a sentence

Figure 5 is an illustration of the list generated after clicking the word *thought* in the Word Cloud. This list also includes every sentence across all collaborator’s interviews where the word *thought* is used.

This tool on WordSift.com allowed me to visualize the data from a perspective whereby each sentence includes an idea that is expressed by all participants, providing for a clearer picture of how the word is expressed throughout all of the participants’ experiences. This step allows the data to reveal how participants utilize ideas rather than to make sense of their shared themes. In coding, I created the categories. In clouds, the participants created the themes and categories. I could grasp a clear idea because I could click on the words that were most commonly expressed, visualize the sentences in which the participants use these words, and then form an idea of what theme was emerging by examining their words alone.

To find the invariant constituents or core themes of the phenomenon (Moustakas), I reduced the Word Clouds further. After examining the words: *like*, *just*, and *kind*, I was able to identify that these words did not give me insight into to the experience. For example, each participant frequently used the word "something." Figure 6 exhibits an example of sentences that utilize the word *something.*



1. It's also something that's made me a lot stronger and I've learned a lot from it too.
2. I feel like right now I need more of something to be scared of being taken away.
3. Once I have all that, maybe since it'll feel like i'm fighting to keep something then it'll be easy.
4. And later on i found out that people were coming up to my little sister and asking if i had cancer or something cause apparently i had a really bad sickness or something.
5. So something inside of me was like...you just need to turn in this essay that you wrote.
6. So i got called in with the program director and my dietitian talked to me and something really has to change and that we have to fix this.
7. They were like 30 something and i was like fresh in college and i was like staying out until 5 A.M. and having 8 A.M. classes and doing drugs.
8. So i come back and the first week is horrible like I'm so overwhelmed, but then the week after i don't really know something just shifted cause i felt like i put everything i had into it and things got really good my family.
9. I just got the idea that if i didn't look better than this other girl then shes going to take away something that i wanted.
10. Its like April something, so its been about 80 days here now and im at a much better place.
11. If i see something that's wrong or rubs me the wrong way, i can speak out for a person when everyone else is too scared to say.

Figure 6: Participants' use of the word *something* in a sentence

This figure exhibits how, though this word was used often; it did not give me vital information that related to the research question. Each participant used the word to represent different scenarios. In the next step of the analysis, I looked for only the words that most related to the participants' experiences. Figure 7 is an example of my reduction process.

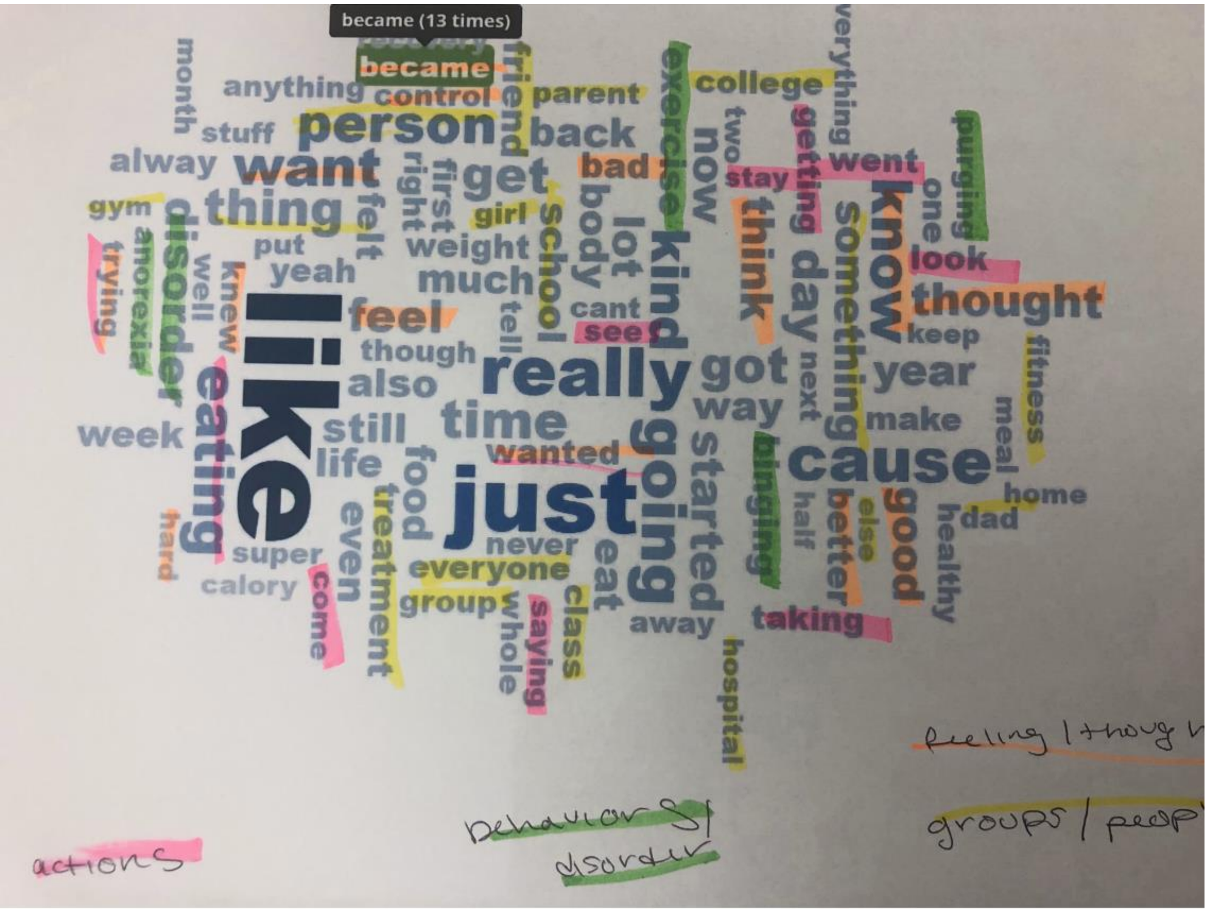
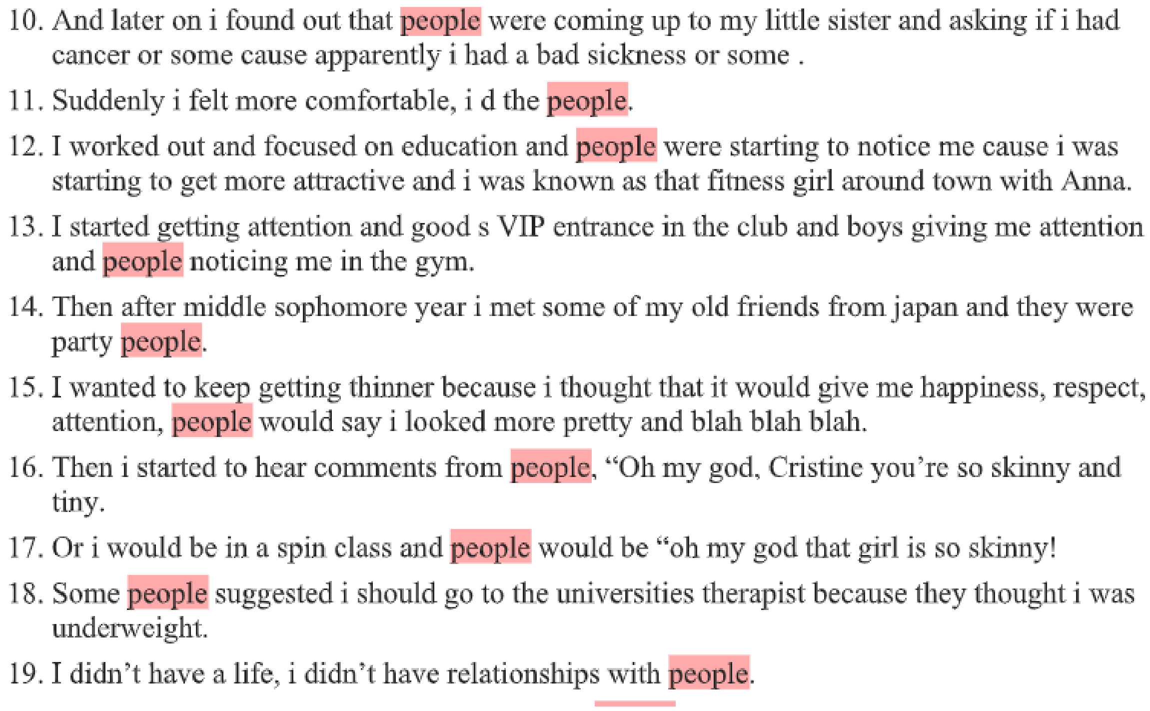


Figure 7: Recognizing invariant constituents

This figure exhibits the reduction of transcripts. The highlighted words are those that, when used in a sentence, directly relate to the participants' experiences. For instance, the words *people* and *person* are commonly expressed. Figure 8 is an example of the word *people.*



10. And later on i found out that people were coming up to my little sister and asking if i had cancer or some cause apparently i had a bad sickness or some .
11. Suddenly i felt more comfortable, i d the people.
12. I worked out and focused on education and people were starting to notice me cause i was starting to get more attractive and i was known as that fitness girl around town with Anna.
13. I started getting attention and good s VIP entrance in the club and boys giving me attention and people noticing me in the gym.
14. Then after middle sophomore year i met some of my old friends from japan and they were party people.
15. I wanted to keep getting thinner because i thought that it would give me happiness, respect, attention, people would say i looked more pretty and blah blah blah.
16. Then i started to hear comments from people, "Oh my god, Cristine you're so skinny and tiny.
17. Or i would be in a spin class and people would be "oh my god that girl is so skinny!
18. Some people suggested i should go to the universities therapist because they thought i was underweight.
19. I didn't have a life, i didn't have relationships with people.

Figure 8: List of all participants' uses of the word people

In this figure, the word *people* is used to explain many different members of the collaborators' primary groups. This use means that any time the word cloud also revealed words like *dad, sister, or friend,* the participants were also talking about people in their primary groups. I started to highlight all of the times the participants spoke of someone in their primary group. By highlighting these people, the theme "primary group" is expressed (highlighted in yellow in Figure 7). I analyzed the words *binging, exercise,* and *purging* in sentences across all transcriptions and coded these words with another category that directly represented them all: ED behaviors. After each reduction, fewer words were revealed on the "50 most used word cloud." At this point, the words *think,* *thought, know, and knew* remained. My analysis of these words led to the creation to the category “feeling/thought.” Three categories emerged: people/person, ED behaviors and thought/feeling.

As the word cloud included the most used words from all the transcriptions together in one document, I needed to then check each participant's transcription for the themes that emerged separately. This action ensured that I was not relying on data that came from only one participant’s interview. For example, one participant's interview was longer than the others; therefore, this participant said more words. This step ensured that all of the common themes, found through the expression of the most commonly used words across transcriptions, did not come from just one interview. To search the individual participants’ interviews for their most commonly expressed word, each transcript was entered into WordSiftcom. The following list includes each participant and the top six words used in their interviews.

1. Brittny: feel, eating, person, think, cause, college
2. Lani: didn’t, know, got, thing, eat, parent
3. Catherine: person, want, time, friends, exercise, thought
4. Jackie: eating, food, thought, anorexia, control, started

During my analysis, I confirmed that each participant included these categories based on the words above. For instance, Brittny used the following words: *feel, eating, person, think, cause, college*. The word *feel* belongs to the “think/thought” theme, the word *eating* belongs to the ED category and the word *person* belongs to the “people/person" theme. Therefore, Brittny's interview includes all three categories, which means the categories are not just expressed in the transcripts as a whole, but are also in her individual interview.

The rest of the participants had at least two themes present. This process of analysis confirmed the final categories by highlighting their expressions across each all individual transcription.

I then searched the documents for sentences that contained words assigned to each category. For instance, to search for how participants spoke of the category "thought/feeling," I searched for the words *think, know, want,* and *feel* and compiled a list of all sentences that expressed each theme. Sentences that involved more than four themes were considered vital to the experience. For example, Brittny expressed each category when she stated: "I think (think/thought) it was put upon me by other people (primary groups) and by the way I was raised, the way you're supposed to look and always eating (ED behaviors) healthy and being put on diets in middle school" (Brittny). In this sentence she expressed people/person, thought/feeling and ED behaviors.

After confirming the final sentences for analysis, a clear connection emerged between categories: how the influence of primary groups led to the creation of a self-concept. And further, how the perceptions of others in their primary groups led to changes in their behaviors, which is explored in their internalization of shared ideas. In the section that follows, I will illustrate this finding as it is revealed by each participant.

Brittny

In each interview, the word *thought* in relation to *person* or *people* revealed how others' perceptions had the authority to change the participant’s self-concept. Brittny is a 21-year old with anorexia purge type. When Brittny talks about her poor body image, she attributes these ideas to the expectations of others. She says, “I feel like a lot of people think they’re born with it. I disagree. I think it was put upon me by other people, and by the way, I was raised, the way you’re supposed to look and always eating healthy and being put on diets in middle school” (Brittny). In this statement, Brittny reflects on how her ED began. When she says, “the way you're supposed to look,” she is talking about the perception that others have of dancers. Here, Brittny’s ED behavior emerges out of an inadequate self-concept. She created an identity of what a dancer is from within shared ideas in her community -for instance being thin- and then she compared herself to this idea. This creation of her false self, discussed in previous studies (Rodin, et al), was as a result of her inability to meet her identity as a dancer. She felt that other dancers looked differently than she did, which led to poor self-esteem and the emergence of restricting food (an ED behavior) to alter her image to live up to the identity she created.

Brittny attributes the need to change her body to her desire to meet others’ expectations. She explains that dieting started while she was in the 5th grade due to being part of a dance team and always needing to fit into a costume. She states: “I tried to fit the mold of what dance teachers want and what everyone else looked like” (Brittny). She explains that restricting was a way of attempting to “fit the mold” (Brittny). This statement reveals her perception that there was only one way that a dancer should look, which created her idea of a false identity because she did not fit that mold. Brittny felt that if she restricted her calories, she could change her body image and then others would have a positive view of her. They would see her like all the other dancers, which she viewed positively and with whom she shared an identity. Later in her interview, the power of others' perceptions to change her behavior emerges again. This time, in a different way.

Brittny states, “I went into college, and I joined a college dance team where almost everyone on the team had an ED, and it was totally normal, and we got weighed.” Here there was a normalizing of ED behaviors from her dance team, therefore making an ED part of the shared identity in this community. She felt a sense of community for herself and her ED behavior. She, therefore, took part in the same behaviors that the other members of the community did, behaviors like binging and purging, over-exercising, and restricting her calories.

Brittny’s ability to stop engaging in ED behavior, or to recover, was also impacted by her community. She states that going into therapy did not change her binging and purging, like treatment later would, because others were not present and able to watch her all the time. She states: “I could go to therapy and then do whatever I want because nobody was watching me” (Brittny). Here, she recognizes the authority that knowing someone was watching her has had on her actions. This statement furthers the argument that the perception of others is vital to the phenomenon. She felt later, while in inpatient treatment, people were “watching her.” Having others watch her meant that people would know when she engaged in behaviors, and she would be judged poorly for those behaviors. This “recovery minded” perspective became the residential treatment shared identity. In order to have a positive view of her identity within this community, she altered her behaviors to the status quo. Unlike on her dance team, where the status quo was to engage in ED behaviors, this community focused its shared identity on being “in recovery.” To create a sense of identity where she would have good self-esteem in this group, she changed her behavior to that of the status quo.

Lani

Lani, a 19-year old with bulimia and anorexia purge type, also expressed low self-esteem due to the expression of a false self-concept. She explained that she was an extremely anxious kid because she never knew “how to act.” She talked about how her mother was very big on time and place and acting appropriately, which she was never able to do. Her self-concept then became that she was always out of place, and further, she felt her body was constantly out of place. This feeling of her body being out of place led to extreme anxiety, poor body image, depression, and body dysmorphia.

Much like Brittny, Lani found a place of community and support, where she did not need to change her ED behaviors. She discusses a group on Tumblr and says:

> They’re very supportive like we were all super supportive and super nice. Like “Oh, I eat this many calories to keep everyone in check, and we would weigh ourselves every day, but then we would have a weekly check-in with the group. And you were checking in all the time. The less meals or calories you were doing was better. People would send like pictures and update pics on how you were

> doing. Then the skinniest in the group would become the person that like got praised and you wanted to be her.

Here she discussed specifically how this community has a shared identity of ED. She explained that "support" meant being able to talk about your disorder. She found a place where the upkeep of her disorder was the status quo. This acceptance of ED behaviors as part of the shared identity led to the further upkeep of her behaviors. Lani also expressed the normalization of ED behaviors in competitive sports. She felt that in this community, throwing up was a good thing and meant that you were working hard. She states

> From a young age, it was kind of ingrained from coaches and stuff that you practice or exercise until like you feel like you must puke, or if you don't feel like puking you continue for a little bit longer. And that's how you know you've had a good workout.

Here she discussed how over-exercising and throwing up was commonplace in the community. Coaches would even praise you if you could achieve both. In this community, throwing up was part of the shared identity. This common place of ED behavior created positive reinforcement for Lani to binge and purge.

Like Brittny, Lani discussed the importance of a recovery community, which created a place to change one's behaviors. She stated that after entering residential treatment, she felt more comfortable. She discussed that people in treatment liked her, and she bonded with them, which created a new shared identity for her. She attributed eating her meals, lessening behaviors and being recovery-oriented to being in treatment and finding good friends. This change in her behavior was created by a sense of belonging in a community where these behaviors are the shared ideas of the group.

Catherine

Catherine, a 23-year-old with bulimia and anorexia purge type, also internalized the seemingly negative perception that she felt others had of her, which led to low self-esteem and a false self-concept. Catherine self identifies as half Japanese on her mother's side and half American on her father's side. Growing up, she felt that she did not receive the attention she wanted from her father, but her sister did. Catherine states, “my sister looks more half white (American); she has Hazel eyes and everything. I always thought he liked her more.” She expressed a desire to change her appearance to be more like her sister’s so that she would also receive his attention. She says, “I always wanted to look more white so he would like me. I felt like I would be more beautiful, and I would fit in more and all that.” This need to change her identity underscores Catherine’s low self-esteem. Her poor self-image led to attempts to change her body, by over-exercising and restricting calories.

Much like the previous interviews, Catherine found a sense of community where her ED was part of her identity and therefore maintained. After she met her friend Anna, who was a “gym freak”, Catherine, felt that she now had a friend who did not see over-exercising as a problem. Rather, Anna accepted her behavior, and therefore they took part in over-exercising and restricting their diets together. Further, it was the norm in the bodybuilding community to weigh yourself frequently, to obsess over calories and to restrict your diet. Therefore, she maintained these concepts as part of her identity.

When Catherine discussed her recovery, she also attributed changing her behavior to being accepted in the recovery community. When talking about this new shared community, she states, “and people like me for who I am on the inside versus how I look externally.” She feels that people like her for who she is and not just what she looks like, in contrast to her experiences in her bodybuilding community. In her recovery community, part of the shared identity is having good body image. Therefore, she feels no need to engage in behaviors to change what she looks like. She states, “I have this new sense of inner confidence now where it’s like it’s not about the appearance.” Here she reflected on the change in her behaviors based on the acceptance of shared ideas of the recovery community.

Jackie

Jackie, a 26-year old with anorexia purge type, also exhibited a false self, which led to the emergence of ED behaviors resulting from her denial of an ED identity. She states, “I thought, I’m not a purger!” A “purger” is someone who has bulimia. The fact that she did not say “I don't have bulimia,” but rather said “I'm not a purger” means that she was not rejecting the disease itself, but rather the identity that she felt those who have bulimia hold. She was not the identity of a purger. Throughout her interview, she discussed the power that different diagnoses had on her ability to lessen certain behaviors. She states, “It felt good to have a diagnosis put on me in that sense because it made sense for me. I felt like I was finally being understood.” Her denial of the previous diagnosis was, in large part, due to the attributes she connected with other individuals. She states that she would go to ED groups where she did not feel like she “fit in.” She would listen and say, “Okay, I’m not that, but I am this.” She did not say “I have that” or “I do that.” She constantly applied the identity she created of what someone with anorexia or bulimia was like to herself. When it did not fit her behaviors, she rejected it, leading to a worsening of her behaviors. She also felt rejected by others in her ED therapy groups. She says that everyone else was much thinner, which to her meant that they were sicker than she was. She did not feel like she belonged in the group because she was not as thin. Therefore, she not only felt that she did not have anorexia (which she was later diagnosed with), but she also did not want to lessen her behaviors, as she did later due to the acceptance of a shared identity.

When talking about recovery, Jackie expanded upon how the shared identity of recovery created change in her ED behaviors. Jackie says, “a support network is huge too. If you tell someone you’re struggling, and you’re not holding it all in and bottling it all up, and it's not coming out in your ED.” Here she discussed how talking to others in residential treatment and feeling a sense of positive belonging meant that she could open up to them about her struggles. She feels that since she used her ED as a way of coping with stress, if she chose a different way to cope, she would lessen her behaviors. In sharing this identity with the members of the group, she also then changed her behaviors.

Conclusion

Findings

In this study, I explored the research question: “What is the lived experience of having an ED?” with feminist research methodologies. I conducted open-ended interviews with four women who had been diagnosed with, and sought treatment for, an ED and analyzed them using Interpretive Phenomenological Analysis (IPA). The results, supported by existing research, indicate that this phenomenon emerges from the internalization of a false self-concept, which leads to poor self-esteem and the emergence of ED behaviors to alter one’s body.

Lani, Brittny, Catherine and Jackie all exhibited a false self-concept. In other words, others' perceptions of them led to their poor self-esteem and the emergence of ED behaviors in order to alter their bodies. Though each collaborator has no way of knowing what others think, internalizing what they thought others perceived led to the creation of this false self-concept. For instance, Brittny felt she was not really a dancer, Lani felt that she was out of place all the time, Catherine felt as if she was not white enough and Jackie felt she was not anorexic. These were all false identities. The internalization of a false self-concept led to poor self-esteem and the emergence of ED behaviors in order to alter these identities.

The collaborators also identified communities within which they found support from others. If the community had a shared identity of having an ED, the participant engaged in behaviors that met the status quo. For instance, Brittny's dance team accepted her ED behaviors because they were part of their shared identity, which led to over-exercise. Lani’s online community supported her ED behaviors because ED behavior was encouraged tremendously in this community as part of their identity; therefore, she maintained her behaviors. Catherine’s bodybuilding community shared her ideas of over-exercise; therefore, she maintained shared behaviors in this identity.

However, after entering residential treatment where recovery is part of the shared identity, most participants spoke about changing their behavior to meet the new shared ideas, which were recovery-minded. Specifically, these women talked about changing their behaviors to adapt to the new community, which in turn influenced their identities.

Limitations

Originally, when I began this project, my intent was to create a pro-recovery website, which is an online space where users can share their experiences or photos from the perspective of someone who wants to recover from disordered eating. Recovery communities discuss the challenges of mental disorders and promote treatment and support services for users who are recovering from mental illness (Chancellor). I felt inspired to create a site for pro-recovery because some individuals who suffer from EDs suffer alone due to their feelings of shame and loneliness, and social media platforms have become their “first step to recovery by promoting a sense of togetherness and a place to openly share experiences and emotions with others” (Chancellor, 219). I initially asked all of the individuals involved in my study “What is your experience with an ED?” They all knew I intended to post their narratives to an online platform. This awareness likely affected how they responded in the interviews. It also affects what I was looking for when I asked them about their experiences. I knew that we had all attended treatment together, and I assumed that because they were no longer in treatment, and still alive, they were on the road to recovery. I had hoped they would share an experience of some part of this recovery path. Our interviews focused only on this open-ended question, “What is your experience with having an ED?” without any further structure. If I had conducted this research with IPA in mind, I would have used a semi-structured interview to ask follow-up questions that focused on the phenomenon.

Another limitation is that all of my interviews were with women I consider to be close friends because they shared the experience of inpatient treatment for 30 days. By only including this small group of women, I do not offer a broad sample size for analysis. Limited range of perspectives means other perspectives remain underrepresented. Being an insider in a community can greatly benefit the interview process. For example, my participants and I had an established rapport and shared knowledge prior to these interviews. However, my insider status did not guarantee more valid and reliable data. Hesse-Bibler states that “being an outsider might encourage you to ask questions you might otherwise have taken for granted as shared knowledge and you might discover the unique perspectives your participants have on a particular issue” (142). If I were an outsider, my participants would have had to explain the entire phenomenon in their interviews. For example, I was left wondering how my data would have potentially changed if I had asked: “What is an ED?” If I were an outsider, I would have gained a full explanation of the phenomenon being explored from the perspective of each participant.

Recommendations

Self-concepts are vital to the ED experience. My participants' perceptions of themselves by others directly affected and altered their self-concept. Ultimately, others' perceptions led to the emergence of a false self-concept, low self-esteem, and ultimately of ED behaviors. However, research suggests that "identity issues are not often considered formally in treatment" (Kent, et al 482). Therefore, treatment modalities that do not consider the identity of the patient are missing a vital part of the ED experience. Treatment modalities that focus on an individual's self-esteem and her concept of identity may be vital to the achievement of better treatment outcomes.

Further, treatment modalities that consider the ED patients' shared ideas in their primary groups may be one key to providing treatment with better outcomes for recovery. Clinicians could ask patients to define the groups they belong to as well as what shared ideas these groups may have. For example, in Catherine's bodybuilding group, she might identify a shared idea, the importance of meal prepping. However, for someone with an ED, this may turn into the restriction of calories. Therefore, focusing on *how* groups affect individual behavior creates knowledge about what a shared identity means for an ED patient.

My research also explores how vital a recovery network is to the phenomenon. The shared ideas in a recovery community can influence individuals to change their behaviors. Therefore, residential treatment may be considered the most effective treatment for those with ED because patients internalize the shared ideas of their surrounding communities, separated from other primary groups which may hold and encourage ideas that are not recovery-minded. The social aspect of recovery in alcohol addiction is widely accepted in Alcoholics Anonymous (AA). In fact, research shows that the social network of AA is why the program is so effective. McGreevey notes:

> of the behavioral changes associated with AA attendance, changes in social networks — more contacts with people who supported abstinence and fewer with those who would encourage drinking — and greater confidence in the ability to maintain sobriety in social situations were most strongly connected with recovery success. (“What Makes AA Work”)

This statement exhibits how vital the social aspect is to the effectiveness of AA. This research suggests that attendance in AA as a primary group enables the person who identifies with that group to change their behavior. Further, this research exhibits how associating with AA allows the individual to maintain the recovery identity even while not present in the group. For instance, the research states individuals had “more contacts with people who supported abstinence and fewer with those who would encourage drinking” (What Makes AA Work). This statement exhibits the importance of forming new relationships with others who share an identity that focuses on sobriety. This same recovery network could be beneficial for people with EDs. Because EDs are experienced in private, residential treatment is the first place in which an individual may find a shared identity of recovery.

However, residential treatment is costly and out of reach for many individuals. From my own experience, I had to be near death for my insurance to cover the cost of my inpatient treatment. If nothing is done to reduce the cost of this largely-privatized care, people with EDs will continue to die at alarming rates. It is no wonder that EDs have the highest mortality rate of any mental illness (Choudhury) because very few can afford the necessary treatment.

Future Research

My research reveals that we need more qualitative studies that speculate on the connection between “self” and EDs to examine how social environments impact how individuals create their identity. Likewise, additional studies that take place after inpatient treatment for an ED are necessary to explore how ED behaviors change based upon the shared identity of the recovery community.

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