2018

Young Women's Perceptions of Factors Influencing Eating Disorders

Francisca Masawi
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Francisca Masawi

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Amany Refaat, Committee Chairperson, Public Health Faculty
Dr. Magdeline Aagard, Committee Member, Public Health Faculty
Dr. James Goes, University Reviewer, Public Health Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2018

Abstract

Young Women's Perceptions of Factors Influencing Eating Disorders

by

Francisca Masawi

MS, Wright State University, 2003

BS, Viterbo University, 1993

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

November 2018

Abstract

Eating disorders (EDs) cause irreversible physical damage, including organ failure and death. Although EDs receive considerable attention, the number of affected young women who seek help remains low. The purpose of this phenomenological study was to understand the sociocultural and socioenvironmental factors influencing ED development from the perspective of young women, and to explore why the rate of EDs continues to rise in this population. The sociocultural model served as a guide for the study. Ten young women 18-24 years old from Southwest Ohio participated in in-depth, semi structured, face-to-face interviews. Data coding and analysis revealed recurring themes, with findings indicating that family relationships and social media were major factors influencing young women's perceptions of personal image and attractiveness. Participants described that social media's negative portrayal of beauty leads to internalization of the thin-ideal, leading to body dissatisfaction, with subsequent negative dieting behaviors that increase the risk for eating disorder development. Family relationships were described as the main source of positive support to neutralize these external negative forces by creating environments where these young women are accepted. A combination of media, availability of fast food, and society's portrayal of beauty, had significant influences on ED development by creating "*constant internal struggles*" on body image, good food choices and acceptance in society. The study impacts social change by adding new information for public health program developers and policy makers that may be used to introduce ED programs in local schools that will empower these young women to seek help without fear of stigma or alienation.

Young Women's Perceptions of Factors Influencing Eating Disorders

by

Francisca Masawi

MS, Wright State University, 2003

BS, Viterbo University, 1993

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

November 2018

Dedication

I would like to dedicate this work to the dignity and honor of all women living and deceased, the women who know their value and worth as God intended. These women have made the world a better place for me, and will leave this world a better place for generations to come.

Acknowledgments

I would like to acknowledge my dissertation committee chair, committee member, and university research reviewer for their patience and scholarly feedback, support, encouragement, and advice. I am also grateful to all the women who participated in this study for their courage to tread the dangerous territories of eating disorders with me. I also would like to thank all those who contributed to the success of this study in any way. Above all, I give special thanks to God Almighty for guidance and providing me with an excellent committee to work with. To my family and friends, special thanks for your prayers and support.

Table of Contents

List of Figures

Chapter 1: Introduction to the Study

Background

Eating disorders (EDs) are not prevalent in the general population, but mostly affect adolescents and young adult women (Monell, Högdahl, Mantilla, & Birgegård, 2015). Anorexia nervosa (AN) and bulimia nervosa (BN) are the most well-known EDs identified in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed; *DSM-5*; American Psychological Association [APA], 2013); however, the most frequently diagnosed ED in clinical and community samples is the category of "eating disorder not otherwise specified" (EDNOS; Smink, van Hoeken, & Hoek, 2012). EDNOS is a heterogeneous group, not a clearly defined set of EDs, and may consist of partial symptoms of AN and BN, purging disorder, and binge eating disorder (BED). Following a 2012 epidemiological study, Smink et al. showed AN to be prevalent among young women, and although the incidence rate remained stable for the past few decades, the high-risk group of 15- to 19-year-olds increased; meanwhile, the occurrence of BN has declined since the 1990s.

Researchers have found diverse biological, psychological, and physical variables affect the risk of developing EDs (Chao, Grilo, & Sinha, 2016; Hilbert et al., 2014; Phan & Tylka, 2006; Thamotharan, Hubbard, & Fields, 2015). Apart from these vulnerabilities, particular environments created by families, schools, neighborhoods, and the media that reflect certain social beliefs, attitudes, and practices may increase the risk of disordered eating, especially for individuals with shape- and weight-related concerns (Fitzsimmons-Craft, 2011; Hilbert et al., 2014; Loth, MacLehose, Bucchianeri, Crow, &

Neumark-Sztainer, 2014). Biological, psychological (Sanders, 2010), and physical factors may be the main drivers of EDs, but environmental variables can be the force that "pulls the trigger" (Bulik, as cited in Fitzsimmons-Craft, 2011, p. 1225). Adolescent and young adult women are particularly vulnerable, especially when they grow up in families or societies that adopt the Western ideal of thinness as beautiful (Fitzsimmons-Craft, 2011; Salafia, Jones, Haugen, & Schaefer, 2015; Smink et al., 2012).

The purpose of this study was to identify individual and socioenvironmental risk factors of EDs from the perspectives of young women with and without EDs. The focus of previous studies had been on the biological/psychological/physical side of EDs and/or social risks thereof; however, few researchers had taken a phenomenological approach (Fox, Larkin, & Leung, 2011). Saunders et al. (2007) described phenomenology as the study of extensive arrays of consciousness from the first-person point of view. Researchers use phenomenology to examine and identify experiences in a critical manner; for this reason, I used the approach to explore how different women experience diverse personal and socioenvironmental factors that may be associated with disordered eating. The findings from this study contributed to a deeper understanding of how perceptions both affect an important life transition (adolescence to young adulthood), and influence the development of more effective intervention efforts for young women.

Problem Statement

Risks and conditions influencing the onset, development, and persistence of EDs have received considerable attention from researchers. Although ED prevalence has remained the same for the past few decades, it has increased among adolescent and young

adult women (Smink et al., 2012). The mortality rate due to EDs is high, as is comorbidity (Ekeroth, Clinton, Norring, & Birgegård, 2013). According to recent results from the National Eating Disorders Screening Program for high school students, nearly 15% of girls and 4% of boys scored at or above the threshold of 20 on the ED screening test, a score that suggests a possible ED (Austin et al., 2008). None of the participants had sought treatment or medical assistance for EDs.

EDs are not well understood within the general population (Smart & Tsong, 2014). With increased understanding, the acute and chronic medical and psychiatric consequences of EDs may be preventable (Ekeroth et al., 2013). A need exists to find more ways of understanding EDs to prevent the disease at individual, family, school, and societal levels. Current research on EDs is rife with methodological weaknesses because of confusing ideas about etiology and prevalence, absence of cultural factors in analysis, and insufficient understanding of women's views as both patients and witnesses of those who suffer from EDs (Gleaves, Pearson, Ambwani, & Morey 2014; Smart & Tsong, 2014).

Previous researchers showed interdependent biological (Ekeroth et al., 2013), psychological, physical, and environmental factors to complicate EDs. In addition, some factors differ across individuals and cultural groups, making prevention and treatment of EDs difficult (Soh & Walter, 2013; Zhao & Encinosa, 2009). Close monitoring and supervision from health care professionals and social support from close family members and peers are necessary for those with EDs (Fitzsimmons-Craft, 2011; Hilbert et al., 2014; Loth et al., 2014; Smart & Tsong, 2014). Exploring and synthesizing individual

narratives broadens what clinicians know about how young women view EDs, either as sufferers or as witnesses (Salafia et al., 2015). Those with EDs can explore feelings and ideas about eating in general, and their own disorders in particular, by finding connections to personal perceptions of their physical appearances and attractiveness. These women may further examine the individual, interpersonal, and community factors that influence the development of their ED (Smart & Tsong, 2014), which can deepen their understanding of the gap between social shaping of beauty ideals and accepting the idea of a healthy body (Salafia et al., 2015). Witnesses can offer narratives that corroborate the ideas of those with EDs; in turn, ED sufferers, especially young women, can find new meaning regarding how EDs contribute to or hinder the development of unhealthy ideals about beauty and health (Glans, Rimer, & Viswanath, 2008).

In the current study, phenomenology offered an exploratory framework for helping young women make sense of EDs in ways that expose individual, interpersonal, and social factors contributing to disorder development and persistence. Healthy behaviors can be learned (Glans et al., 2008); likewise, knowledge of EDs can result in new understanding, which may improve the response to educational needs among this high-risk group. Accurate information about EDs, perceptions, and experiences can also decrease the stigma about EDs and encourage those who display symptoms to seek medical help (Treasure & Schmidt, 2013).

Purpose of the Study

The purpose of the study was to explore perceptions of EDs among young women ages 18 to 24 years in Southwest Ohio. The intention was to understand young women's

perceptions of EDs, their physical appearance, and attractiveness, as well as individual, interpersonal, and community factors that influence ED development. An increased understanding is important, because EDs are complex psychiatric illnesses with high rates of morbidity and mortality (Nowakowski, McFarlane, & Cassin, 2013; Rikani et al., 2013; Surgenor & Maguire, 2013). EDs are not limited to food; rather, these disorders can result from a lack of coping mechanisms when faced with life circumstances that are difficult to deal with directly (MacGregor & Lamborn, 2014; Salafia et al., 2013). EDs are associated with certain genetic predispositions (American Psychiatric Association, 2013), and can also result from surrending to external pressures to look a certain way (Waldman, Loomes, Mountford, & Tchanturia, 2013). The cause may also be distorted self-concepts and maladaptive attitudes about body image (Harrison et al., 2014).

Addressing these complicated health issues requires a systematic approach (Bailey et al., 2014). Researchers have agreed that community-based research is required (Bailey et al., 2014; Cohen, Chavez, & Chehimi, 2010; Salafia et al., 2013) to improve awareness and understand disease determinants from the target population's point of view. Adolescents and young adult women ages 18 to 24 years are most vulnerable to EDs (National Institute of Mental Health [NIMH], 2013). However, few researchers who focused on this population addressed a community-based preventive approach carried out in a community setting instead of a clinical setting (Fitzsimmons-Craft et al., 2014). The purpose of this study was to narrow the information gap by conducting a community-based study focused on this population's perspectives regarding EDs. Results from the study provided guidance and information for developing effective interventions to

address EDs at individual, interpersonal, and community levels. Outcomes may inspire the target population to speak more openly about EDs, and to seek help to prevent the disease from progressing to chronic illness. Treatment of EDs is important, but prevention is primary (Blumenthal & DiClemente, 2013; Cohen et al., 2010).

Research Questions

Qualitative research involves two categories of questions: research questions and interview questions (Patton, 2015). For this study, the research questions and subquestions were as follows:

Research Question 1: How do young women (ages 18 to 24 years) perceive eating disorders?

Research Question 2: How do young women (ages 18 to 24 years) view their physical appearance and attractiveness?

Research Question 3: How do young women (ages 18 to 24 years) perceive individual, interpersonal, and community factors that influence the development of eating disorders?

Subquestions

Subquestion 1: Do young women (ages 18 to 24 years) see themselves as at risk of developing an eating disorder?

Subquestion 2: What is the influence of peer pressure on young women's behaviors and attitudes related to their weight and appearance?

Subquestion 3: What is the influence of family relationships and views on young women's eating behaviors and attitudes related to their weight and appearance?

Subquestion 4: How do current social norms influence eating behaviors, beliefs, and perceptions of body image in young women?

Theoretical Frameworks

Sociocultural Model

The sociocultural model of eating disorders can help explain the pathology of women with EDs. According to this model, multiple social and environmental factors interact with the biological, psychological, and physical risks of disordered eating (Fitzsimmons-Craft, 2011). The sociocultural model explains disordered eating as a product of internalizing mounting pressures for women in Western cultures to attain the thin ideal as a vital component of beauty (Fitzsimmons-Craft et al., 2014). The sociocultural model of EDs incorporates three theories supporting an exploration of how and why young women see themselves and other women using certain sociocultural models and standards; these theories are the social comparison theory (Festinger, 1954), objectification theory (Fredrickson & Roberts, 1997, as cited in Fitzsimmons-Craft, 2011), and uses and gratifications theory (Rubin, 2009, as cited in Fitzsimmons-Craft, 2011). Utilization of these theories explained how perceptions of physical appearance and social factors shape self-image and the consequent body dissatisfaction that leads to EDs (Alleva, Jansen, Martin, Schepers, & Nederkoorn, 2013; Fitzsimmons-Craft, 2011; Ward & Hay, 2015).

Social Comparison Theory

Through social comparison theory, Festinger (1954) asserted that people have a drive to evaluate their advancement and standing, looking for standards of comparison to

do so. In the absence of objective standards, people use social comparisons from their environments in developing body image (Alleva, Jansen, Martijn, Schepers, & Nederkoorn, 2013), comparisons that can be intentional or unintentional (Fitzsimmons-Craft, 2011). Daughters often initially compare themselves to their mothers without the express intention of social comparison; as they grow older, however, they may assess their bodies alongside those of their friends and other women, having an increased intention of evaluating self-image. Festinger (1954) stated that affective outcomes of these comparisons can have directional and targeted effects. One form of directional effect, upward social comparison, occurs when individuals assess themselves against others who are better than they are; conversely, people comparing themselves to those worse off are practicing downward social comparisons (Alleva et al., 2013). Festinger (1954) noted people usually make comparisons that result in positive outcomes, and they normally compare themselves to familiar others (e.g., family and peers) as opposed to dissimilar, distant persons (e.g., people in the media).

Researchers have been unable to support these assumptions in the context of women who made social comparisons of their bodies, and with regard to disordered eating (Fitzsimmons-Craft, 2011). According to Schaefer, Thibodaux, Krenik, Arnold, and Thompson (2015), "Social comparison may be one of the most important means through which individuals self-evaluate" (p. 153). Many women with EDs practice upward comparisons with women in the media whom they do not personally know, which frequently produces feelings of discontent and dissatisfaction (Dakanalis, Zanetti, Riva, & Clerici, 2013; Schulte, Grilo, & Gearhardt, 2016; Vann, Strodl, & Anderson,

2013). Women at risk of or already having EDs also assess themselves alongside unrealistic models, especially when they have dominant cultural views of the thin ideal (Frederick, Kelly, Latner, Sandhu, & Tsong, 2016).

The tripartite influence model of body dissatisfaction and disordered eating from Thompson, Heinberg, Altabe, and Tantleff-Dunn (1999, as cited in Schaefer et al., 2015) incorporates the social comparison theory to indicate how sociocultural influences could lead to body dissatisfaction and disordered eating. The foundation of the tripartite model is the idea that women undergo social pressure to follow the thin ideal. This leads to internalization of the ideal and social comparisons with others, the subsequent outcomes of which are higher body dissatisfaction and disordered eating because of poorer body image (Schaefer et al., 2015; Treasure & Schmidt, 2013). Social comparisons affect how young women view their physical appearance and attractiveness; how they perceive individual, interpersonal, and community factors influencing the development of EDs; and how these perceptions shape ED onset and judgment (Treasure & Schmidt, 2013).

Objectification Theory

Objectification theory from Fredrickson and Roberts (1997, as cited in Fitzsimmons-Craft, 2011) is the second social psychological theory to explain the development and maintenance of EDs. According to this theory, the media has a negative impact on women's health because of how it sexually objectifies women; as a result, women become overly concerned about their bodies and have lower and inaccurate body images (Frederick et al., 2016). Women regularly monitor their physical appearance through surveillance, which causes them to recognize or imagine imperfections in how

they look. Self-objectification, also referred to as "internalization of the 'objectifying observer's' . . . perspective" (Fredrickson et al., 2016, p. 270), behaviorally manifests through body surveillance (Fitzsimmons-Craft, 2011, p. 1226).

Constantly seeing advertisements featuring seminaked women with stomachs, buttocks, and breasts visible (in part or in whole) may cause women to see themselves as objects appraised based on their physical appearances. They may then feel the need to constantly check their bodies, to increase the probability of achieving social standards of desirability (Fitzsimmons-Craft, 2011). High body dissatisfaction, combined with the desire to habitually assess and monitor body appearance, can enhance selective attention to disliked body parts, compelling women to fixate on unhealthy strategies to reduce perceived body imperfections and comply with social standards of beauty (Fitzsimmons-Craft, 2011).

Frederick et al. (2016) asserted that harmful effects of surveillance on body image would be more significant for heavier and minority women because surveillance highlights their differences from the "ubiquitous slender White ideals" (p. 114). Surveillance may also deepen the discrimination and disparagement of physical attributes connected with Asians (Yoo, Steger, & Lee, 2010), as well as increase body image awareness for Asian American women, who are regularly shown as passive, mysterious sexual objects in popular media (Kim, Seo, & Baek, 2014). The more they compare themselves to others who are (or are imagined to be) thinner, women who are overweight may develop a preoccupation with weight.

Uses and Gratification Theory

The last social psychological theory that may explain EDs is the uses and gratifications theory from Rubin (2009, as cited in Fitzsimmons-Craft, 2011), which focuses on how people are exposed to media images and messages, and their reactions to the latter. Uses and gratifications theory extends to how people choose to react to media messages, or "modes of communication," not received directly from mass media, but from others such as peers, classmates, and roommates (Fitzsimmons-Craft, 2011, p. 1229). Becker et al. (2011) found that adolescent Fijian girls' interactions with peers exposed to television increased their risk and degree of having EDs, an indirect effect of media. Uses and gratifications theory asserts that adolescents' motives for watching television influence their viewing experiences and the degree to which they are affected by what they see (Schooler & Trinh, 2011, p. 40).

Comprehensive viewers, for whom all television is considered pleasurable, have a different motive from other teens. Those vulnerable to EDs may be unable to criticize television's content and more disposed to idealize what they see, displaying avoidant coping styles and escapist viewing tendencies. In addition, Schooler and Trinh (2011) found a correlation between television viewing and body dissatisfaction among both genders.

According to the uses and gratifications theory, people may use or expose themselves to particular messages for rewards such as diversion and entertainment (Schooler & Trinh, 2011). During adolescence and early adulthood, when self-concept is still changing and developing, individuals may purposely seek ways to understand

themselves, others, and media messages, becoming active media consumers instead of passive ones (Fitzsimmons-Craft, 2011). Through the combination of media consumption and EDs, at-risk populations may selectively expose themselves to the thin ideal of beauty. Media consumption motives further dictate exposure, helping to explain the effects of media on psychological and physical welfare.

Conceptual Framework

I used a phenomenological approach to explore the lived experiences of EDs among young women ages 18 to 24 years. Interconnected concepts about body image and disordered eating comprised the conceptual framework, with conceptual lenses including individual, interpersonal, and community factors influencing the development of EDs. Figure 1 shows how the sociocultural model provides an understanding of subjects' experiences.

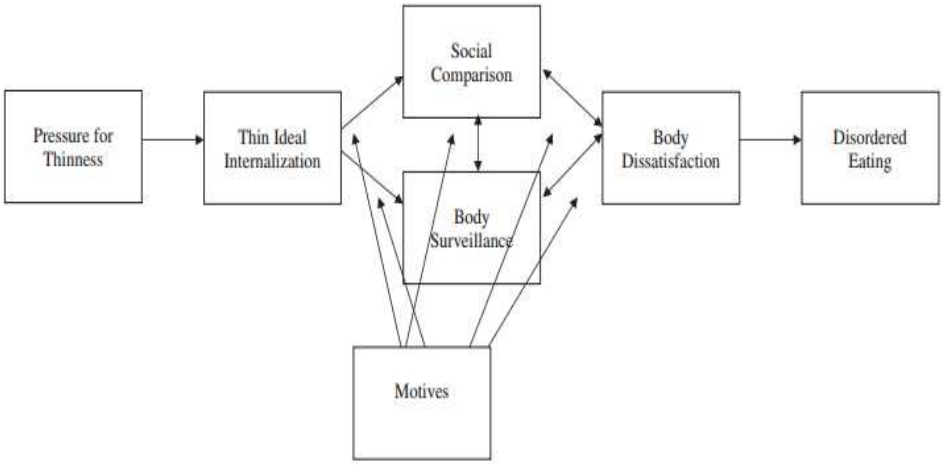

Fig. 1. An elaborated sociocultural model of disordered eating. Social comparison and body surveillance are conceived as mediators of the thin ideal internalization-body dissatisfaction link, and motives are seen as moderators of different paths in the model. Additionally, the double-headed arrows linking the paths between social comparison, body surveillance, and body dissatisfaction indicate the potential reciprocal nature of these relations.

Figure 1. Sociocultural model of disordered eating. From "Social Psychological Theories of Disordered Eating in College Women: Review and Integration" by E. E. Fitzsimmons-Craft, 2011, *Clinical Psychology Review, 31*(7), p. 1231. Copyright 2011 Elsevier Ltd. Adapted with permission.

The sociocultural model integrates the main concepts of social comparison theory, objectification theory, and uses and gratifications theory that relate to perceptions of disordered eating. Motive is an independent factor both impacting how internalization of the thin ideal shapes social comparison and body surveillance, as well as affecting social comparison, body surveillance, and body satisfaction (Fitzsimmons-Craft, 2011). Social factors can increase pressure to attain thinness, social comparison, and body surveillance (Fitzsimmons-Craft, 2011; Smeets et al., 2011). Compulsion for thinness affects internalization of the thin ideal, which also impacts social comparison and body surveillance (Fitzsimmons-Craft, 2011). Body surveillance and social comparisons, in turn, interact with each other and with body dissatisfaction, the latter of which can lead to an ED. Subsequent researchers gave insight into how these concepts are interconnected in shaping body dissatisfaction and EDs.

Social comparisons can result in body surveillance. Schaefer et al. (2015) studied the frequency of appearance comparisons among White, Black, and Hispanic women, as well as the power of associations between appearance comparisons, body image, and disordered eating. Compared to White and Hispanic women, Black women made fewer social comparisons of appearance, demonstrated more positive appearance evaluations, and had fewer ED diagnoses (Schaefer et al., 2015). The lower frequency of social comparisons resulted in more positive appearance evaluations and decreased levels of disordered eating among Black women. Although the findings were relevant, the study was limited by its cross-sectional design and sampling.

Arroyo (2014) examined the relationship between three body image theories—self-discrepancy theory (Higgins, 1987), social comparison theory (Festinger, 1954), and objectification theory (Fredrickson & Roberts, 1997, as cited in Fitzsimmons-Craft, 2011)—and fat talk. He found that body dissatisfaction mediated relationships between weight discrepancy, upward comparison, body surveillance, and fat talk. Upward social comparison, in turn, affected body surveillance, with both linked to fat talk.

Alleva et al. (2013) connected social comparison with body surveillance by examining whether participants with EDs assessed other participants more positively, and whether they restricted judgment to their own bodies. The researchers categorized their sample into high symptomatic (participants high in ED occurrence and symptoms) and low symptomatic (those who met few criteria for ED). Alleva et al. hypothesized high-symptomatic participants would view all other bodies as more attractive than their own, thus revealing the lack of a self-serving body image bias and the propensity to make self-

defeating comparisons with other women. Low-symptomatic individuals, on the other hand, would rate all other bodies as less beautiful than their own because of a self-serving body image bias. The researchers found high-symptomatic participants did not evaluate other bodies differently than their own, except when considering the spectrum of fat and thin, at which time they assessed others, including similarly high-symptomatic people, as having bodies thinner than their own. Low-symptomatic participants assessed other bodies as less attractive than their own, and admitted to finding other low-symptomatic bodies less attractive and less beautiful, but similarly thin. Findings suggested high-symptomatic individuals have an inaccurate perception of their bodies or a poor body image (Alleva et al., 2013), and that social comparison, in turn, leads to body dissatisfaction and EDs (Fitzsimmons-Craft, 2011).Social comparisons against peers and family members resulted in body monitoring effects. Loth et al. (2014) examined the personal and socioenvironmental risk factors connected with the onset and persistence of dieting or disordered eating among adolescents and young adults. The researchers found that personal factors of weight concerns, weight importance, and depressive symptoms during adolescence predicted dieting and EDs for young male and female adults. Parental weight concerns, peer dieting behaviors, and exposure to body shaming led to engagement in dieting and EDs at the 10-year follow-up (Loth et al., 2014). The researchers thus showed that social comparison can result in body surveillance, which may affect body satisfaction and result in disordered eating. A sampling bias for White women with high socioeconomic status limited the generalizability of findings.

When correlating gender with food cravings and ED psychopathology, Chao et al. (2016) found women at risk of disordered eating. Women more frequently conduct social comparisons that increase their risk for disordered eating, according to Stephen et al. (2014). Fitzsimmons-Craft et al. (2014) studied social comparisons (e.g., body, eating, and exercise comparisons) and body surveillance to determine whether these behaviors are mediators of body dissatisfaction based on thin-ideal internalization. They found that, although social comparison was a strong mediator, body surveillance was not; rather, results showed internalized standards variously impacted disordered eating for different women with EDs (Stephen et al., 2014).

Hilbert et al. (2014) revealed that exposure to perfection in the media and other sources of body image messages affects body surveillance. The researchers performed the first direct comparison using interviews for diagnosing and assessing both symptom onset and risk factors for AN, BN, and BED. The researchers identified different risk factors, with AN showing greater "exposure to perfectionism and BED reporting greater exposure to conduct problems, substance abuse, severe childhood obesity, and family overeating; however, the groups did not differ in terms of family history of dieting or personal history of pregnancy" (Hilbert et al., 2014, p. 504). BN risk factors were also present in participants with AN or BED. As with other survey research, the study was limited by participants' memory recall, with data seeming to suggest risk factors rather than predict them.

Smart and Tsong (2014) confirmed how outside forces shape thin ideals. Using the sociocultural model of disordered eating, the researchers observed that the strongest

themes referred to sociocultural influences, especially the pressure to be thin. As indicated in Figure 1, the pressure for thinness resulted in thin-ideal internalization, and when women feel fat, body dissatisfaction is high (Smart & Tsong, 2014). Smart and Tsong found that, contrary to Western thin ideals, being Asian American increased the pressure to be thin, as this population is smaller in stature. Limitations of this study were the specific information participants chose to express and the ambiguity of some terms (e.g., *healthy*).

Internalization of the thin ideal can also interact with anxiety, leading to EDs. Dakanalis et al. (2013) studied the effect interactions among body dissatisfaction, body surveillance, and self-esteem had on ED symptomatology. They found higher self-esteem reduced the negative effects of body dissatisfaction, while social interaction anxiety, body surveillance, internalization of media ideals, and attachment anxiety increased the main body dissatisfaction–eating disorder symptomatology relationship.

Other researchers illustrated how ED maintenance occurs through personal beliefs about the diseases. Fox et al. (2011) used a qualitative approach to answer two questions: "[W]hat are the people's experiences of living with eating difficulties, and how do people make sense of those experiences?" (p. 117). Fox et al. identified three main themes: "experiencing the eating difficulties as functional, the negative effects of the eating difficulties [and] feeling ambivalent about the experiences of eating difficulties" (p. 122). *Functional* can be defined as an individual believing disordered eating is normal, which fits the internalization of the thin ideal. The second theme applies when an individual with ED knows the harmful effects of the illness on family and friends, and the third

identifies participants' ambivalence due to the belief of having greater control of their lives through self-imposed dietary restriction. Fox et al. (2011) revealed the thin ideal internalization promoted body dissatisfaction, with ED sufferers denying the disease's negative effects and focusing on imagined positive ones, such as feeling more in control of their lives by closely managing their eating habits (Dakanalis et al., 2013).

Nature of the Study

For this study, I used qualitative methodology with a phenomenological design. Qualitative research has the distinct potential for illustrating the phenomena of disordered eating (see Smart & Tsong, 2014). The ability to obtain descriptions of EDs from individuals' perspectives merited the phenomenological design (see Denzin & Lincoln, 2000), which increased comprehension regarding experiences of women with eating and body issues, as well as those who did not have disordered eating, but did have ideas about how individual and social factors shape EDs. These viewpoints were not limited to participants' personal reasons for or beliefs about EDs, but also included thinking and experiences regarding social and cultural factors that shape these illnesses.

Data collection through semistructured interviewing allowed these 10 women 18 to 24 years old to express ideas and feelings in their own words, describing how they saw themselves, as well as how they perceived symptoms of EDs and diverse causes for illnesses. The semistructured interview format facilitated the use of follow-up questions to clarify vague or ambiguous answers, resulting in greater validity and reliability. Interviewing women with and without EDs enabled me to identify differences and similarities in how the two groups perceived themselves and EDs.

Salafia et al. (2015) studied the perceptions of women and men with and without EDs regarding the causes of disordered eating. Participants with EDs reported that psychological/emotional and social problems caused their illnesses, and endorsed genetics/biology and media/cultural ideals the least. Participants without EDs identified psychological/emotional problems and media/cultural ideals as the main causes of EDs, with traumatic life events and sports/health as minor factors. Those without EDs also highly stigmatized others suffering from disordered eating. Results furthered understanding of how women from varying backgrounds and circumstance view ED causes and development, which could mitigate cognitive rigidity to treatment for those with EDs, and reduce ED stigmatization among those without the illnesses (Salafia, et al., 2015).

Definitions

This section includes definitions of key terms used in this study.

Appearance evaluation: A positive assessment of one's looks accompanied by feelings of being physically and sexually attractive, beliefs that are also attributed to others (Frederick et al., 2016).

Body dissatisfaction: Individuals' discontent regarding their body shape and weight (Rakhkovskaya & Warren, 2016).

Body surveillance: The practice of individuals regularly monitoring their body and identifying flaws and other imperfections in physical appearance, whether imagined or real, inaccurate or accurate (Frederick et al., 2016).

Disordered eating: A range of behaviors falling between acceptance of and "normative discontent" with body shape, weight, and normal or disordered eating habits, to AN, BN, and other EDs (Fitzsimmons-Craft, 2011).

Eating disorders: Eating illnesses as defined in the *DSM-5* (APA, 2013).

Fat talk: Self-deprecating dialogue between women regarding body dissatisfaction, including worry about getting fat (Arroyo, 2014).

Objectification theory: Asserts that the media has a negative impact on women's health because it sexually objectifies women, making them overly concerned about their bodies with lower and inaccurate body images (Fredrickson & Roberts, 1997, as cited in Fitzsimmons-Craft, 2011).

Overweight preoccupation: Obsessive anxiety over weight, becoming fat, and unhealthy eating habits (Frederick et al., 2016).

Pressure for thinness: The personal feeling of needing to be ultraslender (Fitzsimmons-Craft, 2011).

Self-discrepancy theory: The idea that discordance between perceived traits (actual self) and desired traits (ideal self) provides motivation to achieve the ideal (Arroyo, 2014).

Self-image: "Self-directed behavior, i.e., how an individual treats him-/herself" (Monell et al., 2015, p. 3). Self-directed behaviors guide understanding and interpretation of external interaction and have "cognitive, emotional and social implications" (p. 3).

Self-objectification: Internalizing others' perceived views and seeing oneself not as a person, but an object (Fredrickson et al., 1998).

Social comparison: The practice of comparing specific aspects of the self to others in an individual's life or in the media (Fitzsimmons-Craft, 2011).

Social comparison theory: To evaluate their advancement and standing in life (Festinger, 1954), people look for standards of comparison, without which they will use social comparisons from their environments in developing their body images (Alleva et al., 2013).

Thin-ideal internalization: When exposed to the thin ideal, some people begin to embrace the appearance as a personal ideal (Rakhkovskaya & Warren, 2016). The practice of internalizing an ultraslender figure because of social comparison can lead to body surveillance, with a goal of reducing the gap between the thin ideal and actual body shape (Fitzsimmons-Craft, 2011).

Uses and gratifications theory: Explains how people choose to receive media images and messages and how they react to them (Fitzsimmons-Craft, 2011).

Assumptions

Five assumptions underscored this dissertation, the first being studies intended to gather personal and in-depth information are best suited for qualitative methods (Patton, 2015). Indeed, qualitative methodology was appropriate because I needed to gather material about EDs that was in depth and intimate (Patton, 2015). Another assumption was study participants would trust me enough to give accurate and honest responses. I also assumed I had sufficient communication and interpersonal skills to develop rapport and select an interview climate conducive to open communication. In qualitative studies, the researcher is the main instrument of the study (Patton, 2015); therefore, I anticipated

having appropriate knowledge and skills to conduct the research. Next, I assumed the selection criteria were appropriate for representing the target population (see Galman, 2013), including diverse racial, ethnic, and other social characteristics (see Patton, 2015). Because EDs are highly stigmatized personal illnesses, I selected an environment in which participants would feel comfortable and willing to participate.

Scope and Delimitations

The scope of the study included gathering personal narratives of young women with and without EDs, to find social and individual solutions for preventing and treating EDs. The population was young women in Southwest Ohio, a community in which EDs were understudied phenomena (Ohio Department of Health [ODH], 2013a, 2013b). I restricted the study to individuals between 18 and 24 years of age because, as observed by Fitzsimmons et al. (2014) and Fitzsimmons-Craft (2011), this is a critical stage for young women as they transition from high school to college, and from adolescence to young adulthood. Given the phenomenological approach, the focus of the study was personal observations and perceptions regarding a wide array of experiences concerning EDs. I approached the study with no assumptions about how participants perceived disordered eating, an important attribute of qualitative phenomenological research (see Patton, 2015; Smith, Flowers, & Larkin 2009).

Limitations

The self-reporting data collection technique used in this study was appropriate for identifying participant views and perceptions following the phenomenological in-depth interview approach (see Kvale, 1996, 2009; Smith et al., 2009). The use of proven

qualitative methodology (Bogdan & Biklen, 2007; Patton, 2015) added to the strength of study results. Addressing potential limitations enhances a study's transparency, which is the benchmark for quality and validity in qualitative studies (Hiles & Čermák, 2007). I used purposeful sampling to recruit 10 women ages 18 to 24 years living in Southwest Ohio, a small sample size that, while appropriate for qualitative research, limited the generalization of results (Creswell, 2013a; Patton, 2015). Findings were unique to participants in this study and reflected the views, opinions, and beliefs of individual interviewees (see Smith et al., 2009); as such, data were not necessarily representative of similar young women in Southwest Ohio or elsewhere. As Lincoln and Guba (1985) observed, providing a detailed and thorough account of the data facilitated transferability of results, which will help readers and future researchers evaluate whether they can apply these findings to other studies or situations.

I established validity using Lincoln and Guba's (1985) trustworthiness approach, applying credibility, dependability, transferability, and repeatability techniques to establish trustworthiness and demonstrate validity of results. Smith et al. (2009), Patton (2015), and Creswell (2013a) recommended these techniques in qualitative research evaluation. I used audit trails, reflective reviews of interview transcripts, thick description (see Kvale, 2009; Smith et al., 2009), verbatim transcription, and member checking to ensure validity. According to Kvale (2009) and Smith et al. (2009), the practice of sharing interview texts with participants (transcript review) is important for the trustworthiness of data. This is a form of validation, as interviewees get the opportunity to comment and elaborate (if needed) on their original responses (Creswell, 2013a; Smith

et al., 2009). To establish a professional relationship, I approached interviewees without prior judgments and treated them according to ethical conduct guidelines as described in the American Psychological Association (2013) research guide. I did not begin data collection until the Walden University Institutional Review Board (IRB) granted approval.

Significance

Given the popularity of social media, it is important to understand EDs from the points of view of young women ages 18 to 24 years, the group most at risk. The results of this study expanded the knowledge of EDs and the spectrum of disordered eating because of the broad questions posed about the topic. I asked participants to describe their perceptions of EDs; their views of physical appearance and attractiveness; and their awareness of individual, interpersonal, and community factors that influence the development of EDs. Results may advance the practices of sociology and psychology through a more nuanced understanding of EDs, leading to further accurate and effective education and treatment. Findings may provide deeper understanding of how social norms and relationships act as buffers or mediators to EDs. The phenomenological approach used in this study may facilitate positive social change by contributing to more customized educational and treatment programs for women with or at risk of EDs.

Summary

EDs among young women ages 18 to 24 years constitute a growing mental health issue, and understanding these diseases from the perspective of those most at risk is key in addressing this problem. The most effective way to deal with a health issue is by

understanding the disease from those most impacted, thereby producing evidence-based findings that will inform and educate program planners about the issue (Issel, 2008). Health planners create effective public health programs targeting the impacted population in collaboration with community stakeholders (Cohen et. al., 2010; Issel, 2008; Minkler, 2004). EDs are complex illnesses; for that reason, deeper understanding is critical (Issel, 2009).

In Chapter 1, I provided a brief overview and history of EDs. I also illustrated how using different themes related to EDs enhanced the framework for guiding analysis of ED experiences. Individually, theories cannot explain the onset, development, or persistence of EDs; used together, however, they can show how personal and social factors interact in escalating ED risks, especially among young women. This chapter included a review of the conceptual framework, which showed the way motives for social comparison affect how thin-ideal internalization impacts social comparison and body surveillance. In Chapter 2, I provide a review of relevant literature and discuss its importance to this study.

Chapter 2: Literature Review

The purposes of this study were twofold: explore what makes some young women more susceptible than others to develop and suffer from ED-related health issues, and uncover what public health professionals can do to help young women develop healthy relationships with food and avoid EDs and related issues. I compiled questions emphasizing the use of an ecological approach to understand EDs among this population. Levels of influence abound relating to the occurrence of EDs (APA, 2013), with a gap in understanding how these influences impact those with EDs, especially young adult and adolescent women (Steiner & Lock, 1998). I sought to understand young women's perceptions of EDs to gather baseline data for community-based ED research among the population most at risk.

EDs are a dangerous group of mental illnesses affecting mostly young women 18 years and older and posing a worldwide public health challenge (APA, 2013; NIMH, 2013). Eating disorders arise from feelings (NIMH, 2013) manifest as unhealthy relationships with food, resulting in negative physical and emotional health outcomes and often life-threatening conditions. Focusing on people at risk through a community-based approach is crucial to understanding and addressing this condition (Becker et al., 2014; Cohen et al., 2010). Factors behind EDs may include a history of sexual or family abuse, weight-related teasing or bullying, difficulty expressing feelings, and low self-esteem, among others (Chan & Kelly, 2014). Social factors known to trigger EDs in young people include peer pressure and distorted cultural norms that assign value based on weight or appearance (Golan, 2013; Soh & Walter, 2013).

Alternative approaches to understanding the disease will go far in protecting those most at risk. More than 29 ED-related hospitalization stays occurred between 2008 and 2009, a 24% increase over the previous decade (Zhao & Encinosa, 2011). Some patients also received secondary diagnoses, including mood disorders, nutritional deficiencies, diabetes, depression, and cardiovascular diseases, as shown by Zhao and Encinosa. By clinical definition, EDs are illnesses that sometimes coexist with substance abuse disorders (Substance Abuse and Mental Health Services Administration, 2011). Given EDs' complexity of diagnosis and the various experiences and manifestations therein, community-based exploratory studies add important insight as to how the disease develops in target populations (Serpell, Stobie, Fariburn, & van Schaick, 2013).

At any given time, more than 10 million Americans report symptoms of an ED, such as AN or BN (American Psychiatric Association, 2013). Millions more struggle with BED, with adolescent and young adult women most frequently affected (Kostro, Lerman, & Attia, 2014; NIMH, 2013). Regardless of growing evidence for behavioral characteristic of EDs—such as overevaluation of weight (Dawson, 2014), binge eating, purging (Chan & Kelly, 2014), and dysfunctional self-talk (Bailey et al., 2014)—most people with these illnesses do not seek help (Churruca, Pérez, & Ussher, 2014). Additionally, numerous health risks copresent with EDs, such as cardiovascular and gastrointestinal health problems (Scott, Hanstock, & Thornton, 2014), psychological distress and low quality of life (Golan, 2013), and severe dehydration (Nicely, Lane-Lonely, Masciulli, Hollenbeak, & Ornstein, 2014; NIMH, 2013). An alternative approach to addressing the issue is merited because of the vulnerability of the target population

(Zwickert & Rieger, 2013). A need exists for research on how these individuals experience ED risk factors, empowering them to seek help and talk about their experiences without fear of stigma (Zwickert & Rieger, 2013) or societal alienation.

Behaviors, diagnostic criteria, and symptoms of EDs also reveal the gravity of the diseases. Although it is normal for people occasionally to think about how they look, for people with EDs, the attention to self-image is constant, extreme, and obsessive (Hoetzel, Brachel, Schlossmacher, & Vocks, 2013). Although criteria vary by ED, young women show higher frequency of ED behaviors than men, regardless of race and ethnicity (Becker et al., 2014; Dawson, 2014). Further research will provide understanding of this imbalance and help those most at risk.

This chapter includes a review of the strategies used to locate relevant literature related to the theoretical framework and ED determinants, including individual, social, biological, and genetic. The purpose of conducting a literature review was to understand the range of personal, social, economic, and environmental factors that influence EDs among this population as determined through existing studies. Public health advancements and failures regarding EDs also appear in Chapter 2. Following an explanation of the complex nature of EDs comes information on EDs among different groups, presented to understand varying ED determinants in relation to particular populations. For the literature review, I focused particularly on how social and physical determinants impact EDs in young women, with the purpose of understanding their perceptions of EDs, views of physical appearance and attractiveness, and individual and interpersonal factors that influence ED development.

Literature Search Strategy

I located resources for this study by searching academic databases through the Walden University Library, including EBSCOhost, PubMed, and CINAHL, as well as Google Scholar and the *Journal of Eating Disorders*. In addition to primary keywords *eating disorders* and *women*, I searched the more specific terms of *anorexia nervosa*, *bulimia nervosa*, *self-image, body image*, *body mass index*, *eating disorder symptomatology*, *eating disorder severity*, *eating disorder and society*, *stigmatization*, *body mass index*, *guilt*, *self-blame*, *psychotherapy*, *anxiety*, *depression*, *borderline personality disorder*, *obsessive compulsive disorder*, *comorbidity*, *early intervention*, *attachment disorder*, *cognitive behavioral strategies*, *purging mental illness*, and *binge eating*. The only empirical studies reviewed were those with a publication date of 2000 or after. Although I considered older articles for their ability to establish historical relevance of theories and insight into the progression of thinking about EDs over time, most articles had a publication date within the last three to five years. The literature review also encompassed community-based studies on EDs. I found no research articles addressing EDs from the perspectives of young women 18 years of age and older who were not ED patients.

Literature Review

Because they are searching for their place in the world and vulnerable to external sources telling them how they need to appear, young women are at the greatest risk for EDs (Fitzsimmons-Craft, 2011; Hilbert et al., 2014; Loth et al., 2014). These influences affect the way women view and talk about themselves, with distorted self-image a main

driver of EDs (Neumark-Sztainer, 2014). Determining this young population's perspectives and experiences of factors behind EDs is imperative to create effective intervention programs and prevent disease occurrence.

The objective of the literature review was to obtain a broad overview of issues associated with EDs, primarily AN, BN, and BED, and how they are connected to ED occurrence in young women. I reviewed major issues behind EDs, such as self-identity and self-perception, as well as causes, effects, and personality traits highly correlated with EDs (Neumark-Sztainer, 2014). I also examined low self-esteem and its negative effects on self-perception. As social stigmatization is a common problem for this population, the social view of EDs also warranted examination.

Characteristics of Eating Disorders

Typically, the primary symptom of EDs is an excessive focus on body image and weight. While it is normal for people to occasionally think about how they look, for people with EDs, this hyper focus on self-image is constant, distorted, extreme, and obsessive. Criterion behaviors vary with each ED, complicating comprehension of the disease.

Refusal to maintain a normal body weight, regardless of being significantly underweight, characterizes AN (APA, 2013; Dahlgren, 2014). Evidence shows satisfying the need to meet this underweight criterion is a driving force behind sufferers' actions (Golan, 2013). The individual engages in dangerous behaviors to lose weight, including starvation or eating only minimal amounts of food. Any eating is usually followed by purging (self-induced vomiting, excessive exercise) or fasting. The most visible symptom

in those with AN is showing rapid signs of aging due to the nutritional lack. Because optimal body weight is necessary for proper functioning (Dawson, 2014; Rikani et al., 2013), AN has the highest mortality rate among all mental diseases combined (NIMH, 2013; Wade, Keski-Rahkonen, & Hudson, 2011). The reasons behind such behaviors, although widely researched, are complex, because anorexic behaviors manifest themselves differently for each individual (Becker, Grinspoon, Klibanski, & Herzog, 1999). Triggers causing these young women to ignore logic and obvious warning signs of dangers of AN are still not understood. Attempting to identify these causes, Kelly and Carter (2014) found individuals with AN to have low levels of compassion toward their own suffering, which explained the tendency to overlook the seemingly obvious danger signs of these behaviors (Attia, 2010). Similarly, Scott et al. (2014) identified a correlation between dysfunctional self-talk and ED symptomatology, including for AN.

The second most dangerous ED is BN, behaviors of which are binge eating or bingeing, feeling a loss of control during the binge followed by deep shame, which subsequently leads to purging. Although such actions are dangerous (Churruca et al., 2014), a young woman with BN ignores or rejects the risks. Disease overlap, one of the main factors in addressing ED, is evident, because AN and BN sufferers have a distorted body image accompanied by an intense fear of gaining weight (Kelly & Carter, 2014). After bingeing, the individual maintains an abnormal focus on body image and weight; this, in turn, may be the main driver for subsequent purging behaviors, including diuretic use, self-induced vomiting, excessive exercise, and a sense of shame (Dawson, 2014). Without treatment, individuals may associate such shame with other behavioral health

concerns, including self-injury and suicide (Hudson, Hiripi, Pope, & Kessler, 2007). In a similar study, Hoetzel et al. (2013) argued low motivation or desire to change is a main factor undermining recovery and treatment efforts for people with BN. Bulimia is a serious public health illness not fully understood (Churruca et al., 2014); hence, more studies of a qualitative nature are needed to explore the development and nature of the illness.

Unlike AN and BN, a person with BED does not purge (Hudson et al., 2007; NIMH, 2013). Instead of frequently overeating, BED sufferers have only occasional bingeing episodes. Similar to BN sufferers, people with BED also experience loss of control during a binge, followed by intense guilt and shame (APA, 2013; Salafia et al., 2013). As soon as one episode ends, the sequence of behaviors begins anew. Observed as early as 1999 (Becker et al.), this cycle of symptoms remains unchanged (APA, 2013; Churruca et al., 2014; Lindsdedt, Neander, Kjellin, & Gustafsson, 2015). Researchers argued this vicious cycle of distorted and dangerous behaviors exists in people with BED because of the disorder's direct relationship to feelings of distress (NIMH, 2013; Smink et al., 2012).

Obesity and overweight issues are public health concerns, because people with BED do not obsess over eliminating food by fasting or purging. Statistical updates from NIMH (2014) showed the average age of onset for BED is 25 years, with its appearance more common in people (both genders, but mostly women) under age 60. BED is associated with emotional imbalance and stress (Becker et al., 2014) and, similar to AN and BN, people with EDs often have a distorted body image (Waldman et al., 2013). EDs

are complex, manifest differently in different people, and are not well understood. To understand behavioral triggers, there is a need for more community-based research exploring these illnesses from the perspectives of those affected.

EDs and Body Image

Prevalent social perceptions of beauty often affect young women's self-image in unhealthy ways. Not surprisingly, social media and peer perception are strongly linked to EDs in young women, who practice distorted behaviors with the intention of looking a certain way. The goal for those with EDs is changing their image to be perfect or more desirable, in line with social norms. Successful therapy treatments focus on helping patients accept themselves for who they are (Lindstedt et al., 2015; Reid, Flowers, & Larkin, 2005), instead of the media ideal of a young woman (Nicely et al., 2014; NIMH, 2013). In therapy, patients with EDs are encouraged to develop a healthy body image characterized by self-acceptance, including a lack of obsession or shame about their appearance, love and acceptance of their body in the present moment, and a clear understanding of the importance of valuing themselves as a person—not as their appearance. People with EDs, especially BED, have an unhealthy body image, disliking their bodies and who they are, comparing their appearance to others, and talking negatively about how they look. Whether one develops a healthy or unhealthy body image depends on outside influence—in other words, a healthy body image is learned and not something one is born with. According to Dawson (2014), interactions with others determine how young women view themselves and their bodies, in either healthy or unhealthy ways.

Martino and Lester (2013) found sociological factors such as media and peer perceptions were highly related to EDs in young women. Bailey et al. (2011) conducted similar research and came to the same conclusions. The way young women are exposed to billboards, magazines, television commercials and series, films, and other media dictating how they should look, think, and act in regard to self-image all lead to a distorted sense of self.

Familial criticism from a parent/caregiver, sibling, aunt/uncle, or other significant individual can inadvertently reduce young women's self-confidence and self-esteem (MacGregor & Lamborn, 2014), making them more likely to engage in behaviors leading to an ED. A lack of positive parental influence can be problematic for some women who do not receive love and attention from other family members (Tchanturia, Davies, & Campbell, 2007). Negative self-thoughts and dissatisfaction with one's body are also part of the ED discussion; however, more empirical studies are needed to determine if these tendencies occur naturally, or if they become ingrained because of negative exposure to the aforementioned sociological and familial factors (Churruca et al., 2014). Although some researchers argued EDs may be of genetic origin (Bulik, 2007; NIMH, 2013), the disease appears triggered by a deep need to look a certain way (American Psychiatric Association, 2013; Dakanalis et al., 2013; Pike, Walsh, Vitousek, Wilson, & Bauer, 2003). EDs are complex; as such, developing effective intervention approaches should focus on the perceptions of those most at risk (Bailey et al., 2014).

Cultural factors are also related to the prevalence of EDs. Zhao and Encinosa (2009) studied the disorders among cultures with similar genetics, but found prevalence

rates were not the same. In cultures such as the United States, where food is abundantly available and unhealthy options such as fast food are promoted both in the media and economy due to being inexpensive and readily available, ED rates are higher (NIMH, 2013). While at one time women of a higher socioeconomic class were more likely to develop an ED, this is no longer the case.

Culture is the only factor involved in the rate of EDs, with some individuals more vulnerable to social calls for beauty than others (Gabriel & Waller, 2014; Polivy & Herman, 2002). Women are much more likely than men to develop EDs (Zhao & Encinosa, 2009) due in part to the overrepresentation thin women in ads, as well as emotional issues that make women more susceptible to social perceptions (Ward & Hay, 2015).

Peer relationships are also determinants for EDs. As women frequently develop EDs early in adolescence, when peer influence increases, it is likely girls with peers highly concerned with body image will show increased concern for their own body image, something that exceeds the boundaries of many cultures and ethnicities. Caucasian young adult women once seemed most at risk for EDs; however, this no longer is the case, and perhaps never was. Western European, North American, Asian, Northern European, and African American women are also highly susceptible to cultural messages that promote EDs (Ward & Hay, 2015). According to the International Association of Eating Disorders Professionals (IAEDP; 2014), EDs are now a global health issue, as women from every background and race are affected by the same cultural realities that promote EDs. While ED-inducing influences may seem different on the surface, the

relationship common to each is they undercut a female's sense of safety and/or identity (Martino & Lester, 2013).

Once a female's sense of self-worth is undermined, it becomes increasingly more important for her to regain a sense of personal control, the essential component in the development of any ED. Just as a woman with AN gains a feeling of control while refusing to eat and getting slimmer, a patient with BN achieves a similar sense of control from bingeing and purging (Polivy & Herman, 2002; Rodger & Paxton, 2014). These behaviors provide feelings of calm and comfort. After persistent episodes of nutritional abstinence, excessive exercise, and/or bingeing and purging, patients inevitably develop a sense of shame and guilt, knowing they are causing both psychological and physical self-harm. The behavior that once calmed the patient now merely reduces the guilt and shame. A vicious cycle exists by which the actions consistent with an ED—actions meant to assuage guilt and shame—serve to increase disordered eating. As women with EDs become progressively more shamed by their actions, they develop a negative effect, a central identity feature also found in high percentages of women between the ages of 18 and 65 years who have EDs (Martino & Lester, 2013).

Some who have assessed the relationship between borderline personality disorder and EDs revealed that, theoretically, researchers should look at EDs via a naturalistic cluster approach rather than a *DSM* diagnosis, the latter of which may be highly lacking in terms of giving appropriate weight to the individuality inherent among women who present with EDs. Even individuals suffering from an ED within the same *DSM-5* category vary greatly in the underlying causes and manifestations of symptoms (APA,

2013). Such cases lend support to the naturalistic cluster approach, which suggests it is more beneficial to consider a patient's self-perceived sense of identity as it naturally exists as opposed to attempting to warp parameters of behavior to fit within predetermined diagnostic categories. Considering patterned differences among every woman is a better approach than lumping patients into one discrete category. According to Gabriel and Waller (2014), patients with EDs may be one of three personality types: high-functioning perfectionist, constricted/overcontrolled, or dysregulated/ undercontrolled. Using an ecological momentary assessment method, Wonderlich et al. (2007) found a somewhat different pattern among individuals with BN, with three personality subtypes—interpersonal/emotional, stimulus seeking/hostile, and low personality pathology—validated by a range of clinical differences.

Ecological momentary assessment allows patients to report on their symptoms at a time close to the incident that caused upset feelings. Cognitive behavioral therapy (CBT) consistently incorporates ecological momentary assessment. While undergoing CBT, patients write about anxiety-causing moments immediately after experiencing related symptoms, with the intention of capturing how they felt at the onset of anxiety. Patients then speculate why these moments originally made them anxious (Moskowitz & Young, 2006). Later in this chapter, I will further discuss the mechanism by which CBT is effective, particularly in patients with BN and other binge-and-purge–type EDs.

Genetics and Family Environment

As with many genetic prevalence considerations, the question of nature versus nurture arises, as it is generally accepted that both genetics and the environment in which

individuals grow up may influence their behavior. In numerous ED studies of twins and close family members, the underlying genetic relationship is highly valuable. A strong genetic predisposition undoubtedly exists in the case of EDs; however, the specifics warrant further research (NIMH, 2013). Following a study about the hereditary predisposition for EDs, Klump, McGue, and Iacono (2000) estimated that 50% to 83% of the variance in EDs is related to genetics. Medical professionals who suspect a patient may suffer from an ED should obtain relevant information about the prevalence of EDs within the patient's family (Bailey et al., 2014).

In addition to genetic predisposition, there appears to be a strong link between EDs and parenting or family environment. Hughes, Allan, Le Grange, and Sawyer (2013) found family environment to be an integral part of EDs because assessment, treatment (e.g., family therapy), follow-up treatments, and life after treatment mainly center on the family. The authors also noted the patient was impacted differently depending on the relationship (e.g., mother-daughter versus father-daughter), where assessment scores differed because both parents had their own perceptions of EDs (Hughes et al., 2013). Such findings are in line with observations by other researchers that EDs are complex with no single approach to effectively tackle these mental illnesses, giving further support that understanding and treating EDs is difficult (NIMH, 2013). The need exists for phenomenological research focused on understanding a phenomenon from the point of view of the target population (Creswell, 2013a; Patton, 2015; Smith et al., 2009).

ED development is associated with family environment in terms of possible psychological and physical exposure to EDs. Arroyo (2014) showed individuals exposed

to negative self-talk from other family members related to body dissatisfaction were more likely to internalize negative comments, creating an environment for unhealthy thoughts, motives, and behaviors to evolve and trigger EDs. Environments in which young women grow up are important for developing healthy relationships with themselves and with food (Attia, 2010; Austin, 2012; Austin et al., 2008). Family is crucial for creating a healthy environment in which individuals develop healthy attitudes about who they are (Dakanis et al., 2013). Even in cases in which a parental figure or other close family member does not suffer from an ED, researchers (Chan & Kelly, 2014; Chao et al., 2016) suggested additional factors in parent-daughter relationships may be driving forces in the development of AN, BN, and/or EDNOS.

One prevalent theory suggests parental bonding and attachment to one's caregivers may be of notable consideration in female patients who suffer from an ED. According to attachment theory (Bowlby, 1969), several types of attachment between child and parent exist, some more likely than others to promote healthy behaviors. Tetley, Moghaddam, Dawson, and Rennoldson (2014) found children's behaviors were directly associated with the attention they received from caregivers. Tetley et al. reviewed studies on parental bonding in women diagnosed with EDs, finding difficulties in parent-child relationships predispose women to EDs and other mental illnesses. In strong support of attachment theory, ED patients, especially women, engage in eating pathology behavior as they seek to avoid rejection (Fitzsimmons-Craft, 2011; Fitzsimmons-Craft et al., 2014). In this way, college women are vulnerable to rejection avoidance as they seek acceptance in a new environment (Fitzsimmons-Craft, 2011) and may develop EDs as a

way to cope. Findings from this study (Fitzsimmons-Craft, 2011) revealed women suffering from an ED often reported ineffective or neglectful care from one or both parents. Indeed, an estimated 50% of women with BN reported lower maternal care; similarly, 46% of those with AN said they did not have strong relationships with their parents (Tetley et al., 2014). An avoidant attachment style is the only style that correlates with, and may be responsible for, the introduction of developmental and psychological identity problems in young women. On the contrary, more than 30% of women with AN, BN, and/or EDNOS reported having overprotective parents (Tetley et al., 2014). Parental attachment is a highly relevant factor in the development of self-identity, and in resilience against or exposure to other environmental factors that may elicit unhealthy eating behaviors.

Family environment is also connected to experiences that may lead to EDs. Adverse or traumatic events are related to a myriad of issues, among them parental divorce, physical and/or verbal abuse, sexual abuse or molestation, severe accident or traumatic brain injury, and death of a close family member or friend (Pike et al., 2003). Pike et al. found incidents such as rape or molestation more common in individuals with diagnosed EDs. There is much support for this (Hilbert et al., 2014; Salafia et al., 2015), albeit with debatable frequency and inconsistent findings. Sex-related assaults against women often cause dramatic and lifelong instances of depression and anxiety that, in turn, may trigger EDs (Bailey et al., 2014).

Common to each cause of EDs is that the internal relationship a woman has with herself highly determines if she will develop a healthy or unhealthy relationship with

eating. Psychological and internal factors also predict whether an individual will acquire an ED, something illustrated by Fitzsimmons-Craft et al. (2014), who found a connection between college women's internalization of external sociocultural factors and ED development. Some women who appear more likely to succumb to social or peer pressures develop unhealthy relationships with food and dieting. They may not have necessarily lacked appropriate parenting or been genetically susceptible, yet some predisposition exists to make them more likely to develop an ED than other similarly appearing females. Therapists and medical professionals must develop tools to better understand EDs and their progression, according to MacGregor & Lamborn (2014), who took a public health approach to contribute much-needed information toward understanding EDs so as to develop more effective preventive and treatment techniques.

Comorbidity Nature of EDs

People suffering from EDs often have comorbid mental and psychiatric illnesses, further complicating care trajectories. Sometimes, such comorbidities can even obscure symptoms of an underlying ED (Becker et al., 2014; Dawson, 2014; Nowakowski et al., 2013), making disordered eating difficult to treat. The topic merits further research to better understand of EDs and their comorbidities. Gearhardt, Boswell, and White (2014) studied the association of food addiction with disordered eating and body mass index (BMI). They found an association between addictive-like eating and elevated current and lifetime high BMI, weight cycling, and eating pathology. Food addiction was more prevalent in participants with BN than with BED. Understanding the disease from all angles is necessary if treatments and interventions are to be effective (MacGregor &

Lamborn, 2014), including this variant of food addiction among young people, especially women.

Rodgers and Paxton (2014) noted a correlation between symptoms of depression and AN (40%) and BN (50%). Although researchers debate the correlation between the initiation and progression of depressive symptoms and EDs in women, depression likely develops at one of three times: simultaneously with, prior to, or after the eating disorder (Rodger & Paxton, 2014). No matter the progression, it is essential both concerns receive quick, effective treatment. Care may extend to screening family members for depression and/or symptoms of EDs, as shown by Klump et al. (2000), who found not only a high frequency of EDs in families, but also the development of EDs and depression in twins.

Anxiety predated the onset of AN and/or BN in many patients. In a study (N = 374) that included 359 females 18 years of age or older, Gabriel and Waller (2014) found 64% to have lifetime anxiety disorders, a percentage significantly greater than in the general population of same-aged women. In the same study, 41% of women exhibited strong signs of obsessive compulsive disorder (OCD), and 20% also suffered from generalized social phobia (Gabriel & Waller, 2014). Almost half the women who suffered from EDs concurrent with anxiety had developed their anxiety early in life (Gabriel & Waller, 2014). Although Gabriel and Waller's study was not longitudinal and relied heavily on patient reports of when anxiety problems began, it provided evidence that anxiety coexists with EDs.

Patients may be concurrently diagnosed with an ED and patterns of borderline personality disorder, a relationship perhaps more complex than it may seem (Gabriel &

Waller, 2014). Both systematic evidence based and anecdotal reports within published case studies identified patients suffering from personality, anxiety, and depressive disorder(s) as more likely to develop EDs; however, not all findings point exclusively and consistently to this conclusion. Following an electroencephalography study, Jauregui-Lobera (2011) found no significant relationship between sleep disturbances in patients who suffer from anxiety alone versus patients who also suffer from an ED. While the lack of a neurophysiologic association by no means negates the relationship between anxiety and EDs, it suggests an ED has its own set of predispositions and quantifications not picked up by the same measures utilized in anxiety assessments (Churruca et al., 2014).

Comorbidity of EDs with other illnesses complicates treatment. Zhao and Encinosa (2009) identified more than 29 ED-related hospital stays in 2008 and 2009, a 24% increase compared to the previous decade. The same people also received diagnoses of one or more secondary EDs, including mood disorders, nutritional deficiencies, diabetes, depression, and cardiovascular diseases. Given the complexity of ED diagnosis and the different experiences and manifestations of the disease across individuals, exploratory, community-based studies add important insight as to how the disease develops in target populations (Serpel et al., 2013).

Beyond the 10 million individuals currently suffering from EDs such as AN or BN (American Psychiatry Association, 2013), millions more struggle with BED, with adolescents and young adult women most affected (Kostro et al., 2014; NIMH, 2013). Regardless of growing evidence for behaviors characteristic of ED, such as weight overevaluation (Dawson, 2014), binge eating, purging (Chan & Kelly, 2014), and

dysfunctional self-talk (Bailey et al., 2014), most people with these illnesses do not seek help (Churruca et al., 2014). Female adolescents and young women report other numerous health risks associated with EDs, including cardiovascular and gastrointestinal health problems (Scott et al., 2014), psychological distress and low quality of life (Golan, 2013), and complications such as severe dehydration (Nicely et al., 2014; NIMH, 2013). An alternate approach to addressing the issue is clearly needed (Bailey et al., 2014). Because young women ages 18 to 24 years are vulnerable to what others think or say about them, researchers should focus on how this population experiences ED risk factors, empowering ED sufferers to seek help and share their experiences without fear of stigma (Zwickert & Rieger, 2013) or societal alienation.

Behaviors, diagnostic criteria, and symptoms of EDs also reveal the gravity of the diseases. Although everyone occasionally thinks about their appearance, people with ED have a constant, extreme, and obsessive attention to self-image (Hoetzel et al., 2013). Researchers need to explore and listen to the experiences of young women who, regardless of race or ethnicity, show higher risk of ED behaviors than males (Becker et al., 2014; Dawson, 2014). Obtaining a comprehensive understanding of disease coexistence must occur to ensure proper disease assessment and the development of effective preventive techniques (Kostro et al., 2014). In addition to comorbidities, people with EDs often experience social stigma and societal misunderstanding.

Social Stigma and Eating Disorders

Eating disorders are complicated mental illnesses (NIMH, 2013) that are highly stigmatized. To more deeply understand perceptions of the causes of EDs, Salafia et al.

(2013) compared responses from individuals with and without EDs. Results showed different criteria between the two groups, demonstrating misconception among the general public regarding EDs. Both groups rated psychological/emotional problems as the most significant cause; however, people with EDs also included social problems, whereas those without named media and culture. Although researchers have not defined all social stigma causes, some felt it may be due to the lack of understanding of EDs (Allan & Goss, 2014; Dahlgren, 2014). This purpose of this study, therefore, was to close these knowledge gaps by using an exploratory point of view in a community-based approach to study EDs.

Zwickert and Rieger (2013) defined common stigmas against ED patients as a lack of sympathy stemming from not understanding that EDs are real illnesses in need of medical attention (NIMH, 2013). Although some might initially envy the self-control of those with EDs (Polivy & Herman, 2002), once a women's support group identifies the presence of the disorder, this envy often turns to disgust. Because self-control is socially revered and many without EDs view disordered eating as a lack of control, they may quickly disparage the woman who is suffering. Some non-ED individuals relate EDs to an attempt to become sexually enticing, which can also cause stigmatization (Martino & Lester, 2013).

While a few methods, such as familial informational counseling, have decreased social stigma in the short term, little to no research exists to support any strategy providing long-term relief (Griffiths, Mond, Murray, Thornton, & Touyz, 2015). Stigmatization is an area that requires a great deal of purposeful, well-developed research

in the form of randomized controlled trials, as many patients who suffer from EDs are already highly affected by the opinions of others. In fact, constant perceived stigmatization could cause an increase in symptoms, both in terms of anxiety and the ED itself (Lasalvia et al., 2013). Perceptions of social stigma and self-stigma can also make women less likely to adhere to ED treatments that might otherwise be effective. Some women feel inadequate merely seeking therapy (Griffiths et al., 2015). Treatment nonadherence can promote long-term ill effects and lengthen ED duration. Another likely progression from self-perception of stigmatization is the reduction of self-esteem, hope, and empowerment, factors that are also related to the effectiveness of treatment.

Stigmatization may also prevent individuals with EDs from seeking necessary help (Wingfield et al., 2011). For this study, I utilized a phenomenological approach to allow young women to speak about their experiences (Smith et al., 2009), views, opinions, and beliefs about EDs without fear of stigma or shame. The data added much-needed knowledge about this population's experiences and shed more light on the disease, including cause and effect of related social stigma.

EDs and Treatment

Determining the course of ED treatment from a mental health standpoint requires measuring the severity of the specific disorder. Treatment providers may use a tool such as the Stirling Eating Disorder Scale (SEDS) to assess the severity of a patient's ED (Allan & Goss, 2014), and then determine if outpatient therapy would provide adequate treatment, or if a more intensive inpatient treatment is necessary (Bailey et al., 2014). With this guidance, the practitioner can implement the therapeutic strategies most helpful

to the patient. In general, CBT and interpersonal psychotherapy remain the best treatments for BN and other related BEDs (Wilfley, 2013). However, as effective as these strategies are in managing BN, they may not be the best treatment for patients with AN. This highlights another important theme in ED theory: Although EDs are a single family of illnesses, their subcategories are distinct and manifest differently in each individual (Wingfield et al., 2011).

Behavioral therapy strategies can assist patients in managing their day-to-day struggles with negative thoughts surrounding food intake. Assuming negative thought processes cause unhealthy behaviors surrounding food, CBT would be a useful approach in ED management (Tetley et al., 2014), requiring patients to recognize negative thoughts as they arise. Once individuals can systematically break down thought processes and recognize situations invoking feelings of stress, depression, or anxiety, they theoretically should be able to replace a negative thought process with a healthier one. This strategy can prove useful for long-term management of many disorders, including EDs. However, it does require vigilant cooperation by the patient and consistent therapeutic management by the mental health care professional.

Because response to ED treatment using traditional therapy is also an issue (Ekeroth, et al. 2013). Schmidt (2017) developed the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) specifically for patients who did not show a reduction in symptoms after more traditional approaches. According to Kass et al. (2013), MANTRA addresses cognitive distortions about the utility of AN and rigidity, socioemotional deficits, and parents' enabling behaviors. In randomized controlled trials,

MANTRA appeared not only to be effective for women with AN, but to produce results within a 60-week follow-up period—relatively quickly in comparison with other treatments for this population. Young women showed a 50% rate of remission when they adhered properly and consistently to this treatment (Kass et al., 2013). MANTRA's success stems from family involvement in a controlled therapeutic environment, which discourages familial stigmatization.

This may not be the only method of treatment for patients with AN or other EDs not successfully treated via other approaches; however, it is an effective starting point. Although group therapy requires further research before being deemed effective for women with various types of EDs at different ages (Attia, 2010), Kass et al. (2013) suggested young women in particular may benefit from a therapeutic group environment.

Beyond the value of therapy for this vulnerable population, antidepressants may be helpful in remediating the effects of EDs. The FDA supports the use of fluoxetine (trade name Prozac), a selective serotonin reuptake inhibitor (SSRI), for treatment of BN. SSRIs are one of the most commonly prescribed drug families for women with EDs. Several trials utilized reversible inhibitors of monoamine oxidase-A (RIMAs) in treatment of patients with AN, BN, and EDNOS (Mitchell, Roerig, & Steffen, 2013), while others included nonantidepressant drugs such as ondansetron, topiramate (an anticonvulsant), and androgen antagonist flutamide used in conjunction with citalopram (Mitchell et al., 2013).

Psychotherapeutic agents showed some success in patients suffering from various disorders; however, no mental health professional should suggest administering any ED

drug without the guidance of consistent psychotherapy, an essential component of treating patients with EDs. Not only does therapy help the individual recognize the root of the problem manifesting as unhealthy eating habits, it also encourages consistent care by a medical health professional. Many patients with an ED, particularly those suffering from BN, discontinue their medication for a multitude of reasons, among them weight gain caused by some antidepressants. In general, patients with EDs are likely to regress to their old eating patterns, even after experiencing long periods without symptoms. Reaching a symptomless period can be difficult in itself, with many women still suffering from an ED nearly five years after initial treatment (Polivy & Herman, 2002). Rather than being discouraging, however, this information should invite new and creative methodologies into the discussion to find treatments most beneficial to ED patients, as individualized service is of utmost importance in effective ED management.

Summary

The prevalence of EDs among young women 18 to 24 years old is not a new finding; however, research approaches that are relevant to the communities most affected, and that take into account the perspectives of those most at risk, are greatly needed. It is important mental health professionals are well informed and aware of issues underlying EDs. As young women are particularly susceptible, they merit extra consideration and study. Social, genetic, and familial factors are all relevant considerations, as each has a strong link to the development of unhealthy eating habits. ED assessment and treatment occur from both scientific and behavioral perspectives, with certain personality types highly correlated to the development of various EDs. While similarities exist among

female patients over the age of 18 who suffer from AN, BN, or BED, each woman deserves a unique plan of treatment relative to her individual needs.

In this chapter, I presented a review of the literature on EDs along with methods used for the literature search. I centered my literature review on characteristics and determinants of EDs in general, with a specific focus on young women. My research revealed stigma as a main barrier of ED treatment, as well as identified current treatment approaches. Findings indicated EDs received attention as a health issue, yet approaches focused on understanding the disease from the point of view of those most impacted were still lacking. My intention with this study was to help close this gap.

In Chapter 3, details on the research method used in this study—including the research design and methodology rationale; the role of the researcher; methods and procedures for sample selection, data analysis, and storage; and ethical considerations in data collection and participant selection—appear, along with verification of data for trustworthiness.

Chapter 3: Research Method

With the rise in thinness idealization, EDs are a growing health problem across the world, especially in among young women ages 18 to 24 years (Newton, Boblin, Brown, & Ciliska, 2006). The purpose of this study was to determine individual and socioenvironmental risk factors of EDs from the perspectives of young women with and without EDs. Methods of studying diseases are improving; however, understanding and treating EDs is still a challenge, because these illnesses are complex and manifest differently in each individual. Understanding this group of illnesses from the perspectives of those most at risk is critical (Allan & Goss, 2014; Anderson & Braud, 2011) in providing information that may lead to audience-directed interventions before the disease occurs (Bailey et al., 2014; Patton, 2015).

The purpose of this study was to contribute empirical data from a public health perspective by collecting perceptions of EDs among young women in Southwest Ohio using a qualitative phenomenological methodology, an approach used in exploratory research (Becker et al., 2014; Creswell, 2013b) with a focus on how and why the target population perceives and experiences a phenomenon—in this case, EDs. I collected data through one-on-one, semistructured, in-depth interviews. The sections in this chapter include descriptions of the methodology, design, participants, research questions, and ethical issues. Appendices provide documentation to support the study's ethical procedures, data collection and analysis processes, and findings. The chapter concludes with a brief summary.

Research Design and Rationale

The purpose of this study was to describe the subjective reality of EDs as perceived by young women ages 18 to 24 years who are most at risk. The qualitative approach enabled me to investigate young women's views, subsequently aiding in developing meaningful health programs to address EDs. Qualitative studies are important when variables are not identified (Creswell, 2013b). Patton (2015) emphasized the importance of qualitative inquiry for exploration because it cultivates the capacity to learn, one of the most useful human capacities. The phenomenological design provided the best fit with the goal of this study: examining lived human experiences in a natural environment, unbiased and free from preconceived notions about the phenomenon under study. The phenomenological design was the best approach because it effectively utilizes qualitative research questions similar to those used in this study (see Creswell 2013a, 2013b; Patton, 2015).

Addressed in this study was an area that is understudied (American Psychiatric Association, 2013; Dahlgren, 2014; Haines & Neumark-Sztainer, 2006; NIMH, 2013) and in need of more attention from a public health approach (Austin, 2012; Austin et al., 2008). Meaningful information on ED risk behavior in Ohio is lacking. At least 15 ED treatment centers are located in Ohio, including major institutions (colleges and hospitals) working on disease treatment. This significant investment in ED health for Ohioans illustrates the magnitude of the disease (ODH, 2013a).

EDs are caused by a number of issues, beliefs, perceptions, and ideologies (Churruca et al., 2014; Salafia et al., 2013; Scott et al., 2014). In women with EDs, health

and personal issues, along with the influence and impact of peers and families, are primary associations. In the presence of such issues, it is impossible to ascertain root causes without understanding the disease from the points of view of those most at risk, given that causes and development of EDs are not fully understood. Qualitative methodology enabled me to probe the issue more deeply than a quantitative approach would have. According to Groenewald (2004), Denzin and Lincoln (2013), Davidson (2000), and Jones (2001), the phenomenological approach is the preferred method for this type of study, and provided much-needed insight into experiences of young women ages 18 to 24 years regarding determinants of EDs. Findings from this study may help health planners create programs in which young women are free to express their views on EDs and to seek help without fear of social stigma.

Role of the Researcher

In qualitative studies, the researcher is the main instrument in data collection (Groenwald, 2004; Patton, 2015). My primary roles in this study were to conduct in-depth interviews (see Smith et al., 2009), interpret data, summarize results, and disseminate findings. According to Patton (2015), phenomenological research involves exploring the structure, meaning, and essence of lived experiences of a phenomenon on a group of people or an individual. The purpose of this study was to explore, rather than measure, EDs as experienced by young women ages 18 to 24 years in Southwest Ohio. Conducting interviews that resulted in valid and accurate research findings was imperative (Groenewald, 2004; Patton, 2015). To produce credible results, I conducted thorough background research and information gathering on EDs to obtain greater

knowledge on the topic and determine the best manner by which to obtain answers to research questions, according to guidelines for phenomenology studies (Lincoln & Guba, 1985).

Research trustworthiness is not only established in data analysis, but is a dynamic and evolving technique applied throughout the study (Creswell, 2013b; Gibson & Brown, 2009; Lincoln & Guba, 1995). One of the ways to demonstrate trustworthiness is to establish confirmability of findings by using audit trails or thorough recordkeeping of study details (Lincoln & Guba, 1985). Audit trails are a transparent and organized way to show what the research revealed and how it progressed (Smith et al., 2009). In this study, audit trail documents included information for instrument development, such as preliminary schedules, observation formats, pilot forms, interview procedures, consent forms, recruitment emails, and research process notes. Ensuring all research details were in order throughout the study was of great importance in evaluating findings at the end (see Smith et al., 2009).

Participant selection is a crucial part of qualitative methodology (Patton, 2015). Because participants are the main source of data in qualitative studies, it was critical to conduct the study according to ethical standards (see Smith et al., 2009). Protecting study participants from harm is not only of utmost importance (Creswell, 2013a), but also crucial for trustworthiness, as it creates credibility in data collection (Lincoln & Guba, 1985). Upon IRB approval, I notified potential research participants of the study to assess interest, subsequently sending a formal letter of invitation. I then distributed an informed consent form, which participants signed after reviewing detailed information about the

study, including what to expect in interviews and how I would use results (Kvale, 2009). I also shared an interview guide (Appendix A) with participants prior to our interview. Maintaining good rapport and trusting communication with study participants was important to ensure they were comfortable and provided honest answers to interview questions (Patton, 2015) without reservation.

According to Smith et al. (2009), the practice of ethical research is a dynamic process maintained throughout the data collection process, from IRB approval to publication; avoidance of harm for study participants is critical. In accordance with Smith et al. (2009) and Patton (2015), I reminded participants over the course of the study that all participation was voluntary, even after our interview. Data anonymity came from the use of codes instead of names (for example, P1 March 1, 2016, referred to Participant 1 in the interview from March 1, 2016). The P1 and date format appeared on manual (field) interview transcripts and in results summary and reporting (see Chapter 4), with only "Participant followed by number" (no date) noted for added anonymity. Data transcripts and information pertaining to study participants will remain confidential, as I maintain sole access to participant names and identifying information. I have stored interview documents with codes, corresponding names, field notes, and study audit trails in a locked cabinet at my residence, where they will remain for five years before destruction.

Interview scheduling and other time management practices require advanced preparation, and are an important part of being a good data collection instrument (Smith et al., 2009). The research timeline had second interviews due before thorough analysis of first interview data. Following Smith et al.'s (2009) guidelines, I considered the time of

interview duration (45 to 60 min), audio review and data transcription (1 week), data coding (1 week), member checking (1 week), and data interpretation (1 week). More information about the successful collection of data and the subsequent analysis appears in Chapter 4.

This section describes the researcher's role as a qualitative instrument, including thoroughly preparing for the study in alignment with the approach (Galman, 2013; Patton, 2015), and gathering materials and necessary processes (e.g., detailed written description of the study procedure, interview questions, interview guide preparation, IRB application, etc.). Because interviews were the main source of data collection for this study, I maintained professionalism and created an environment in which each participant felt comfortable to share her honest and accurate responses. I conducted interviews without prior judgment or prejudice, which is especially important, as EDs are a sensitive and highly stigmatized topic (Kostro et al., 2014).

Methodology

Phenomenology is the study of wide arrays of consciousness experienced from a first-person point of view (Saunders et al., 2007). The central idea is based on intentionality, directed toward something as if the experience is about someone else or some other object. Researchers use phenomenology to identify and examine people's lived experiences in a critical manner (Lincoln & Guba, 1985). With regard to EDs among women 18 to 24 years of age, the idea was to understand their perspectives on environmental influences by families, friends, peers, and society. I considered other

methods of qualitative inquiry, but found them less effective for identifying the experiences of women and answering the research questions.

From the phenomenological perspective, self-consciousness plays an important role based on conscious experiences (Lincoln & Guba, 1985; Patton, 2015). These immediate and firsthand experiences come via prereflective self-consciousness mode (Best, 2004). A number of researchers believe self-consciousness does not happen in one moment, but is based on mindful perceptions of the world. Because real-life experiences are often perceived differently, they are hard to define in the third person; nonetheless, they are critical in understanding diseases and giving power to the affected so they seek timely assistance. The importance of phenomenology is in the context of interviews, which tend to focus more on personal observations and perceptions regarding a wide array of experiences that, since not based on immediacy, further strengthen the case for self-consciousness happening at regular intervals.

Creswell (2013b) felt biographical study was possible, but only if the researcher focused on the transition of individual life stages. Biographical studies are associated with experiences and incidents of people's lives that often act as a study of personal life in a critical and illustrative manner. Such studies pass through different phases, making it difficult to ascertain and identify all incidents and experiences. Ethnography, the study of cultures and people, is also appropriate for describing experiences of an identified sample (Saunders et al., 2007), but may not be useful individually. A number of researchers have favored this method when restricting their study to a specific culture; however, because the population in this study was not so restricted, I felt ethnography may not have been

useful in assessing the research topic and questions. Creswell (2013b) identified the case study approach as one that focuses on single or multiple cases; however, this was not the situation for the present study, with its focus on highlighting not prior experiences, but current ones.

Participant Selection

Because the purpose of qualitative research is to explore, there are no absolute rules on sample size. The number of participants depends on multiple factors, including study goals, objectives, time constraints, and others (Creswell, 2013a; Larkin, Watts, & Clifton, 2006; Patton, 2015; Smith et al., 2009). According to Saunders et al. (2007), research participants play a crucial role in supporting research and underpinning new findings and outcomes. All participants came from counties in Southwest Ohio, the area most in need of phenomenological study on EDs. Participants were young women (18 to 24 years old) either directly affected by EDs or with indirect experience and knowledge. I used purposive sampling, considered by Waldman et al. (2013) to be the most important kind of nonprobability sampling, to identify initial participants. Although I planned to obtain additional participants by the snowball sampling method, whereby respondents refer others to achieve an appropriate sample size, and this proved unnecessary when the flyer yielded enough participants. To ensure adherence to proper ethical research, I did not contact participants until the Walden University IRB approved the proposal.

Following this approval, I obtained study participants by means of a recruitment flyer. After a local church leader granted permission via a signed a letter of cooperation, I posted the flyer on the church bulletin board. Interested parties self-identified using the

criteria and information on the flyer, initially contacting me by email or phone. At this time, I thanked them for their interest, provided additional information, and informed them the study was voluntary. I emailed a study recruitment letter or study invitation, as applicable, and an informed consent form to formally confirm interest. Interviews occurred at a place mutually agreed upon by each study participant and me, in most cases a private study room in the local library. The purposive sampling method was ideal, because it was less expensive and had shown in historical qualitative studies (Patton, 2015) to produce quality data collection and appropriate sample size.

Participants who qualified for the study were young adult women from the Southwest Ohio region who may have either suffered from EDs or heard about them. Age was another criterion, as participants had to be between 18 to 24 years old; in addition, they needed to be willing to share their own perspectives and/or experiences regarding EDs. I required proof of age, with study selection following age criteria fulfillment. A large data set was not necessary because, in a phenomenological qualitative study, the goal is not to generalize data, but to create an in-depth, reflective understanding of individual experiences about the phenomenon (Creswell, 2013a; Smith et al., 2009). I selected a sample size of 10, because it was ideal for the research process and allowed for the answering of research questions. I exercised flexibility in terms of adjusting the sample size, while considering the fact that quality matters more than quantity in qualitative phenomenological studies (Creswell, 2013a; Smith et al., 2009). Although I initially considered a sample size of 10 to 15, in the actual study, 10 was ideal in terms of allowing participants to share their views and opinions on disordered eating, which I then

associated with findings from the literature review in forming logical conclusions. To ensure relevance, only 18- to 24-year-old women in Southwest Ohio participated in interviews to share their views and opinions. With regard to the relationship between saturation and sample size, saturation determines the qualitative sample size and is often a matter of degree. Saturation occurs when no new perspectives or ideas emerge from study participants after repeated data collection (Fink, 2005). In this study, I collected data until reaching saturation.

Measures

The purpose of the research was to study perceptions of EDs among young women in Southwest Ohio, focusing on how the target population perceived EDs. Because women face EDs due to a number of factors, making identification of a key cause difficult, it is important to focus on few widely researched and accepted factors in the social environment. Questions may arise related to underpinning and identifying factors not often researched. In this study, it was important to focus on factors well known to contribute to triggering EDs among women ages 18 years and older.

Research Questions

Research Question 1: How do young women (ages 18 to 24 years) perceive eating disorders?

Research Question 2: How do young women (ages 18 to 24 years) view their physical appearance and attractiveness?

Research Question 3: How do young women (ages 18 to 24 years) perceive individual, interpersonal, and community factors that influence the development of eating disorders?

Subquestions

Subquestion 1: Do young women (ages 18 to 24 years) see themselves as at risk of developing an eating disorder?

Subquestion 2: What is the influence of peer pressure on young women's behaviors and attitudes related to their weight and appearance?

Subquestion 3: What is the influence of family relationships and views on young women's eating behaviors and attitudes related to their weight and appearance?

Subquestion 4: How do current social norms influence eating behaviors, beliefs, and perceptions of body image in young women?

Ethical Protection of Participants

According to Blackburn (2001), ethics play a crucial role in achieving research goals and objectives. Ethics are based on general principles, which are drawn from the pillars of honesty and transparency. Each research participant received an interview invitation letter and a consent form, which assisted in safeguarding their privacy and confidentiality. Personal details of research participants will remain confidential until and unless they grant approval otherwise. As researcher, only I have access to interview information, including tapes, field notes, and associated documents, locked in a secure cabinet to which only I have access. I reported participant data without bias and further manipulation, in the spirit of ethics and phenomenological research (Patton, 2015). While

the study was for doctoral research, it also represented study participants, me as researcher, and Walden University; therefore, I strictly observed the University's ethical guidelines. Overall, remaining honest and transparent in the research approach was important to maintain a high degree of integrity.

Recruitment, contact, data collection, or any communication with potential study participants occurred only after Walden University granted formal approval (IRB approval Certificate Number 02-27-17-0252873). Participants were 18- to 24-year-old women from counties in the Southwest Ohio region. Because researchers select participants in a phenomenological study according to specific study needs (Smith et al., 2009), I chose the target sample, age range, and location for this study based on participants who agreed to share their experiences and views on EDs.

Participant protection is of utmost importance to ensure their safety, well-being, and privacy (Patton, 2015; Rudestam & Newton, 2007). I rejected participants who were not able to read, understand, and speak English, as this was necessary for obtaining informed consent. Age range, gender, residence in Southwest Ohio, and willingness to share views, opinions, and beliefs on EDs comprised selection criteria. No other exclusion and inclusion specifications existed for this study.

The use of specific procedures ensured ethical protection of participants and included steps for collection, analysis, and validation of results.

1. I selected Warren County in Southwest Ohio as the recruitment location. Via email, I introduced myself as a Walden University student to an area church leader, and requested use of the church bulletin board to post a recruitment

flyer for my study. I explained and gave a brief background of my study, and sent a letter of cooperation with details of my request. The church leader telephoned and I provided additional background and details. After I received positive feedback and affirmation, I delivered the letter of cooperation for him to sign.

2. Specifically, I requested permission to post a study flyer on the church bulletin board following Walden University IRB approval.
3. The individual I approached was very welcoming, giving me permission to post a flyer by signing a letter of cooperation (permission came in conjunction with IRB approval). Due to lack of privacy, I opted not to use church facilities for conducting face-to-face interviews with study participants; instead, I used either a private room at a Southwest Ohio library or a private conference room at a local restaurant, as agreed upon with study participants. My primary emphasis was to make sure the study participant was comfortable with the interview location before confirming the date and time. A private study room in a local library was the most frequent choice for study participants.
4. After receiving IRB approval and a signed letter of cooperation from the church leader, I posted my study flyer, which contained the study title, target audience, and contact information. Interested participants were able to self-identify and then contact me by either email or phone.

5. After receiving messages from interested parties, I responded via email by thanking potential participants for their interest, fully explaining the study background, and clarifying the consent form, which I said they needed to sign to participate. Approximately five days after mailing the consent form, I requested from participants a convenient date, time, and location for the interview.
6. Face-to-face interviews occurred primarily in private study rooms at local libraries, with only one taking place in a private conference room at a local restaurant. My main emphasis was to make sure the study participant was comfortable with the interview location before confirming the date and time.
7. Before each interview, I prepared the audio recorder and interview guide. After showing participants a copy of the IRB approval, I asked them to sign and date the consent form if they had not already done so.
8. One week before participant interviews, I conducted a pilot study with individuals representative of my sample (women ages 18 to 24 years) to confirm my interview questions were valid. I wanted to ensure the interview sessions were neither too long nor too short, with questions probing enough to solicit sufficient data. After conducting the pilot study in the same location as actual participant interviews, I analyzed the data and included it in the full study results.
9. I developed a protocol (Appendix A) for participant interviews to ensure their responses would allow me to answer the research questions. Interviews took

place during 1 hr time blocks at a local library or restaurant of the participants' choosing, where I could maintain confidentiality and keep private their identity. I audio recorded all interviews, the recordings and raw data from which I will securely store for a minimum of five years, during which time Walden University's Office of Research Integrity and Compliance can audit the complete set of raw data. To promote positive and healthy relationships, I gave each participant a chance to clarify any concerns they had before the interview, as well as an opportunity to review the questions prior to the actual interview. I began each session by thanking the participant for her willingness to assist in my study, and reminded her she could at any time decline to answer any questions or exit the interview process.

10. I disseminated study results to participants and stakeholders.

Data Collection and Storage

Saunders et al. (2007) identified two sources for data collection, primary and secondary. Primary data are new and fresh, offering real-time information regarding the subject matter, while secondary data are already available. Primary data adds real-time value, while secondary data adds trust value. There is generally no question of the reliability and validity of secondary data, as a majority of published academic and government data is well supported. In contrast, primary data may raise questions regarding validity and reliability, as outcomes are dependent on researchers' analysis and interpretation based on their knowledge and understanding (Stringer, 2007). To obtain primary data, researchers use interviews, focus group interviews, surveys, and

observational studies, each of which has both limitations and advantages. Surveys facilitate questioning a large number of people, while interviews significantly restrict the size of the sample. Observational studies require watching others' activities and behaviors, which may take extensive time and greatly delay the research process. In this study, I collected data from interviews to obtain participants' views and responses in a systematic manner. Interviews provided illustrative responses that offered appropriate information regarding the subject matter, along with multidimensional perspectives on research questions.

Interviews and surveys each have certain benefits and challenges, and both need critical analysis before research study implementation (Saunders at al., 2007). Whereas quantitative survey analysis produces specific data that may be helpful in identifying key results, qualitative interview analysis using themes provides general results and outcomes that may be unspecific. Because interviews are descriptive in nature, manipulation and falsification may occur if respondents share untrue information; statistically analyzing responses, however, greatly reduces chances for errors and issues. Interviewing people is a time-consuming process requiring patience along with good interpersonal skills; in comparison, surveys are quicker and simpler to administer (Thomas & Brubaker, 2000). However, Anderson and Braud (2011) suggested surveys may not always be efficient, as respondents may answer without reading the questions. Face-to-face interaction enables the interviewer to assess participants' behavior, attitudes, and interest level.

Knowing these advantages and disadvantages aided me in organizing interviews so that I could determine the real reasons behind EDs in women. To study the phenomenon, it was important to interview real women who offered real information in real time. I collected qualitative data in the form of descriptions, opinions, quotes, anecdotes, and interpretations (Leedy & Ormrod, 2005). Through this approach, women had the liberty to share their views and opinions in a transparent manner, with their privacy, confidentiality, and anonymity secured from any unapproved third parties. In seeking outcomes and results, I critically analyzed the collected responses along with secondary data.

Data Analysis

Data analysis requires analyzing collected data and information in a way that leads to relevant outcomes and results (Babbie, 2010). In this qualitative study, I expected data analysis to reveal relationships, trends, and patterns from interviewees, enabling relevant conclusions. Accurate assessment and understanding of data and available information are therefore necessary (Vogt, Gardner, & Haeffele, 2012), making it critical to examine data in an interpretive manner in line with the phenomenological approach (Newton et al., 2006). Interpretive phenomenological analysis (IPA), as described and applied by Smith et al. (2009), was appropriate. While Smith et al. described six IPA data analysis steps, they and other phenomenological researchers (e.g., Brocki & Wearden, 2006; Newton et al., 2006) have encouraged using the steps as a guide, with principles adopted according to the needs of each study.

I modified a version of the procedure for this study (Appendix B) to reflect on collected data—listening to audio, rereading notes on observations (Flowers, Smith, Sheeran, & Beail, 1997; Smith et al., 2009)—soon after the first formal interview to avoid losing critical information. Before beginning any analysis, I transcribed each audio-recorded interview verbatim, a necessary step in collecting phenomenological data, because the goal is to hear more of interviewees' opinions, experiences, and views as accurately as possible, and less of the researcher's (Denzin & Lincoln, 2013). To allow enough time for data analysis (as described in Appendix B) of each transcript, I scheduled interviews at least five days apart.

Researchers must ascertain whether formative evaluation or summative evaluation is required, as both types of analysis are useful. Summative evaluation requires adjusting the analysis process in accordance with the flow of information. I selected formative evaluation for this study, as it is improvement-oriented, based on collecting data and information as it comes, rather after collecting all data.

A qualitative study is complete when sufficient analysis has occurred of not only words and data, but also attitudes, behaviors, and moods (Patton, 2015). For this study, a qualitative research design was more effective than quantitative, because it allowed participants to share their personal views on and experiences with EDs and provided more possibility of definite findings.

Instrumentation

As the researcher in this phenomenological qualitative study, I was the main instrument for gathering data (Patton, 2015), with materials including an interview guide

(Appendix A), data recording audio device, journal for field observations and note-taking, and data storage materials to ensure sound data collection, analysis, and secure storage. I conducted in-depth phenomenological interviews lasting 45 min to 1 hr with 10 women ages 18 to 24 years from Southwest Ohio. Additional, important data collection instruments included observation sheets, on which I recorded observations, information, and field notes; audio tapes for recording interviewees' perspectives and opinions, with consent; pens for taking notes or making textual changes; and additional supporting documents. Interview locations were comfortable, consisting of a chair, desk, or table in a clean, private, well-lit room. Because EDs are sensitive subjects, it was important that participants feel comfortable in communicating their experiences as accurately as possible. Archived and historical data previously published by reliable sources served as points of comparison. Data collection instruments were ideal and sufficient to record all direct contact with interviewees and answer the research questions.

Pilot Study Procedures

I conducted a pilot study to ensure the interview questions answered the research questions. According to Groenewald (2004) and Patton (2015), thorough preparation for qualitative interviews, along with ensuring proper operation of interview equipment and materials, are of utmost importance, especially when there is little time to troubleshoot technology or repeat interviews. In the pilot study, I conducted one-on-one interviews with volunteers in the same population as the general study: women ages 18 to 24 years who are residents of Southwest Ohio.

Exiting the Study

At the end of the interview, participants heard again that all information would remain confidential and they were free to withdraw from the study at any time. As Smith et al. (2009) observed, maintaining participant trust is important, as ethical research is dynamic and ethical practices must be maintained to ensure participant safety.

Verification of Trustworthiness and Authenticity

Without rigor, reliability, and validity, research loses its value (Creswell, 2013a; Guba & Lincoln, 1989; Lincoln & Guba, 1985; Patton, 2015). Demonstrating rigor in qualitative research means collecting, interpreting, and presenting data and results in such a way as to convey trust that researchers measured what they intended, and the results truly represent what they wanted to measure (Creswell, 2013a). Similarly, establishing and demonstrating credibility, transferability, dependability, and confirmability are necessary components of achieving trustworthiness (Lincoln & Guba, 1985) or verifying results (Creswell, 2013a), as well as establishing credibility of the qualitative research, as outlined in Patton's (1989, 2015) five criteria of qualitative data evaluation. Accordingly, I followed Lincoln and Guba's (1985) criteria of credibility, dependability, transferability, and confirmability to establish trustworthiness.

The purpose of this study was to understand EDs and their determinants from the viewpoints of women ages 18 to 24 years in Southwest Ohio. I hoped that results would not only close the information gap on these mental illnesses, but also inspire and add to the research that will help these young women talk about how ED affect them, so they can get the timely assistance they need (Stein, 1996; Wingfield et al., 2011). It is

important that results accurately present views, perspectives, and opinions of these young women; along those lines, Lincoln and Guba's (1985) criteria for qualitative research evaluation helped to establish the trustworthiness of the study. According to Lincoln and Guba, establishing trustworthiness in qualitative research requires four criteria: dependability, credibility, transferability, and confirmability. Application of this approach in similar qualitative studies is well documented (Creswell, 2013a; Groenewald, 2004; Patton, 2015; Silverman, 2013; Smith et al., 2009).

Dependability

In qualitative research, dependability is demonstrating findings consistency and research repeatability (Patton, 2009). In this study, dependability came from describing each study process in detail, so someone else could follow the same procedures and achieve similar findings. Specific to qualitative research, dependability refers to method and not results, because results are connected to a particular point in time and may not be repeatable (Patton, 2009); however, this does not diminish the dependability of the research (Lincoln & Guba, 1985). I maintained detailed documentation such that a future researcher could conduct or repeat the study, as needed.

Credibility

According to Lincoln and Guba (1985), credibility is one of the most important criteria for demonstrating trustworthiness in qualitative research. Credibility ensures a study's internal validity (Creswell, 2013a), in this case measuring participants' opinions, views, and perspectives on EDs. I utilized prolonged engagement and persistent

observation to establish confidence in the truthfulness of results (Patton, 2009; Shenton, 2004).

Prolonged engagement. To gain an in-depth understanding of the scope of EDs in Southwest Ohio, I reviewed literature on EDs in general, as well as specific to the region (ODH, 2013a), before data collection began. Regional reviews shed more light on the significance of the phenomenon in Southwest Ohio.

Persistent observation. While prolonged engagement provides scope, persistent observation affords depth (Lincoln & Guba, 1985, p. 304). Persistent observation helped to identify elements and characteristics most relevant to young women's experiences with EDs. The process also helped me focus on these elements in more in detail (Creswell, 2013a), and guided me in witnessing and notating nonspoken communication in the field journal during interview sessions.

Triangulation

According to Shenton (2004), triangulation is important in qualitative studies, because "a single method can never adequately shed light on a phenomenon. Using multiple methods can help facilitate deeper understanding" (p. 73). Patton (2015) found triangulation important to ensure results provide an account that is rich, well established, comprehensive, and robust. In this study, triangulation of theories and data sources helped produce thick and rich descriptions of results. Data triangulation came from field observational notes, interview transcripts, audio tapes, and literature review. Following data collection, I used multiple theories and perspectives to interpret each set of data, thereby achieving theory triangulation. This also increased validity by ensuring

comprehensive information gathering and thorough data analysis. The use of audit trails is another form of triangulation (Patton, 2015; Smith et al., 2009), leading to added validity.

Member Checking

Member checking is additional tool I used to establish the validity of research findings. In qualitative research, member checking is also known as informant feedback (Saunders et al., 2007), an important technique to improve the accuracy, validity, and credibility of research studies (Creswell, 2013a; Lincoln & Guba, 1985). I also used a number of subcategories of member checks, such as narrative accuracy checks, descriptive validity, theoretical validity, and evaluation validity, giving the transcription to participants to ensure its authenticity and reliability. Their comments served as an accuracy check on findings and interpretations (Patton, 2015).

Member checking occurred both during the interview process and at the conclusion of data analysis as a way to increase credibility and authenticity, and to build honest and transparent rapport with participants. This was an important confirmation, as a phenomenological study and results must accurately represent participants' points of view (Smith, 1996; Smith et al., 2009). In this study, the advantage of member checking was that it gave participants a chance to provide feedback on my interpretation of results to ensure accuracy (Lincoln & Guba, 1985). After each participant had the opportunity to comment on research findings and agree to updates, member checking was complete. All participants appreciated this type of research, so no results needed to be shared with them.

Transferability

While a small sample size limited transferability in this and similar qualitative studies (Lincoln & Guba, 1985), sufficient data compiled via thick description produced adequate information to allow for data transferability (Shenton, 2004). I used thick description to establish transferability. To ensure the collection of all information, as well as provide a thorough and detailed description of EDs as perceived by each participant, I thoroughly analyzed collected data. Such comprehensive records provide a certain degree of external validity in qualitative research (Lincoln & Guba, 1985); with sufficiently detailed descriptions, the reader is able to evaluate the degree of conclusions applicable to similar people, settings, situations, and times (Cohen & Crabtree, 2006).

Confirmability

According to Lincoln and Guba (1985) and Creswell (2013a), confirmability of results is the extent to which research results and accounts of findings are free from researcher interest, bias, or motivation, and shaped solely by respondents. Techniques for establishing confirmability of findings in this study included audit trails and triangulation.

Audit trail. An audit trail is an accurate, transparent, well-organized, and detailed account of research steps from beginning to end, through development to reporting of results (Angen, 2000; Smith et al., 2009). Audit trail categories followed Hapern's approach (see Lincoln & Guba, 1985), raw data, data reduction and analysis products, data reconstruction and synthesis products, process notes, and materials relating to intentions, dispositions, and instrument development.

Reflexivity. Researcher bias is a threat to internal validity in qualitative research studies (Lincoln & Guba, 1985). Transparency regarding bias is important in qualitative research, because "a researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions" (Malterud, 2001, pp. 483–484). As such, bias check is an integral part of establishing trustworthiness in qualitative research such as this. By applying the technique of reflexivity—constantly acknowledging potential biases and documenting procedures undertaken to reduce or prevent personal biases from entering into results—I achieved validity and confirmability of findings. As part of bias check, I maintained a reflexive journal for conducting ongoing bias checks throughout the study. Because information gathered pertained to young women's perspectives of EDs, the data are their opinions and not mine, thus eliminating the possibility of researcher bias. Reflexivity helped to keep bias in check over the course of the study (Lincoln & Guba, 1985).

According to Smith et al. (2009), the choice of qualitative methods and strategies depends on a study's particular objectives, as techniques that fit one situation or method may not be appropriate for another. The validity techniques and approaches I selected were appropriate, because they best fit the purpose and objectives of the study (Groenewald, 2004). Verification methods help researchers ascertain the validity and reliability of interviews and findings in a critical manner (Creswell, 2013a; Lincoln & Guba, 1985; Patton, 2015; Reed et al., 2005; Roulston, 2010) according to principles of the qualitative research paradigm and the phenomenological approach. Using methods

well established in similar studies further increased the validity of the research (Groenewald, 2004; Smith et al., 2009).

Summary

The purpose of this study was to examine perceptions of EDs among young women in Southwest Ohio. The objective was to learn how the target population experienced, viewed, and described EDs and related determinants. Women face EDs due to a number of factors, making the identification of key reasons for these behavioral and mental illnesses a daunting task (Bulik et al., 2007; Morse, Barrett, Mayan, Olson, & Spiers, 2002). My goal was to ascertain perceived individual, interpersonal, and community factors affecting EDs, in an attempt to address the issue from the points of view of those most impacted and to prevent diseases before they happen. A phenomenological approach with personal interviews was best, as it tends to focus more on personal observations and perceptions regarding a wide array of experiences. In addition, purposive sampling is both effective and less expensive (Patton, 2009).

I maintained a high level of honesty and transparency in accordance with guidelines for research on human subjects, thus ensuring an ethical study. Participants received invitations and consent forms, with their personal details kept confidential. I collected data from interviews, which I correlated with the research interpretation and summary as accurately as possible. Credibility, dependability, transferability, and confirmability techniques, as described by Lincoln and Guba (1985), facilitated the trustworthiness of findings.

This purpose of this chapter was to explain in great detail chosen methods and procedures for the study on young women's experiences, thoughts, and beliefs about EDs. In Chapter 3, I reviewed data collection, data analysis, and storage techniques, as well as discussed recruiting and ethical considerations to protect participants from harm. In Chapter 4, I detail the data collection and results analysis process.

Chapter 4: Results

The purpose of this qualitative phenomenological study was to understand EDs from the perspective of young women ages 18 to 24 years, the primary group impacted by disordered eating due to their high vulnerability to sociocultural and socioenvironmental determinants of EDs. The sociocultural model of EDs helped me to ascertain why ED incidence continues to rise in this population; this model postulates that internalization of the thin ideal in young women leads to body dissatisfaction, with subsequent negative effects and dieting behaviors that increase the risk for ED development (Allan and Goss, 2014). I collected data on lived experiences of EDs from the population most at risk to present findings augmenting public health research on EDs and their prevention. Implications for positive social change included an improved understanding of sociocultural influences on EDs in participants' lives.

Three research questions and four subquestions guided the study. Research questions focused on the perceptions, attitudes, and opinions young women had of EDs, their physical image, and factors that influence ED development. Subquestions addressed the young women's behaviors, family relationships, and social norms in comparison to their perceptions of EDs.

In this chapter, I detail the pilot study, interview process, participant demographics, data collection procedures, study setting, data analysis process, and themes. I also describe steps taken to ensure data quality and trustworthiness.

Research Questions

Three research questions were used to guide the study:

Research Question 1: How do young women (ages 18 to 24 years) perceive eating disorders?

Research Question 2: How do young women (ages 18 to 24 years) view their physical appearance and attractiveness?

Research Question 3: How do young women (ages 18 to 24 years) perceive individual, interpersonal, and community factors that influence the development of eating disorders?

Subquestions

Subquestion 1: Do young women (ages 18 to 24 years) see themselves as at risk of developing an eating disorder?

Subquestion 2: What is the influence of peer pressure on young women's behaviors and attitudes related to their weight and appearance?

Subquestion 3: What is the influence of family relationships and views on young women's eating behaviors and attitudes related to their weight and appearance?

Subquestion 4: How do current social norms influence eating behaviors, beliefs, and perceptions of body image in young women?

Pilot Study

After obtaining Walden University IRB approval, I conducted a pilot study with three young women from Southwest Ohio ages 20, 21, and 23 years. So that I had sufficient time to analyze the data and make sure questions were relevant and elicited

sufficient data to answer research questions and satisfy study objectives (see Kvale, 1996, 2009; Smith et al., 2009), I conducted the pilot study one week before beginning data collection for the primary study, allowing time for any necessary adjustments. In qualitative research, a pilot study helps improve the efficiency and effectiveness of the actual study (Kvale, 2009). To maintain privacy and confidentiality, I interviewed each pilot participant individually on different days at different times. The pilot study helped me confirm the interview protocol and provided me with experience conducting interviews.

The three pilot study participants were between the ages of 18 to 24 years, from Southwest Ohio, and able to communicate effectively in English. Participants were willing to share their personal accounts and perceptions of EDs, along with the factors that influenced their attitudes regarding personal image, attractiveness, and subsequent risk of developing EDs. After they expressed interest in the study, I contacted potential participants via telephone and email. They signed a consent form, and then confirmed their availability for an interview in a community library private study room at a mutually convenient date and time. Before each interview, I asked the respondent if she would like to receive interview transcripts and study results; however, none were interested. Each participant, however, expressed appreciation that an ED study was occurring.

After switching on the recorder, I asked the interview questions and took observation notes. Depending on the answers I received, I often included additional prompts and recorded responses in a notebook. Each interview lasted 45 to 60 min, after

which I expressed gratitude and confirmed that information provided would remain confidential.

The pilot study was successful. The recorder functioned without technical problems and recordings were clear and free from external interferences, confirming suitability of the venue. Clearly recorded interview data are critical in a qualitative research study (Patton, 2015), as without proper preparation, technology may disrupt interviews (Kvale, 2006, 2009). Following the pilot study, I determined no adjustments were necessary regarding interview questions, as they were comprehensive and detailed enough to solicit responses that met the study objectives.

Setting

For the actual study, all interviews took place in Southwest Ohio, in either a private study room at a local library or a private conference room at a local restaurant. With the exception of one participant, all opted to meet at a library. The quiet nature of each location provided an ideal atmosphere for conducting interviews; similarly, the absence of background interference and noise enhanced the accuracy and quality of recordings (see Patton, 2015) and enabled participants to open up, knowing what they said was not audible outside the room. Chairs in the library's private room were comfortable, allowing participants to sit for the interview without having to stretch or ask for a break.

Each participant looked relaxed and seemed familiar with the environment. I arrived at least 15 min early to set up the consent forms, audio recorder, and interview materials, and to relax and prepare myself to welcome interviewees. This step is crucial

in qualitative research, because as the researcher, I was the main instrument (Patton, 2015) and had to be thoroughly prepared. When each participant arrived, I welcomed her with a cheerful smile, eye contact, and a handshake, and then offered her a place to sit. After briefly chatting, I presented the consent form if she had not signed ahead of time, and then reiterated the purpose of my study

According to Smith et al. (2009), ethical research practice is a dynamic process that needs to be maintained from IRB approval throughout data collection and up to results publication; accordingly, avoidance of harm to study participants was one of my primary roles. I emphasized the voluntary nature of the study and privacy of shared data, and then gave participants time to ask questions before the interview. My intent was to make participants feel more comfortable with me before the interview started. As in the pilot study, the library study rooms as well as the restaurant conference room were ideal for these interviews, with no background or environmental interferences.

Demographics

Selecting an ideal target setting and population is critical in qualitative studies (Becker et al., 2014; Creswell, 2013b). Fluency in English enabled participants to read the flyer, self-identify as suitable for the study, read and understand the consent form, speak and communicate effectively, share perceptions of EDs, and add extra information when necessary. Ten young women who met these criteria participated in this study, with each being residents of Southwest Ohio for at least two years, fluent English speakers, between the ages of 18 and 24 years, and willing to share their views, perspectives, and experiences on the determinants of EDs.

Two of the participants were White: Participant 4 (P4) was a college graduate working as a cosmetologist and P10 was taking time off work to recover from AN. Originally from India, P3 had recently graduated with a Master's degree in Chemical Engineering and was working part-time while looking for a permanent job. P7, who was Hispanic, was a junior in college and living with her mother. Of Asian descent, P5 was a receptionist at a local nursing school. Finally, five participants were of African descent: P1 was a recent college graduate working in research at a local corporation; P2, a college freshman, worked part-time as a receptionist at a local hospital; P6 was a senior in high school, an athlete who lived at home with her family; P8 was studying to be a nurse's aide at a local nursing school; and P9, having studied physical education in college, worked as a personal trainer.

Data Collection

Using one-on-one, face-to-face interviews as the primary method of data collection, I gathered information from all 10 female participants ages 18 to 24 years. Interview questions in qualitative studies are an extension of research questions (Patton, 2015); as such, I designed 14 questions accordingly (Smith et al., 2009) focused on participants' perceptions of ED determinants, lifestyle risks, and opinions about personal image and attractiveness (see Appendix A). Depending on participants' responses during the interview, I asked follow-up questions when necessary (Kvale, 2009; Smith et al., 2009). To go through all questions and allow participants to comfortably express their views without feeling rushed, each interview took 45 min to 1 hr. This is in line with

Patton (2009), who found no set limit for either the number of question or the duration of the interviews in qualitative research.

I recorded all interviews using a digital audio recording device designed and recommended for qualitative interviews. Participants expressed genuine interest on the topic and showed enthusiasm, with each welcoming questions and appearing pleased to be there. As they answered my questions, I wrote down observations so as not to miss unspoken responses (Kvale, 2009; Smith et al., 2009). A secondary data source, these notes supplemented the audio recordings (Patton, 2015). Participants' body language, tone, and expressions revealed their comfort with and interest in the study.

Following each interview, I listened to audio-recorded data twice or more to fully understand and immerse myself in what the participant communicated (Kvale, 2009; Smith et al., 2009). I transcribed their responses verbatim, reading them several times to identify common and recurring themes (Smith et al., 2009). I used Microsoft Word for this, after which I analyzed data in NVivo 11.

Data Analysis

The first step in data analysis was to read and reread all transcripts to gain a deeper understanding of participants' words. I used the six IPA steps (Smith et al., 2009) to gain a deeper understanding of each woman's personal views, experiences, and thoughts on ED determinants, followed by modifications (see Appendix B). The steps were as follows: (a) identifying common themes emerging from the responses; (b) looking for relationships or connections of these themes across the collected data; (c) adding reflection notes for themes in relation to the research questions addressed;

(d) summarizing themes; (e) creating a list of final themes; and (f) writing a comprehensive report of my findings.

Formative evaluation, rather than summative evaluation, was appropriate for data evaluation (Creswell, 2013a), because I needed to also analyze data as it was collected, rather than only at the conclusion of all interviews. According to Smith et al. (2009), conducting data analysis soon after an interview is important in qualitative study to capture and understand what the participant was trying to present. Similarly, performing analysis immediately after the interview meant that participant-provided information was still fresh in my mind, making it easier to connect spoken and unspoken messages (Kvale, 2009). After I concluded analyzing responses from all 10 participants, I analyzed the entire data set as a unit to connect themes across all collected information. Although the approach was time-consuming, it was necessary to ensure comprehensive capture of all information. The approach helped me to maintain critical information and build an in-depth data set (Kvale, 2009; Patton, 2015).

As this research project progressed, I noticed repetition of themes I had identified in previous interviews. I reached data saturation, as defined by Patton (2015), at P8, with no new perspectives or themes emerging from P9 and P10. Even so, I completed analysis of all 10 transcripts to ensure complete data analysis and saturation. Reaching data saturation with a sample size of 10 was in line with the recommended sample size of 10 to 15 suggested by Lincoln and Guba (1985) and Patton (2015) as sufficient for qualitative study.

I transcribed all interviews in Microsoft Word, creating a table to track the different themes identified during analysis. Through a systematic review of transcripts, I was able to connect themes to the three research questions and four subquestions, extracting main ideas, compiling data, and identifying, noting, and summarizing subthemes.

I rereviewed all transcripts to ensure exhaustive data analysis, noting any new themes and connecting them to the previously identified themes. After composing a final list of themes and subthemes, I sifted through all data, noting ideas that answered my research questions and discarding others that were not relevant. These actions are in line with qualitative data analysis, in which the study owner is responsible for making sense of data collected from each study participant (Lincoln & Guba, 1985).

For an item to appear on the list of themes, text must have supported it; Microsoft Word's search function facilitated this determination. NVivo 11 was a significant tool in relevant assessment of text that supported themes. I used NVivo 11 to more effectively organize and store analyzed data, and then manually analyzed data in Microsoft Word. Finally, I condensed data into themes with relevant supporting text so as to answer the research questions.

Evidence of Trustworthiness

Because qualitative research without rigor loses its value (Patton, 2015), I took all measures necessary to maintain research trustworthiness through reliability and validity (Creswell, 2013b). Qualitative research is trustworthy when it accurately represents the

experiences of the study participants (Creswell, 2013a; Patton, 2015); thus, I presented the interviewees' true views and perspectives.

In qualitative studies, data trustworthiness requires through validity and reliability of results (Lincoln & Guba, 1985; Morse et al, 2002). Rigorous qualitative research requires the collection, presentation, and interpretation of results in such a manner as to assure a general reader the evaluations and results are a true reflection of what the researcher measured (Patton, 2015). Prior to conducting interviews, I ensured participants met study criteria. To achieve a high level of data trustworthiness, I used the four criteria of measuring trustworthiness in qualitative research (Lincoln & Guba, 1985)—credibility, dependability, confirmability, and transferability—a well-documented historical approach in evaluation of similar qualitative studies (Creswell, 2013a; Groenewald, 2004; Silverman, 2003; Smith et al., 2009; Patton, 2015).

Credibility

Credibility is one of the most important criteria for demonstrating trustworthiness in qualitative research (Lincoln & Guba, 1985; Patton, 2015). I achieved credibility by applying the four techniques of prolonged engagement, persistent observation, triangulation, and member checking, thus ensuring internal validity (Creswell, 2013a). In this way, I measured participants' opinions, views, and perspectives on disordered eating, thereby establishing confidence in study findings. Prolonged engagement involved reviewing data from ODH (2013a, 2013b) on EDs so as to develop in-depth understanding of this phenomenon (Patton, 2009). Persistent observation helped in identifying specific elements relevant to the study. This technique complemented

prolonged engagement, adding depth to the scope of the study. Additionally, interview observations enhanced credibility by capturing unspoken communication relevant to the study.

Method and theory triangulation facilitated deeper insight of the study and results through the use of multiple methods and theories. Triangulating data sources allowed for rich, robust, and comprehensive compilation of results. Specifically, I achieved data triangulation by connecting reviewed literature to research findings, observational notes, audio recordings, and interview transcripts. Different theories enabled multiple points of view when identifying themes (Kvale, 2009; Patton, 2015). Audit trails detailing transparency and beginning-to-end processes are available, including consent forms, letter of invitation, and the study recruitment flyer, providing the reader with a complete description of the research steps, from the start of the study to the development and reporting of findings (Patton, 2015; Silverman, 2003; Smith et al., 2009). Member checking (Saunders et al., 2007) involved participants providing feedback on my evaluation of their responses. All participants consented to receive a copy of their interview and the final research findings, thus allowing for member checking.

Dependability

Dependability comes from demonstrating consistency of research findings and repeatability of research (Patton, 2015). In this study, I maintained consistency throughout the study, including interview preparation and administration, audio transcription, and theme identification (see Appendices). I followed research methodology and procedures in detail, making these documents available for another

researcher to conduct the same study using the same procedures and arrive at the same results; this is known as dependability.

When asking interview questions, I avoided researcher bias (Patton, 2015), posing additional questions only when the situation demanded. Building a rapport helped interviewees freely express themselves, providing honest opinions and perceptions of EDs and personal image.

Transferability

Maintaining transferability is challenging in qualitative studies (Shenton, 2004) due to small sample sizes. Using a relatively small sample size of 10, I needed to thoroughly document every detail provided by participants. Thick description enabled me to extensively analyze all data and ensure no information was left out (Cohen & Crabtree, 2006) as I explored participants' perceptions from both critical and analytical angles. When results are detailed enough, as was the case with my thorough documentation of participant responses, readers can easily judge if conclusions may be applicable to similar situations or settings (Cohen & Crabtree, 2006).

Confirmability

I avoided researcher bias by shaping results exclusively from research participant responses (Patton, 2015) using audit trail and reflexivity techniques (Smith et al., 2009). The audit trail ensured adherence to the necessary steps in the study, with an accurate, transparent interview process leading to the development and presentation of research findings. Audit trails included raw data processing, data reducing, product analysis, data reconstruction, process notes, and product synthesis.

Reflexivity involves acknowledging bias is likely and putting measures in place to avoid it. I maintained a reflexive journal to record any step that appeared biased, and then paused to review the step and make any necessary adjustments. Qualitative studies involving opinions and perceptions have a high risk of bias (Smith et al., 2009); therefore, I took care to ensure results were free from bias, reflecting the participants' opinions and not my own. A researcher further mitigates bias by articulating any limitations or other elements that may interfere with confirmability of results.

Results

Participant responses revealed themes to be relevant and to answer all research questions and subquestions. I conducted this study to examine the perceptions of EDs among young women in Southwest Ohio. Women are at risk of EDs for a number of reasons (Loth et al., 2014), and identifying a key cause can be a daunting task (Bailey et al., 2014). However, focusing on widely researched areas may inspire questions that lead to less-understood underlying and identifying factors

Research Questions

Three research questions and four subquestions guided the study:

Research Question 1: How do young women (ages 18 to 24 years) perceive eating disorders?

Research Question 2: How do young women (ages 18 to 24 years) view their physical appearance and attractiveness?

Research Question 3: How do young women (ages 18 to 24 years) perceive individual, interpersonal, and community factors that influence the development of eating disorders?

Subquestions

Subquestion 1: Do young women (ages 18 to 24 years) see themselves as at risk of developing an eating disorder?

Subquestion 2: What is the influence of peer pressure on young women's behaviors and attitudes related to their weight and appearance?

Subquestion 3: What is the influence of family relationships and views on young women's eating behaviors and attitudes related to their weight and appearance?

Subquestion 4: How do current social norms influence eating behaviors, beliefs, and perceptions of body image in young women?

Participants gave thorough responses to all 14 interview questions, and also welcomed probing queries. Each participant enthusiastically shared her views of how significant a role social media plays in the development of EDs. Following data collection and analysis, I concluded that, while EDs are a mental struggle, these illnesses are mainly triggered by external factors, particularly social media. Transcripts and themes correlate to specific research questions, as follows.

Research Question 1: Theme 1

All participants demonstrated an understanding and basic knowledge of EDs, identifying them as real illnesses that require treatment. I provided an opportunity for each young woman to elaborate on her responses by either giving an example of an ED or

describing the behavior(s) associated with EDs. Participants expressed strong concern about how EDs affect their age group and young women in general. Eight participants described having knowledge of EDs from secondary personal experiences, with the remaining two having personally suffered from an ED at some point. One of these women (P10) had received a clinical diagnosis; the other (P1) knew by her symptoms that she had an ED. I asked two specific questions to ascertain this information: "Can you tell me what you understand or know about eating disorders?" and "Are you aware of any eating disorder screening tools accessible to you?" In response to these questions, P1 said:

> What I know mostly about eating disorders comes from television and the media. I personally do not know anyone with eating disorders. I guess, traditionally people with eating disorders are those who binge eat, purge, or those who do not eat at all. I have seen eating disorders on the other side where people eat a lot. I have seen that, too. On television, eating disorders are usually explained as bulimia, where people eat a lot and then purge, and anorexia for those who do not eat at all. So I can say that anorexia and bulimia are the main two eating disorders that are mainly explained on television

Similar to P1, P4 responded with enthusiasm, attributing her knowledge of EDs to the media and adding that she personally knew people with EDs:

> Um, I know that it is something that does affect younger women of my age, like I know a few people who have struggled with eating disorders. I know it's something that really happens; that's just about it. I have seen people on Netflix

> talk about it. I see a lot of people talk about it on social media, especially among younger women.

P2 showed concern for her generation as she described her personal experiences regarding EDs among young women:

> There are many different types of eating disorders and they affect both male and females. In my opinion, I feel like they mostly happen among younger girls, like in the middle school, junior high school years. I think so because of what I remember going through when I was in junior high and middle school. See, I have always been small, so people would say that [I was] anorexic. When I was in seventh grade, I weighed like 75 pounds and people commented on that. You would hear girls commenting on anyone's weight and appearance. It still happens even now in my 20s. But back then, people always commented. If someone was big or small, people always made sure they make the person know, but not in a nice way.

P5 knew more about EDs. She described EDs and associated behaviors, but did not know anyone from personal experience:

> I think eating disorders is described as people with anorexia and people with bulimia. Anorexia are people who do not eat pretty much; they are concerned about appearance, so they think they are overweight and they think they do not need to eat, so they exercise and try to lose a lot of weight. Even when they are bony, very skinny and bony people with anorexia think they are way too fat. The other one, bulimia, are people who involve in binge eating. Bulimics consume a

> lot of food and I am told they go to the bathroom to throw up purposely and get rid of the food. They make themselves throw up the food. People with bulimia still want to eat, but they do not want the food to stay in their body. And these types of people probably do have normal weight but they will have some other health issues. But both bulimic and anorexic people end up having health issues, including mental health issues, because psychologically there is an issue there to make them do things like that.

At 18 years of age, P6 was the youngest of the participants and still in high school. She described extensive exposure to EDs among young women:

> From what I know, there are different types of eating disorders. Some eating disorders are where people eat large amounts of food, bingeing, or not eat at all. Furthermore, some even eat things that are not even considered edible. For some people it's because of the way they look, and for some people it's due to emotional issues they may be going through or psychological or an addiction of some sort. Eating disorders are about appearance. Of course, I am still in high school, so I actually see a lot of this. It's something like people do not like the way they look, so they feel like if they eat, they will keep getting bigger and bigger, while in reality it's actually not. So people with eating disorders, especially anorexia, have a fear of how they look.

Although she admitted having little knowledge about EDs, P3 was concerned with the severity of this issue among young women:

> Very frankly, I do not know much about it, but I know that it is highly prevalent in this generation. Especially from the age of 18, where teenagers mainly suffer from eating disorders, leading to different psychological issues, as well. It is a very rampant issue, which needs to be nipped in the bud so that it does not progress into a much further, uh, bigger issue. I do not really know anyone with [an] eating disorder, but I read in articles about how this is more rampant and a growing issue in the past 10 to 15 years than it was before, especially in teenagers.

Having previously recovered from AN, P10 described EDs with greater emotion:

> Oh, wow, just that question alone brings back the pain of what I experienced when I was 16 going on to 18, when I was diagnosed with anorexia; it was so bad that I had to stay in a recovery institution. When you hear the word "anorexia," it's like it's not a big deal, but for the person going through it, it's suffering in silence. When I looked at myself in the mirror, to me I looked like an elephant. People were telling me that I was skinny, but I did not see that; I saw myself as this giant, ugly elephant. Every day I wanted to be more and more skinny. It was so bad that when my dad gave me food, and when he left to go for the shower or something, I would dump the food into the trash and take the trash bag outside so that he would not find out. So it was a long time before my dad knew. My father only came to know when I got so sick that I could not get out of bed. The fact that I was sick and that I did not see it, that is the sickness. It's a mental illness; you

see what is not there. The weight loss and skinny look is only an outward appearance, but the root cause for me was in the mind.

I got help when I was close to suicide, so I was taken to the institution. There at the institution we were not allowed to look in the mirror or weigh ourselves. My illness was severe so I stayed there for six months. Other girls stayed only for three months, but I stayed longer due to the severity of my condition. Thank goodness, I survived. At the age of 16, I was 55 pounds, but today I weigh 110 pounds. Some girls are not as lucky as I am. We have a support group of the alumni, so we keep in touch. My main support for recovery were the nurses, so that is why I want to be a nurse. Right now I am on break from school, because after high school, I decided to take time off, but after next fall, I will start my nursing program in college. I believe in God, so I believe that that God saved my life through those nurses.

Because she was born outside of the United States, P8 framed her knowledge of EDs with reference to cultural differences:

Yes, I'm from Africa. I have heard about eating disorder, but it is not pronounced in my place. It is when I came to America that I learned that eating disorder is an issue. In Africa, you talk of food to eat, yeah, but it's different here, I think because food is too cheap so people can now decide to eat whatever they like. In Africa, people don't get too fat—we exercise and move a lot—but here, I came and see that people are fat, fat, fat. I think in this country, people do not have to worry about lack of food. There is plenty of food and it's cheap, and people do

> whatever they want to do so people eat and eat and eat, and they do not exercise much; it's from the car to wherever. But in Africa, the way we live, we are always active so this is not there; we move a lot in Africa so we do not have eating disorder. The word "disorder" for me means that people are not eating in an ideal way; they are not eating in conformity to how they are supposed to eat. Instead of one bowl of rice, a person eats plenty. So, eating disorder either a person is eating too much or eating too little for reasons best known to the person, maybe psychological reason. People talk about, "Oh, this person is frustrated and has a lot of stress," and I tell them that in Africa, people do have a lot of stress, but no one has eating disorder because of stress.

She continued:

> We have a lot of stress in Africa, but people are still moving. Here, people eat and eat and they say to ease tension, and I say what is their tension? And the one family said that a high school child eats and goes to the bathroom to vomit everything. They say the child is stressed and wants to commit suicide. I say what is this really? It's not normal, so I think it's a mental illness. Sometimes you hear that, "Oh, the child wanted to look like someone else," this actress or whatever, so they do not want to eat. This is really all new to me. It's not normal. This is psychological, honestly. In my place, a person with mental illness will get a hard time to get married. Because they feel that there is madness in the family, so people do not want to associate themselves with that. But here, everything is accommodated, and children can do whatever they like. A teenager can lock

> themselves in a room and vomit, but in Africa, you cannot hide from your parents. Here a child can either be eating and vomiting or not eating at all and the parents will not know. In my place, the parents know everything. I also think that here all this is abuse of what is available.

P9 had no particular reference for EDs, but was aware of them in her own way:

> Eating disorders are problems connected to eating, and the disorder could be in the form of diseases that are directly associated with eating. Those diseases may also affect other things in the person because food is for nutrition and important to us. So, if there is a disease of eating or associated with food, this will also affect our body, brain, and our health in general. So, eating disorders are a big problem to human nature, because the diseases are also affecting our mental and psychological health. Eating disorder is more about a general outlook in life, as well.

When asked about their awareness of ED screening tools, all 10 participants demonstrated surprise that there were diagnostic tools for EDs. As P4 explained, "I think that because eating disorders are not as popular as mainstream diseases like cancer, they are just put in the back burner." P7 responded:

> No, I don't know. I know they screen breast cancer but not eating disorder. I only know that if someone has eating disorder, I just know that if you see them, you will know. You can see the effects if someone has eating disorder, either they are too skinny or too fat. It's the look or appearance, but if someone has breast cancer, if they dress up, you cannot tell.

Research Question 1: Theme 2

After having discussed their general and overall understanding of EDs, participants were eager to share their personal experiences with these illnesses. I asked, "Can you share with me if you had any experiences with eating disorders?"; "Have you been diagnosed with eating disorders?"; and "Do you know anyone with eating disorders?" Most of the participants knew someone in their family or circle of friends who had suffered from an ED. Since those with loved ones suffering from EDs had seen them undergo treatment, participants knew that EDs are treatable illnesses (Loth et al., 2014). As P1 explained:

> I personally have never been clinically diagnosed with eating disorders, but as a kid, I was teased a lot for being overweight, although I have not had any issues with actual eating disorders. So no, not on the side of eating disorders. I probably can eat less but I have not been diagnosed with EDs. However, when I was in junior high school, I know of someone, this girl in my neighborhood, who was diagnosed with anorexia nervosa, but her family helped her to get treatment and she recovered. That was a long time ago, and she is fine now.

P3, P4, and P5 said they did not have any personal experience with eating disorders. P6 described the experience of a close friend in junior high school:

> Yeah, I myself have not experienced any eating disorders. But I think when I was in the seventh grade, I had a very close friend; she also had other emotional type of things going on and she would feel like people were mad at her. As a result, she did not want to eat. I even heard some of our friends comment that she does

> not want to eat at lunch. She was responding by internalizing what other people were thinking of her. That is the closest experience I have ever known. She internalized how other people were looking at her or how others thought about her.

Although P7 had not suffered from an ED, she expressed concern:

> No, I have not been diagnosed with any food-related disease, but if I am not careful, I may end up in that situation. I am planning to make positive changes, especially now that I have participated in this study. So even before you have published this study, you are already making positive changes in people.

Asked if she had personal experience with EDs, P9, who majored in physical education in college, said, "No, I don't, personally; I don't and my plan is not to. It is difficult, especially in college life, but you have to make a conscious effort to be healthy." P10 said she is doing her best to stay healthy following successful recovery from AN.

The 10 young women had varied perceptions of EDs based on whether they had experienced them personally or through family and friends, or if they had heard about EDs from social media or television. When participants knew family members or friends who had suffered from EDs, they viewed EDs as having a significantly negative effect on one's life. P7, whose niece developed stunted growth due to an ED, said people needed education on how to avoid EDs because of the harmful repercussions. P10, who had personally suffered from an ED, said she would never want such a thing to happen to her

again. Overall, participants viewed EDs as something that could be successfully treated because they had witnessed recoveries.

Research Question 2: Theme 3

I asked participants, "Can you share with me what and who is your role model for physical beauty, and how you see or view yourself in terms of physical beauty?" P2, who had a small structure and said she was often suspected of having AN, remarked:

> That's a great question. Honestly, I don't have a role model or try to look like someone. I know people always get wrapped up trying to look like Kim Kardashian, like you have a small waist, but I don't have that. I always try to eat healthy and work hard—but I do not have [an eating disorder]. I definitely love myself, but I try to progress, like gain a little weight, because I have problems in that.

Although she easily answered the first part of the question, P1 described unhappy experiences with regard to how she sees herself:

> Ah, that is a very interesting question. With media and a lot of exposure now to media, there are a lot of images that I see. For example, sometimes I see Black actresses in Hollywood and I feel like oh, man, I want to look like them one day. Actresses like Beyoncé or Rihanna and all of them—l thought I can never look like them, but I aspire to be at least stylish like them, maybe. [*She smiles and chuckles.*] About how I view myself—Wow, that is deep. [*She pauses.*] I really don't like myself that much; I think of myself as normal to average. Influences and why: I feel like the media has a part in self-image and self-esteem. Most of

> that for me happened from school time. I was always being told by others that "You are not pretty" or "You are too fat." It drove me into an eating disorder. I went through it, I survived, but it was hurtful.

P3 seemed to find this question surprising, but described her role model and how she views herself in terms of beauty:

> Physical beauty? Beauty is a very subjective. Mmm, I have never thought about that. Are you talking about personal fitness? [*"Physical beauty," I clarified.*] Oh, OK, give me a minute. [*She laughs.*] I need to think about it for a minute. [*She is momentarily silent.*] For physical beauty, I find Blake Lively, the actress, very pretty because she has a really very good personality; it comes across as a natural form; she does not come across as something that is not achievable. That is why I find her very pretty. As a person, I am selectively introvert; it takes time for me to open up to people. But once I know the person, I am more open. I tend to be more quiet and do not voice my opinion as much. I have received feedback from my supervisor at work that I have good ideas, but I do not speak much. My mom also commented that I tend to bog myself down too much. So I am working on that.

P4, who described herself as a plus-size young woman, admitted she had positive role models, describing how comfortable she was with the way she looked and how lucky she was:

> On social media, I follow a lot of plus-size models. For example, one that comes to mind is Ashley Graham—[she] is a plus-size model. I follow women who look like my size, so that I can look at them and say, "Oh, they are gorgeous," then I

> also can look at myself and feel the same way. Personally, I see myself very positively. You know, my mom is about seeing beauty in yourself regardless of size, so that is something she has really instilled in me since forever. I also have a boyfriend who is very supportive of me and loves me for who I am and tells me I am beautiful and stuff like that. I know it seems really shallow, but having people like that around me [has] helped me to be positive with who I am. I would say I am very compassionate, a people person and creative. Compassionate and creative is how I describe myself.

Describing her experiences in relation to body image, P4 said:

> I think, especially for girls, I feel like every girl has dealt with some body image issues in their life. For me, it was really when I was younger during my school days. I remember feeling like I was going thought an ugly duckling phase, but as I got older, I just started making a habit of [admiring] women who look like me and whom I felt looked like beautiful, so I have started looking at myself positively. I mean, I have my days when I feel down, but I guess everybody goes through the same thing.

P7 also praised her family, and especially her mother for being her role model. "My mother is my role model for beauty and how to look good. She cooks healthy food, does exercises, eats healthy, and also tries to relax." P5 also identified her mother as her role model, but in terms of the impact on food choices and eating behaviors she has learned over the years:

> I look at my mother; I know she is not in perfect shape, so she gives me warning that I need to do what I have to do to be healthy. I have her genes, so I know I may become like her when I get older, so I try to be healthy. I know my food choices and eating habits are from her because of the way she fed us. But when I got older, I learned and studied about better food choices and I made adjustments and try to be better at making good food choices. I also try to help my mother to do the same. See, my mother is diabetic, so I am trying to help her to be healthy.

P9 described herself as her own role model for physical beauty due to her educational background:

> Actually, myself. [*"Can you explain, please?" I asked.*] I just graduated from college and I did physical education in school. So physical education is really directed to keeping fit, and keeping fit is not just exercise, it also involves what we eat. So in my physical education degree, I came to realize that to be physically fit, you have to watch what you eat. Your body has to be able to metabolize what you eat. And to be physically, mentally, spiritually, and psychologically sound, you have to be physically fit; you have to eat good food. To be physically fit, you have to watch what you eat and your body has to be able to metabolize what you eat. So me being myself, I challenge myself to be healthy. And actually, I am a role model of people around me to live a healthy life.

P10 echoed the importance of family support:

> I have many people around me. My aunts—they are very good and are not skinny like we see on television. Because, for me, I think that was the main issue, seeing

> skinny women on television, because that made me think that I was too fat. I feel like I am someone who died and came back to life. I mean, I was literally dead. I remember before I went into therapy, just the sight of food alone made me throw up. Now I admire myself in the mirror; I am happy to weigh myself.

After her recovery, P10 is also happy with the way she looks: "I know I do not have to be skinny sick to feel and look good. I can eat anything I want to eat."

Research Question 2: Theme 4

Preoccupation with negative thoughts about oneself is one characteristic leading to body dissatisfaction and subsequent disordered eating (Frederick et al., 2016). To assess participants' thoughts, I asked "How would you describe yourself?" and "Can you share with me your experiences in relation to body image?" Responses were similar, but varied depending on the environment in which each woman grew up, as shown in this response from P10:

> I feel like am someone who died and came back to life. I mean, I was literally dead. I remember before I went into therapy, just the sight of food alone made me throw up. Now I admire myself in the mirror; I am happy to weigh myself. When we were in therapy, everything was monitored: no TV, no mirror, no media of any kind. At one point, they gave me an IV in [the] hospital, my health was so bad. But today I am good where I am. I know I do not have to be skinny sick to feel and look good. I can eat anything I want to eat. I can look in the mirror and see a beautiful young woman.

P4 described herself in relation to how she treats others: “I am compassionate and a people person.” P1 echoed the same as she recalled:

> Looking in a crayon box as a child, I always felt like a bright pink color; I thought to myself, “That is a nice color for me.” I have beautiful and very nice skin, decent eyes. Overall, I always try to be kind and treat people fairly. I always try to have a smile at each person.

P7 described herself as a happy person who needed to make some physical improvements:

> Physical beauty—as I said, I need to lose some 20 pounds or less, but as my mom says, it is good to look good but it’s more important how you view yourself. Right now, I view myself as obese, but that is because of the food I eat outside, because at home my mom cooks healthy food. I need to make better choices for good health and to feel better, but I am not there yet. Well, I am 22 and soon I will be moving out, find my own place, get married or something, and make better choices for my health.

P4, who had described strong family support, also showed a positive self-outlook, saying, “I am hard on myself in a good way. I do a lot of things and try to accomplish a lot. Failure is not an option; I am always trying to better myself, pushing myself to work harder.”

Similar to P7, P3 shared that, although she may look and feel good, there is always room for improvement. She looks up to her father as a role model for healthy living:

> I actually I feel that I really need to lose weight. [*She laughs.*] So for me right now, it's more important than looking pretty or looking at my physical scale. Everybody find[s] themselves to be pretty—like yourself, you may find yourself to be pretty, but expect yourself to be more fit or thin or stuff like that. But for me, I want to lose weight and become more fit in terms of beauty. I would want to lose weight. [*She laughs.*] Mainly because, since I moved to this area, the rate at which I exercised has gone down; I have lost my stamina and energy. I want to go back to get back my stamina. I am only 24, so I feel that I should not lose my stamina. This is something I learned from my father: He is almost 60 but he looks like a normal 30- to 35-year-old, because he is really fit and believes in exercising and does some sort of physical exercise every day. That is a routine that he maintains every day. So I would like to build the same for myself, although I do not like to put much weight on my waist or something. Personally, I want to lose weight. I want to become fit more than losing weight; that way, I feel more energetic, and also you feel good about yourself.

P5 showed self-acceptance by also emphasizing being healthy:

> I do not like to be really skinny. I do not want to be sickening skinny, or gaining too much weight and being obese. Like my BMI; I do not want it to be too low or too high. I just want to be healthy.

Continuing with the theme of personal description and view of self, I asked, "Can you share with me your experiences with body image?" All participants had strong

opinions about their experiences regarding body image in connection to EDs. P5 said she is more concerned with health than looks:

> I do know that, past the age of 10, with aging, I have gained more weight due to stress and life. As we get older, we gain weight, especially women, due to hormonal changes; it's [true] for most people. For me, [it's] not just for beauty; I am more concerned about being healthy. Because gaining weight will bring a lot of health issues, like becoming type 2 diabetic, or other health issues related to weight; that is more important to me than how I look.

P2 also revealed a positive outlook about life and how she looks, saying, "I don't know . . . all I see in the mirror is that little girl that I once was." P4 described body image experiences from a different angle:

> I think, especially for girls, I feel like every girl has dealt with some body image issues in [her] life. For me, it was really when I was younger. During my school days, I remember feeling like I was going thought an ugly duckling phase, but as I got older, I just started making a habit of [admiring] women who look like me and whom I felt looked, like, beautiful, so I have started looking at myself positively. I mean, I have my days when I feel down, but I guess everybody goes through the same thing.

P3 valued fitness and being healthy, which she viewed as integral to having a good self-image:

> Physical fitness has always been the main thing for me to feel good about myself. I have a brother who is a fitness trainer, and he always tells me that fitness is important to have a good image of myself.

Eighteen-year-old P6, who described herself as plus-size, responded:

> I guess it's kind of like what I was saying before, that body image is something I struggled with when I was growing up in school. Even now that I am in senior high school, I know sometimes me and my mom always argue about this, because she would say, "Wear this, not that"; "Oh, people your size do not really wear this"; "That does not make you look good." But now that I am older, I know that and am more comfortable with what I am wearing; I do not really care what people think about what I wear. But this was an issue for me in my early teenage years. I guess this is because my mom and I have different body types. She is really small and ran track in high school, so the struggles I dealt with, she never experienced the same. I now know where to buy what makes me feel good—for example, I buy from plus-size and they have pretty clothes for plus-size teenagers. So it's better now these days; it was not like this before, because I used to be given plus-size clothes but for older people because there was none for teenage plus-size girls, so I did not feel good about myself. So these days it's different; there is more access now to clothes that make anyone look great, including plus-size teenagers. I was even thinking of going to dances. I can't go a regular store and fit into an extra-large dress because it depends on how and who made the clothing. But now, with accessibility to plus-size clothing, I can get what I need

> for a dance and look good. So that is helpful now, these plus-size and pretty clothing.

P9 seemed grateful her experiences with body image have all been positive:

> I am fortunate, because I will say mine is positive—I mean, I am where I am and I am where I want to be. But I have people around me who are not healthy, some due to food not getting well digested or not eating the right food. Some of it is because of people not eating the right food, because if we eat the right food, some these food-related issues could be prevented. My goals are to have a gym and also a store where I can sell produce; those are my two goals to help others. But I just do not have the money right now.

P1 recalled painful times:

> I had negative experiences with body image. Again with the standards from the media and society on what the beauty is, that makes it hard because I do not fit into those standards. Some days I am like, "Oh, look at me," but most days it's not that. In the last few years, it has probably been a little worse, because I am not in the place I want to be right now.

Research Question 3: Theme 5

Most participants identified their families as the main support for good eating habits, confidence in themselves, and developing and maintaining a positive self-image. Some participants also recognized culture as the foundation of family support for good eating habits and the way they view themselves. Most also connected the role of familial support with developing smart food choices.

To assess this support, I asked," How do your family and friends influence the way you see yourself?" and "What do you think about fast foods and eating disorders?" P3 revealed:

> I grew up in a family where I am the only girl child. I have two sets of parents (my biological parents and my grandparents) who look after me, and I am well protected; I am well pampered with family support. My mom gets on me for eating junk food. Everybody is concerned about getting thin, but my mom and my family are concerned about staying healthy. I find that being healthy is better than stick thin. I have a strong family support. My grandmother, my aunt, uncle, and my parents all look after me. I was well fed and had no lack of food. Fast food once in a while is fine, but there is also need for balance; that is where my family support came in. They taught me good food choices and what I need to be healthy. I am an adult now and I know that eating junk food every day is not a good thing. I think what people who develop eating disorders do is eating junk food without nutritional balance. Good balance is needed to be healthy. For example, I like eating out, but mainly I eat homemade food, like I eat with my family back home. Eating out can be healthy, as well; it's about nutritional choice, the balance.

P2 expressed similar sentiments, with appreciation for her culture:

> My family is very supportive; I have a great support system. In African culture, we all have dinner and meals at table together, so the family environment is very supportive. For example, my sister is vegan. She prepares her own meals because

> she does not eat what we eat, but my mom always makes sure that she does eat, and we all eat together. . . . Everything is good in small portions, but sometimes I do not know if there is a connection of fast foods to eating disorders. I would think that if a person has eating disorders, they would try to stay away from that, especially if they are trying to lose weight. On the other hand, if they are trying to gain weight, maybe they would want to eat more fast food.

P1 described a good support system, as well as strong feelings against tying fast food to EDs:

> Family and friends are very positive. They boost you up. But one of my problems is that family and friends . . . I feel like they like me for me, so I always tell them that you do not count anymore. They do not like it when I say that. [*She laughs.*] On the question about fast foods, well, I think fast foods are a problem for everybody in America. And for kids with eating disorders, fast food [restaurants] are bad places. Fast foods are everywhere in [the] USA; that is the problem. When I went to Germany on [a] business trip, fast foods are rare, and people there eat real healthy meals all the time..

Because she was the eldest child, P9 felt responsible to provide a good example for her siblings:

> [My] parents passed away when I was little. I grew up with my uncle; he raised me well and I was not spoiled. My uncle had a positive influence on me. I learned responsibility and leadership to be good role model for others. That is how I chose to do physical education in school; that helped me to be responsible for my own

> health and how to help others, as well. Family support is important, and in my case, played an important role. I thank my uncle and all the women in my family. . . . Fast foods have played a huge role in [the] development of eating disorders, especially in children. Development of obesity is due to eating of fast food, as most of the foods are not healthy, especially when taken regularly.

P8 saw the fast food industry as counteracting positive family influence:

> Good family upbringing and culture influences the way one sees himself or herself and builds one's self-esteem; one can be able to fit in any group and adopt to new cultures well. People should eat well and not misuse food just because it's available. Parents in the USA are mostly working and rarely spend time with their children; therefore, they do not know what their children are eating and a child can develop an eating disorder without a parent knowing. Without good home cooking and a good family upbringing, a child does not learn how to make good food choices. In America, fast foods are everywhere and the portions are too big. Children eat anything they like anytime; there is no parental control anymore. I was born in Africa, and in my family, we ate food at the same time. My mom knew what types of food we were eating. Home cooking and a strong family support is important for good and healthy food choices, self-esteem, and confidence, especially in young women.

P5 disclosed no body image issues in her family:

> Well, in my family, we always joke that we are big bone[d], so we tend to look taller and bigger than the average person in my race. [*She laughs.*] I know when I

> was in high school, I was teased when I was younger; so did my brother. We are stronger and look chubbier; it's in my gene[s]. I tried to lose weight, but that is how I am. This did not affect the way I eat. We are good eaters.

P6 had mixed feelings:

> I will say, with my family, I know more recently, now that I am older, I am noticing more things. When I was younger, I felt different from everybody. From my dad's side, I noticed that there are my cousins who look like me in terms of body size. And then with my friends, I am noticing the same, so I am more comfortable now than I was in my early teenage years. I never noticed this before, so now I know I fit in. I myself have a lot of fast food. The foods are much cheaper and more filling than the healthy choices. So fast foods always win when people have to make the hard choices between an expensive salad that is not filling or a hamburger, less expensive and more filling. So if you want to feed a family, fast food is much easier in terms of cost, as well. And it is more accessible, too; you can just get it on the drive-thru.

All participants admitted the important role played by family support in self-esteem and the way they view themselves (body satisfaction), a connection identified by Hughes et al. (2013) and others. The 10 young women agreed EDs may develop from the availability of fast food.

After looking at the themes that emerged from the three research questions, I conducted the same analysis of the subresearch questions, which enabled me to give participants an opportunity to look at the main questions from different angles, and offer

responses that otherwise may have been left out. Asking these questions was a way of probing deeper into participants' responses to the main research questions.

Subquestion 1: Theme 6

Most participants did not consider themselves at risk of developing EDs; however, they recognized dangers for developing EDs (e.g., social media) exist. Participants who did not see themselves at risk said this was because they had learned to love themselves and how they look primarily due to strong family support, particularly from positive female figures and role models.

In response to the question, "Do you see yourself as at risk of developing eating disorders?" P1, P2, P3, P4, P6, P8, P9, and P10 responded in the negative. "No, I do not want to go back there again," stated P10, who had recovered from AN. P4 added, "I am not personally at risk, but I do know some young women of my own age who are at risk of developing eating disorders." P1 added, "Honestly, I do not; I love food. Eating disorder behavior is more like a mental issue, something that I am aware of, but I do not see myself at risk." P7 did not view EDs as a personal threat, but expressed concern with her genetics:

> Based on the fact that my aunt has diabetes, I may, but I will try not to be. My mom is very healthy conscious so this will help me to do better. When I move out and am on my own in a year from now, I will take what I learned from her and do better to be healthy. Genetically maybe, but all of this is about what we do to our bodies.

Subquestion 2: Theme 7

To further explore peer pressure and other external influences on ED development from participants' perspective, I asked, "How, if at all, have any of your family, friends, school, church, social media comments, attitudes, et cetera, influenced your eating habits?" All 10 identified social media as one of the biggest influences of disordered eating habits among young women, in line with Alleva et al. (2013). As described by P5, "The media affects most of the young women and contributes to development of eating disorders. Media displays a certain type of people as being the ones with the right bodies and as beautiful, but that is not real."

P6 recognized social media as a source of not only negative influence, but inspiration:

> Social media influences both for good and for bad, because it can be used to better oneself, and good information encourages those with eating disorders because it can be used on a positive. I have always obtained positive influence from social media from that point of view.

P1 expounded:

> People look at my size and I can tell they are judging me. For example, when I go to a restaurant, then I choose to get a cookie for desert—I mean, people say like, "Oh, maybe you should have not eaten that"; people judge. But my family is good; they do not try to do that. But when I am out with a group or out with people at work, someone will say I am not eating a cookie; then I feel like am not eating a cookie, while I know I want the cookie, so I choose not to because of fear

> of judgment. But my family is good. However, it's those social settings and comments that influence good or bad eating habits.

Although not personally impacted, P2 worried about negative influences on her younger sister:

> Well, social media has a huge impact on eating behaviors in young women. For example, people are always posting pictures on Instagram. Rob Kardashian is overweight or had an eating disorder; he posted pictures of himself, and people always make sure that he knows he is overweight. He went into depression and all that. Social media is in the spotlight, so it sure plays a major part. Personally, I do not pay attention to what people do or say on Instagram, so social media does not impact me in this area of eating habits, eating disorders, or self-image.

P3 believed her generation was prone to negative influences from social media:

> I think social media is the major source of influence, at least in my generation. We are social media gadget savvy—everybody has a tablet or a phone—so everything is right there in front of us, because everybody has access to social media. There are people my age who are easily influenced by social media articles; it's up to us to decide on what is good for us. There are different kinds of diets, but not every diet will work for everyone, so what may sound good may end up harming someone's life. We need to choose what is good for us, but it is not easy. My generation was born in the age of social media: Facebook, for example, is such a big part of our lives because it has been around us since we were about

> 10 or 12. Following people on social media is what brings these issues, because we tend to want to do what the others are doing.

P8 zeroed in on the importance of family background:

> Where I come from, families eat together and also inside the house; there is no room for anyone to go and sneak to get the food they should not be getting. Here, people go and get food outside, and children, especially, can get the food they are not supposed to get.

Subquestion 3: Theme 8

I next asked, "Can you tell me what place (if any) eating disorder has in your life and/or family right now?" P2, P3, P5, and P6 denied knowing anyone in their family or circle of friends with EDs; rather, they primarily learned about disordered eating from television. Others identified having someone in their circle of friends with an ED. As described by P4:

> I do not know anyone in my family with eating disorders, but I know a friend who had anorexia. She struggled with it for a long time, but now she has a pretty good control of it and she has been through treatment.

P7 had family members with obesity:

> Many people in my family are obese; they are on the big side. Even myself, I think I will feel better, look better if I can lose about 20 to 25 pounds. On my father's side, my aunt is diabetic and also has a problem with metabolism. On my mother's side, some of them are just obese. I think it's just the food they eat, too much starch and rice. Eating disorder could be in any culture; however, I do know

> that people from other cultures do eat food that is really grown . . . from the farm. But in the Western world, food is chemicalized; chickens grow overnight. All these chemicals are contributing to digesting problems. In other cultures, tomatoes take a long time to grow, apples take like six months at least, and chicken takes months to be ready. But in the Western world, a big fat chicken is produced—I will say "produced," because it's not real—so these chemicals are messing up people's metabolism. And now they are trying to combat this by saying "organic," but I read somewhere that even this organic it's not really organic, so that is why I really do not care about these organic foods any more. My mom tries to buy organic, but who really knows what it is.

Although she had recovered from AN, P10 dismissed the influence of family on her recovery:

> After going to an institution with people suffering with anorexia, the institution changed me, because you had to eat certain amount[s] of food and also was not allowed to look at the mirror so as not to degrade. And also has a group with the people who were suffering from the same anorexia, so the group encourages each other to stay strong and be focused.

P3 addressed her cultural background:

> In my family or close relatives, I have not yet come across any single case where anyone suffers from eating disorders. But, at the same time, I think it's more of the First World problem, for countries like United States of America, where there is too much food. I am originally from India, so environment is different there.

Although she admitted having a personal struggle with obesity, P1 was not aware of EDs in her family:

> Currently, no one in my immediate circle [has eating disorders], but I do know someone with a daughter who is going through eating disorder treatments right now. That is the only incident I know in real life. She is diagnosed with anorexia and the family is working on it with her, from what they told me.

With regard to the presence of EDs in her family, P2 responded:

> Not that I am aware of, no. In my life, I cannot say that I have ever had eating disorders or know anyone with one. I have always been physically smaller and people always assumed and commented, but no, I never had eating disorders.

Although health conscious herself, P9 identified family members impacted by food-related illnesses:

> I have a niece who actually has an eating disorder problem. I do not know what it is, but her body does not metabolize food well, so her when she eats, her body does not get the nutrients she needs for normal growth. As a result, her growth is stunted; she does not grow well. Her body just does not make good use of her food. Sometimes when she eats, she vomits, and even when she does not vomit, her body is not making good use of the food she takes in. [*"Does she make herself vomit?" I asked.*] No, she just vomits naturally. There is something—they have not been able to find out why she vomits, but it's food related. [*"So it has not been talked about as bulimia or anorexia?" I clarified.*] No, it's not one of those;

> it's more biological, because they know it's not bulimia, anorexia, any of those. But she does have an eating disorder.

Based on responses to Subquestion 3, an extension of Research Question 1, participants are aware of EDs from their personal experience, family, or circle of friends.

Subquestion 4: Theme 9

Most participants expressed strong feelings about the social environment's influences on young women and the development of EDs. To explore this further, I probed, "What would you say is the main cause for body dissatisfaction in women? What role does social perception of beauty have on the development of eating disorders in young women?" P1 shared her thoughts about ED causes and society's portrayal of beauty:

> About the causes, oh, I think it is the judgment by others. Eating disorders, behaviors, and illnesses are very much externally driven, but it grows and festers internally. Yes, internally . . . It's an internal struggle. Comments and those things come from an external place, but it's internalized—people take those things to be true and standards, which drive their activities. And on what I think about social standards of beauty, society can definitely drive people to eating disorders, because they have unrealistic expectations and portrayals of beauty. Beauty as shown on magazines is not attainable, because it excludes real women.

P2 shared similar sentiments:

> Cause of eating disorders in young women: honest to God, social media. That is huge. Because everybody on Instagram are all models and everybody just wants

> to look like them, so that really impacts young girls growing up. I know some. My sister, for example, is in middle school and has Instagram, and she says, "Maybe boys will like me if I look like this or that." All young girls want now is to look like these social media images. Social media is a major influence for eating disorders in young women.

She continued:

> I think society thinks skinny, tall, and light skinned is the beauty standard. Yes, this has an impact on young girls with regards to eating disorders, because Hollywood and social media puts images of skinny and tall and best features on, but I do not think all that is real. I do not think even the models look like that in real life. So young women struggle to match these social images or something that is not real, because even those models do not look like those images. Hollywood has and sets standards of beauty. Everyone is trying to match whatever that is, but the standards are not real. People cannot match what is not real. . . . [S]ocial media is definitely a significant influence on eating disorders in our age group.

P3 responded:

> I guess everybody goes though that phase where one feels that I do not like my body. I also go through that sometime, like I say I feel fat, but my mother will tell me to stop eating junk food. [*She laughed.*] It's a passing phase during undergraduate stage, but a person needs a strong support system during that.

She further reflected on social media's beauty standards:

> This is a very good question. I would be wrong if I say media ideas of beauty do not influence us; they definitely influence people, especially in the growing phase. You grow up with certain standards that you look up to from time to time, but then we should always draw a line and differentiate between what is real and what is not. Some things are not realistic; in that process, we need to be careful that we are not harming ourselves by imitating something that is not real. Beauty standards differ from one person to the other person. One person's standards of beauty are not the same as the other person's; we should keep that in mind. Beauty varies from person to person, culture to culture, place to place, height to height, et cetera. There is no one single standard for beauty, as social media wants us to believe.

With regard to body dissatisfaction in women, P5 said, "Social media is the main cause." Asked about the beauty standards set by social media, she continued, "Yes, social media is a big influence on eating disorder behaviors, because their portrayal of beauty is not real. Beauty is about personality and not only about appearance. We should place more emphasis on personal value."

P6 responded similarly:

> The media is the problem, because when you watch television—especially the models: They are skinny; those who do advertisements are skinny, too—so people tend to think that if you are fat, you're not good, but that is not true. People tend to think that a beautiful woman should be skinny. While this might help some

> people to lose weight and be healthy, it depresses others, so the media should encourage people where they are so as to make things better and help people.

P7 also believed social media promotes false images of beauty, which then leads people, especially young women, to dangerous health behaviors in an attempt to look like the idealized images:

> Ooh, it's the media. Media is the problem. If you turn on the TV, all the models or Miss USA are all skinny; even those who advertise Macy's bras are all skinny. The media is trying to tell us that if you are not skinny, you are not good for nothing. Media has ruined people's confidence. Like, I have only 20 pounds to lose, but I already feel like I am not good enough.

"What about the beauty standards promoted by social media?" I asked. She continued:

> The impact is when they give us all this about what a beautiful woman should look like: long hair, skinny, you know. There are many beautiful women who are not skinny, but when they show models, they are all skinny; that impacts us. It's good in a way, because it helps other people to improve themselves, but it also depresses some people who think that "I cannot do this," so they just let themselves loose. So media should help people to be happy where they are, but try to be healthy, not skinny. Skinny does not mean healthy; there are skinny people with diabetes, high cholesterol, and are not happy. I am not skinny but I am happy.

P10 also voiced strong opinions:

> The main cause is the environment, what the environment believes to be the norm: television, the media. I mean, there is no time you turn on the television without seeing skinny, beautiful women. How many times have you seen fat, ugly women on television? No one is ugly, but you know what I mean. . . . I think our society is messing up young children's brains, to make us think that you have to be skinny, you have to be size zero, to be beautiful; that is wrong. So if this study or similar [studies] can help people to be aware, it is important. Eating disorders are deadly diseases. When a person says they have eating disorder, [they] are really suffering. For myself, I will write a book. I hope your study will help to save at least one person.

Having survived an ED, which she claimed was caused by social media images, P10 expressed long-term goals:

> Young women need education about eating disorders. Yes, it's about education. Education should start from home, in schools and in college. Also, it's about availability, accessibility, and affordability of healthy food. I plan to write a book about my recovery from anorexia and my suggestions so that other young women may benefit.

Summary

The purpose of Chapter 4 was to present the themes and findings revealed by face-to-face interviews with young women (ages 18 to 24 years) about their experiences with and understanding of EDs. Because this population is most at risk of and highly impacted by EDs, I conducted this phenomenological study with the goal of

understanding EDs from their perspectives, views, and experiences. I introduced the chapter with a discussion of the research questions and study setting, followed by data collection, data analysis, evidence of trustworthiness, and demographics, before concluding with results.

All 10 participants could define EDs as well as the determinants thereof. They identified EDs as real illnesses in need of attention. Because many of these young women had seen eating-disordered patients fully recover, they believed EDs to be preventable and avoidable, with risks that could be controlled. I found participants were cautious about their eating and lifestyle behaviors because of the reality and existence of EDs. Among factors they identified as affecting their perceptions of EDs were media, family background or cultural upbringing, friends, and society. For instance, participants who watched family members or close friends suffer from an ED were more concerned about the disease than those without firsthand experience.

I also found that women ages 18 to 24 years who have strong family support systems had a positive self-image and self-respect. Even those without such systems identified family support as the main force helping them neutralize negative external influences, especially from social media, on body image and beauty standards. By understanding the negative influences of social media's unrealistic standards of beauty, participants shared a common desire to improve themselves and be proud of who they are. In part, this involved making conscious choices of what to follow on social media instead of exposing themselves to everything. These young women revealed deep concern about their physical appearance and attractiveness, but were also aware that real

beauty goes beyond just looks. Although some admitted to having celebrity role models and trying to imitate their lifestyles, shapes, and sizes, most recognized this may not be attainable. Additionally, these young women regarded physical appearance and attractiveness as what society uses to judge them; subsequently, they try to improve their appearance to receive praise and high regard.

Participants discussed factors influencing the development of EDs and negatively impacting their lives. According to participants, individual, interpersonal, and community risk factors were within their control. No participant saw herself at risk of developing an ED; rather, these young women believed their lifestyle did not expose them to EDs, in part due to strong family support systems. They identified regular exercise, good eating habits, family, and culture as the main reasons they were not at risk. However, each participant did admit that young women in general, especially in this age group of 18 to 24 years, are at risk of EDs due to social media's misrepresentation of female beauty and beauty standards.

Interactions with friends and peers influence young women's behaviors and attitudes regarding weight. Females between ages 18 to 24 years feel dissatisfied with themselves when their colleagues do not approve of their appearance, thus engaging in similar activities or following peers' advice to achieve a certain body shape or size. Young women view their appearance more positively when their family members admire how they look, illustrating the clear, often positive influence of family relationships on young women's views of eating behaviors, and attitudes toward their weight and appearance. Some participants identified family members as role models in beauty.

These interviews revealed that social norms significantly influence young women's eating behaviors, beliefs, and body image. The media presents certain body types and sizes as more beautiful than others, which compels female adolescents and young adults to attain such body shapes and sizes. Similarly, Internet images portrayed as beautiful display for young women society's ideal of beauty. Results from this study confirmed young women's body image perceptions are influenced by social media and social practices. Social factors such as family relationships and peer pressure impact young women's perceptions, behaviors, and attitudes in relation to EDs and appearance. Social media largely affects self-perception, which can contribute largely to body dissatisfaction (Nicely et al., 2014; Salafia et. al., 2015).

The themes and research questions facilitated identifying the context and final outcomes from these in-depth interviews. The chief, fundamental outcome of this study is that family plays a critical role in young women's lives, shaping the way they view themselves; a negative self-image, in turn, may lead to the development of EDs. Participants with a positive family environment, especially from their mothers, described how "lucky" they were not to be at risk of developing eating disorders. Strong family support systems and a positive family structure contributed to positive self-image and the ability to withstand negative social influences promoting "false and unrealistic standards of beauty," which may lead to negative self-image and, ultimately, disordered eating. Participants also described young women who "are not so lucky," falling victim to negative social media influences and developing EDs as they try to "fit into the

unrealistic social media standards of beauty." Even ED survivors described how family support inspired them to get help and fully recover.

In the next chapter, I summarize the study and present conclusions on research results and findings. I integrate the literature review and discussions with my results, identifying commonalities and contradictions between my findings and others. I discuss the need for further study on the problem, including specific recommendations for future research, in hopes further consideration of EDs leads to their elimination. Also in the final chapter, I discuss the potential for social change arising from this study, identifying stakeholders, limitations, as well as recommendations for continued research on EDs.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to investigate the perceptions, beliefs, opinions, and attitudes of young women ages 18 to 24 years regarding EDs. I sought to understand how women in this age bracket perceived body image and attractiveness. Additionally, I explored how interpersonal and community factors related to young women's perceptions of EDs, illuminating the way society affects their opinions and views of attractiveness and beauty.

EDs stem from the pursuit of beauty and attractiveness, with young women engaging in life-threatening behaviors to achieve a desired physical appearance. Through this study, I sought to find out what drives this population to disregard common sense and engage in dangerous behaviors. Study findings may help to close the information gap between EDs and community and societal factors associated with ED development (see Teusch & Fielding, 2013). Public health involvement in addressing diseases impacts large populations (Issel, 2013), and it is needed to address increasing ED mortality rates (Rikani et al., 2013; Surgenor & Maguire, 2013).

I identified themes emerged from participant narratives, including knowledge and understanding of EDs, ED experiences, personal image, personal descriptions, family experiences and environmental support, risk, peer pressure influence on eating behaviors, EDs in the family, and the social environment's role on ED development. To answer the three research questions, I interpreted results based on theoretical and conceptual frameworks. Within this chapter, I identify limitations and delimitations of the study, recommendations for further study, implications, and conclusions.

Findings revealed family relationships and social media as some of the major factors that influence 18- to 24-year-old females' perceptions of personal image and attractiveness. Family support emerged as the main source of positive image, enabling young women to withstand negative external influences about how they should view themselves. Results showed positive influence from family, especially mothers, was long-lasting. The media, availability of fast foods, and how society portrays beauty had significant influences on ED development in young women. I also found this population unaware of ED screening tools, with most believing they were not at risk of developing EDs. Programs are needed to increase the family members' awareness, especially mothers or maternal guardians, of the role they play in the development of EDs in young women.

Interpretation of the Findings

After I conducted interviews with 10 participants, I transcribed and analyzed the data. Following coding and identifying major themes in Microsoft Word, I organized and stored the data in NVivo. I interpreted major themes in the context of the literature review presented in Chapter 2. Some of my findings confirmed what other scholars had found, and some results disconfirmed prior studies.

This study was unique in providing knowledge of the perceptions, attitudes, and views of young women regarding EDs and attractiveness. The study filled a gap in the literature by contributing community-based research on EDs. In this chapter, I interpret the findings in connection with the three research questions and four subquestions addressed in the study:

Research Question 1: How do young women (ages 18 to 24 years) perceive eating disorders?

Research Question 2: How do young women (ages 18 to 24 years) view their physical appearances and attractiveness?

Research Question 3: How do young women (ages 18 to 24 years) perceive individual, interpersonal, and community factors that influence the development of EDs?

Subquestion 1: Do young women (ages 18 to 24 years) see themselves as at risk of developing an eating disorder?

Subquestion 2: What is the influence of peer pressure on young women's behaviors and attitudes related to their weight and appearance?

Subquestion 3: What is the influence of family relationships and views on young women's eating behaviors and attitudes related to their weight and appearance?

Subquestion 4: How do current social norms influence eating behaviors, beliefs, and perceptions of body image in young women?

Research Question 1

Responses echoed reviewed literature, which showed that EDs are not prevalent in the general population, instead mainly affecting adolescent and young adult women (Monell et al., 2015). Results of the current study showed that young women ages 18 to 24 years were aware of EDs and could describe AN and BN symptoms. Participants labeled EDs serious illnesses that affected mostly young women, including girls in middle and high school. Participants believed the negative effects of EDs in young adulthood depended on the family support, especially maternal, they received growing

up. Strong family support helped young women withstand negative forces that could otherwise lead to ED development.

Family support was important because it helped prevent internalization of negative external influences. EDs were triggered by external factors, such as misconceptions of self, desire to be skinny, and excessive concern about what peers or other people think of a person's looks. Participants believed such factors drove individuals to engage in ED behaviors. Results from this study also revealed disease progression and treatment are complicated by the comorbidity nature of EDs, findings consistent with previous studies showing EDs to be complex psychiatric illnesses with high rates of morbidity and mortality (Rikani et al., 2013; Surgenor & Maguire, 2013). EDs are not only about food, but may be the result of a lack of coping mechanisms when faced with life circumstances difficult to deal with directly (MacGregor & Lamborn, 2014; Salafia et al., 2013). EDs may be associated with certain genetic predispositions (American Psychiatric Association, 2013) resulting from ceding to external pressures to look a certain way (Waldman et al., 2013), or distorted self-concepts and maladaptive attitudes about body image (Harrison et al, 2014). Therefore, addressing such a complicated health issue needs a systems approach.

Researchers overwhelmingly recommended starting with community-based research (Bailey et al., 2014; Salafia, 2013) to improve awareness and understanding of disease determinants from the target population's point of view. Young women need more education regarding EDs, including diagnostic and screening procedures, because they frequently remain silent, only getting help after it is too late. Although P10 had

suffered from AN, been to a treatment institute, and recovered, she knew others who had relapsed.

ED education is needed within this population and in the overall fight against EDs. Although most participants said they had witnessed a family member suffer from an ED, none were aware of any ED screening tools. Some believed an individual's eating behaviors, body shape, or size was sufficient to reveal the presence of EDs; others related stories of friends and family members clinically diagnosed with EDs only as a secondary or follow-up to another disease or illness. P4 described a close friend diagnosed with AN only after being hospitalized following a car accident. Doctors determined the cause of her low blood sugar to be from an ED, as she had not been eating for a long time.

Research Question 2

According to reviewed literature (Schaefer et al., 2015; Treasure & Schmidt, 2013), social comparisons can affect how young women view their physical appearance and attractiveness; how they perceive individual, interpersonal, and community factors that influence the development of EDs; and how these perceptions can shape the onset and judgment of EDs. Results from this study differed from previous researchers' findings, as participants did not connect beauty with physical attractiveness. These 10 young women described beauty in terms of personal qualities such as compassion, kindness, cheerfulness, self-acceptance, self-determination, and confidence, among others, but did not mention physical beauty.

Participants had positive images of themselves when we spoke, something that was not always the case. Each described having self-image issues when younger;

however, as young adults, they each viewed themselves positively. Although all participants identified social media as a cause for negative self-image in young women, this was not the case for them personally. Again, they cited strong family support and maternal role models as sources of inner strength and positive self-image.

Among the key themes was that cultural or societal norms affect young women's (18 to 24 years old) perceptions of EDs. Society values people based on their weight and appearance, with slim women revered and plus-size women disparaged. Similarly, Golan (2013) found young women to behave in ways that align with what society holds in high regard, and Haines and Neumark-Sztainer (2006) concluded social factors trigger destructive behaviors among young populations. These triggers certainly impacted P10, the teenager previously with AN who skipped meals to achieve a slim body. In another study, Frederick et al. (2016) concluded that, due to the desire to look a certain way, individuals engage in dangerous behaviors to achieve a slim figure.

Findings from the current study show that strong family support and positive family role models can neutralize these negative influences. However, the young women in this study noted how difficult it can be to continually fight against the onslaught of negative influences. EDs remain a health issue that warrants attention and can benefit from effective public health community intervention programs.

Research Question 3

Besides societal norms, Golan (2013) and Haines and Neumark-Sztainer (2008) found peer pressure influenced young women's behaviors and self-perceptions. In this study, I found that young women in the age bracket of 18 to 24 years old are significantly

influenced by what their friends and family think, with peers' comments or negative behaviors impacting the way they view themselves. All participants acknowledged the strong impact family and peers have on ED development, with family acceptance described as a source of strength against negative influences.

Participants revealed having negative experiences in middle and high school, and described younger girls they knew who were negatively impacted by peer pressure. Mothers served as strong role models for beauty and strength, which helped against negative influences. One participant, discussing Hollywood role models of beauty, revealed ongoing negative experiences in social settings, especially when peers or coworkers made negative comments. She related feeling judged in social settings, which made her uncomfortable.

All participants described family as a source of strength to fight against negative peer influence. Family provided love, acceptance, self-esteem, and realistic standards of beauty, which helped these young women in making good choices against negative external forces and social media. To these women, fast food was an issue in America due to its widespread availability and affordability. Four participants also mentioned the impact of culture, family upbringing, and family structure on young women's consumption of fast food. Participants who ate meals as a family identified EDs as having no impact on their health.

Subquestion 1

No participants believed they were at risk of developing an ED; however, they recognized young women overall had a high risk of ED development because of social

media. Participants attributed their unique situations to "strong family support," especially in setting good examples and acceptance from their mothers. Even with the risks posed by social media, strong family support instilled in them the strength to choose behaviors not detrimental to their health. These findings contradicted those of Churruca et al. (2014), who identified young women to be at risk of suffering from EDs because of their perceptions and attitudes. In this study, participants attributed ED diseases and issues as coming "from an external source, but the struggle is internal." Sociological factors are driving forces in determining young women's perceptions, and strong family support is important so they are able to withstand negative factors that may lead to disordered eating.

Another important finding echoed others related to family relationships and interactions: Young women's behaviors are influenced by people with whom who they interact. In the present study, all participants said family members influenced their behaviors. The types of relationships young women have determined their perceptions of weight, appearance, and EDs. Similarly, Dawson (2014) found interactions with family members and friends affected young women's opinions about their bodies. Whether females viewed themselves as healthy or unhealthy depended on interactions with those around them. A possible reason family relationships have such a significant influence is that, because relatives are close in proximity and relation, young women trust their opinions.

Perhaps one of the most notable factors affecting women 18 to 24 years old is parental influence. In this study, most participants said family members greatly

influenced their perceptions of both self-image and eating behaviors. P5 said closeness to her mother meant she could learn from her maternal role model in matters of health and eating behaviors. In line with Hughes et al. (2013), findings from the current study illustrated how positive parental influences and a supportive family environment can help young women learn healthy eating behaviors and make health choices that will prevent of EDs. Tetley et al. (2013) explored the effect lack of parental influence has on young women's perceptions. Daughters' self-esteem is built when their parents approve of their body image and shape; along these lines, parents should encourage healthy eating in their children. Chen and Kelly (2014) and Chao et al. (2016) recorded similar findings, noting that parental figures or close family members influence young women's perceptions. Chen and Kelly identified the parent-daughter relationship as a strong driving force in the development of EDs; after all, young women follow what their parents do or eat.

Subquestion 2

Martino and Lester (2013) found sociological factors, such as peer pressure and media, to have a close relationship with EDs. Although I did not directly investigate a causal relationship between sociological factors and EDs, my findings were similar to those of Martino and Lester in that young women learn about EDs from the experiences of their peers. Participants who had seen close friends suffer from an ED were cautious about their own eating behaviors. In alignment with the literature review, my results revealed the media's role in informing young women about EDs (Kim et al., 2014). Using the Internet and other media platforms, young women between 18 and 24 years of age can learn what to do, and also what not to do, to avoid developing EDs (Nicely et al.,

2014). Participants described how most of what they knew, good or bad, came from social media.

The Internet is a part of daily life; the prevalence of technology may make it impossible to prevent exposing young women to materials that may negatively affect their self-perceptions of image and appearance. Bailey et al. (2011) identified how exposure to television commercials, magazines, and billboards causes young ladies to think slim women are more beautiful than plump-sized women. The researchers found films and series tell young women how they ought to think and behave regarding self-image. There is evidence of distorted image of self among young women based on which media they consume (Bulik, 2007; Nicely et al., 2014). Findings from this study coincided, as some participants said their perceptions of self-image and appearance depended on what they saw in movies, commercials, and magazines.

Subquestion 4

Media impacts many people's thoughts and behaviors, including the perceptions of young women (Salafia et al., 2015). According to the social comparison theory (Alleva et al., 2013; Fitzsimmons-Craft, 2011), the media educates but also negatively influences. According to Fitzsimmons-Craft, positive influence from media on young women is rare. This is in line with my findings, as only one of 10 interviewees made a positive statement about social media. P4 stood alone in using social media to feel good about herself, her size, and how she looks; she did so by looking for and following plus-size social media role models who look like her and feel good about themselves and their size.

Similar to the other participants, however, P4 attributed no positive impacts to social media. When asked about her thoughts on the root cause for body image issues leading to EDs among young women, she quickly said, “It is media. Like I said a million times already, the mainstream media for sure is a huge part of it.” Findings from my research identified media as doing more harm than good to these young women, and driving them to EDs in pursuit of the thin image.

Many women with EDs practice upward comparisons with females in the media whom they do not personally know, associations that frequently produce feelings of discontent and dissatisfaction (Dakanalis et al., 2013; Schulte et al., 2016). Women at risk of or with EDs may also compare themselves to unrealistic models, especially when they have dominant cultural views that promote a thin ideal of beauty (Frederick et al., 2016).

In this study, findings showed all forms of media lack healthy representation of women. When they present slim women as more beautiful than plump-sized women, they put forth false standards of beauty for women. Using only slim women in advertisements and placing positive emphasis only on slim bodies (Fitzsimmons-Craft, 2011; Schaefer et al., 2015, p. 153; Treasure & Schmidt, 2013) sends an exclusionary message to younger women, who may end up risking their health to look like those images. Previous researchers revealed young women tend to work toward having slim bodies because the media portrays people with such shapes as more beautiful than ones with larger bodies (Fitzsimmons-Craft, 2011; Frederick et al., 2016). In another study, Alleva et al. (2013) showed young women’s perceptions regarding weight and appearance were significantly influenced by what they saw in the media.

When young women have a positive attitude toward a certain image, they may do anything to achieve it. In some cases, young women adopt eating behaviors that lead to EDs. According to Pike et al. (2003), Danakalis et al. (2013), and the American Psychiatric Association (2013), EDs may be triggered by the desire to look a certain way, a sentiment echoed by this study's participants. During interviews, most participants admitted carefully choosing what they ate because they wanted to achieve a certain physical appearance. Young women value their weight and appearance, and may skip meals to achieve the desired physical impression.

P2 said her family members were choosy about their eating behaviors because they were mindful of their weight and appearance, adding that eating together as a family was one of the main reasons she was not at risk of EDs. Women want to look beautiful between the ages of 18 to 24 years, because they consider this time the prime of their beauty. In the process of seeking this beauty, however, young women may rationalize engaging in dangerous behaviors leading to EDs, as Danakalis et al. (2013) similarly observed. Parent-child relationships play a vital role in shaping the perceptions of these young women, especially on self-image and making healthy choices (Attia, 2012; Hughes et al., 2014; Tetley et al., 2014).

In a discussion of EDs among young women, it is almost impossible to avoid the topic of dissatisfaction with self-image and negative self-thoughts. In this study, young women 18 to 24 years of age revealed that extensive concern about their appearance determines their thoughts and perceptions of life in general. With similar findings, other researchers identified the need for more studies to establish whether tendencies are

ingrained due young women's exposure to sociological factors, or if these tendencies occur naturally. Polivy and Herman (2002) recognized sociological factors affect young women's thoughts about themselves, which, in turn, influence their behaviors.

Contributions to Science

A qualitative phenomenological approach emphasizes the importance of lived experience. One of the main objectives of the study was to explore the personal perceptions of young women (18 to 24 years) on appearance and EDs. To ensure adequate understanding of the health issue and identify solutions driven by the needs of the target population, it is crucial to consider the perceptions, experiences, and views of young women when designing and developing intervention programs for complicated illnesses such as EDs. This is line with Blumenthal and DiClemente (2013), who stated that, in theory, both qualitative and quantitative paradigms allow for scientific inquiry and both are valuable for contributions to science.

This research also contributes to science by further supporting the application of the sociocultural model (Alleva et al., 2013; Fitzsimmons-Craft, 2011) of disordered eating as a practical model for studying ED pathology among young women who are primarily at risk. Findings also support the three theories encompassed in the sociocultural model—social comparison (Festinger, 1954), objectification (Frederickson & Roberts, 1997, as cited in Fitzsimmons-Craft, 2011), and uses and gratifications (Rubin, 2009, as cited in Fitzsimmons-Craft, 2011)—that support an exploration of how and why young women see themselves and other women using certain sociocultural models and standards. Similarly, in this study, participants emphasized the impact

external forces have on the development of EDs, which is in alignment with the multidimensional sociocultural model postulating that multiple factors lead to ED development in young women.

In the current study, participants shared perceptions of how the media impacts young women's self-image, leading to EDs as a consequence of body dissatisfaction. Results of this study also contribute to science by further illustrating how technology affects people's thoughts, ideas, opinions, and perceptions. In the future, policymakers and technology regulatory bodies may more carefully consider the effect of technology on people's attitudes and perceptions (Anderson & Braud, 2011). Moreover, outcomes of this research contribute to science by showing how perceptions lead to activities that determine biological and physiological development. Young women engage in different eating behaviors and physical exercises based on their perceptions of image, appearance, and EDs.

Contributions to the Field

EDs are some of the least discussed diseases in society, and people may suffer from them due to ignorance. Results of this study provided credible and important information to enlighten people about how their perceptions can lead to EDs. The use of a public health approach makes the study relevant to the field. Findings showed how different social and environmental factors interact to influence young women's perceptions of personal image and EDs. In the future, researchers may likely pay more attention to sociocultural and environmental factors when investigating the development of diseases. Study findings revealed vital information about young women's perceptions

of image and appearances, and how these views are related to diseases. Results of the study showed women's emotions and attitudes, along with relationships with peers and family members, form a critical element of public health.

The focus of this research study was identifying the development of EDs among young women (ages 18 to 24 years); detailed information provided by participants can be useful to community program developers. By considering the influence of young women's perceptions on the development of EDs, policymakers and program developers can come up with strategies that enhance positive attitudes among women. Young women have great concern for image and appearance, and health-related programs are related to elements that improve their appearances. Study findings are useful in the development of preventive and treatment intervention programs.

Participants said they were unaware of screening tools for EDs and believed they were not at risk of suffering from EDs. Results of the study showed the media has a significant effect on lives of young women and, if used appropriately, can improve the public health field. The media needs to use its influence to create awareness among young women about screening tools and indicate what situations could put them at risk. Public health education programs anchored on social media and mainstream media would reach a large population of young women.

Analysis Based on Theoretical and Conceptual Framework

The most suitable theoretical model to discuss findings is the sociocultural model, which asserts EDs emanate from an interaction of multiple environmental and social factors. Young women face physical, biological, and psychological risks of EDs in their

day-to-day activities (Fitzsimmons-Craft, 2011). As evidenced from research findings, the development of EDs is not attributable to a single factor. Interplay between the media, peer influence, family relationships, personal experiences, and one's own perceptions contribute to disordered eating. Due to young women's exposure to different ED risks in society, they face the challenge of choosing appropriate behaviors that will reduce their vulnerability to EDs.

Different social and environmental factors attributable to EDs mount pressure on women, who, if not mentally strong enough, may succumb to the stress. Westernized cultural trends tend to praise certain body shapes and sizes, leaving 18- to 24-year-old women yearning to achieve these ideals. Western culture portrays personal image and appearance as vital aspects of beauty, and this affects the perceptions of young women (Fitzsimmons-Craft et al., 2014). Most young women desire to achieve the thin ideal because that is what the media portrays as perfect. Western culture has no place for plump-sized women, leading young females to develop a negative attitude toward such body sizes and shapes. In this way, culture forces young women to alter their eating behaviors to fit into society (Alleva et al., 2013).

The sociocultural model comprises several theories used to illustrate why and how young women between 18 and 24 years old behave as they do in relation to eating behaviors, image, and appearance (Bogdan & Biklen, 2007). According to social comparison theory, people are driven to evaluate their advancement and standing in life (as cited in Fitzsimmons-Craft, 2011, p. 1226). As shown in this study's findings and in agreement with social comparison theory, due to the desire to attain these goals, young

women look for standards of comparison. Participants referred to family environment, family members, and positive peer groups for good standards and examples on self-image and positive eating behaviors, identifying themselves to be at no risk of developing EDs. Even P10, who had recovered from AN, described how positive family support meant she was not at risk of relapsing.

In agreement with previous studies, results from this research showed that, in the absence of objective standards, people use social comparisons from their environments in developing their body image (Alleva et al., 2013), comparisons that can be intentional or unintentional (Fitzsimmons-Craft, 2011). For instance, daughters may initially compare themselves to their mothers without the express intent of social comparison; as they grow older, however, they may compare their bodies with their friends and other women with more intention of evaluating their body image (Fitzsimmons-Craft et al., 2014). Likewise, results from this study demonstrated that media plays a vital role in comparisons, because only women with certain body shapes and sizes are used in advertisements. All participants related this when they described the damage done to their generation by the media's failure to represent real standards of beauty. It is no surprise that, as P10 said, during treatment for AN, patients were not allowed to watch television, use the Internet, or read anything from any media.

Young women are vulnerable and prone to comparing themselves with the images they see in media. In some cases, the comparison may lead to dissatisfaction and discontent among young women. The cultural view of the thin ideal as perfect makes

young women lose hope when they are unable to achieve the desired body shape and size (Dakanalis et al., 2013).

Fredrickson and Roberts' (1997) objectification theory concerns how women are portrayed as objects (Fitzsimmons-Craft, 2011). Perceptions of young women are shaped by how the media portrays them, in most cases as objects of beauty. Young women come to believe their image and appearance are all they have to present to society, becoming mindful of the way they look with everything they do. To achieve the perfection put forth by society and the media, young women may adopt eating behaviors that could lead to EDs (Frederick et al., 2016). When the media sexually objectifies young women, they become overcautious with their image, identifying imperfections in their appearance. The drive to achieve cultural standards of beauty due to objectification compels young women (18 to 24 years old) to adopt unhealthy strategies, which could lead to EDs.

The uses and gratifications theory (Rubin, 2009, as cited in Fitzsimmons-Craft, 2011) explains behaviors among young women that predispose them to EDs. This social psychology theory describes how the social communication young women use exposes them to EDs (Schooler & Trinh, 2011). Messages and information from the media shape these females' perceptions of EDs. Older adolescent and young adult women watch television and visit websites for different reasons, with varying reactions; subsequently, they may feel either satisfied or dissatisfied with their body shape and size (Schulte et al., 2016). According to the uses and gratifications theory, external standards on beauty derived mainly from social media influence how young women view themselves.

The concepts of image, appearance, and EDs are interconnected, with EDs often evaluated through conceptual individual and community lenses. Pressure from the media, peers, and family members to achieve the thin ideal of beauty leads young women to adopt certain behaviors. When young women compare themselves with what they see on media platforms, they may become either encouraged or discouraged. For example, P1 was aware of the harm media could cause by influencing ED development. Accordingly, she avoided Instagram because she knew it could negatively influence her eating behaviors.

Interplay between social comparison and body surveillance reveals imperfections, which lead to body dissatisfaction (Fitzsimmons-Craft, 2011). However, comparisons and body surveillance should not be identifying imperfections. According to the sociocultural model, disordered eating results from the desire to achieve a certain body image and appearance by using unhealthy strategies (Dakanalis et al., 2013). Young women must understand it is often not possible to look exactly as the women they see in commercials. By appreciating their own image and appearance, they can use healthy methods to improve themselves and not develop EDs.

Limitations of the Study

The scope of this study was limited to young women ages 18 to 24 years from Southwest Ohio, with a focus on those most at risk (Hepworth, 1994) for determinants that lead to EDs. Although the research provided meaningful data, one limitation was that findings represented females in a specific age range living in one region, factors that increased the likelihood of similar socioeconomic and cultural statuses. Generalizability

of results cannot go beyond this particular sample, in alignment with qualitative phenomenological studies (Patton, 2009).

Another limitation was that I was unable to include women younger than 18 years of age due to lack of time and resources. As study results show, impacts of EDs on young women "start at a younger age, especially junior high school," as most participants shared. All 10 described how they were teased in their early school days, an illustration of increased vulnerability to ED determinants at younger ages. One participant who survived AN said she began to suffer from a younger age, as well. Other participants gave examples of preadolescents they knew who were going through the same thing: struggling with body image and body dissatisfaction due to external pressures to be thin, known risk factors leading to the development of EDs. These limitations did not compromise the quality of the data, but simply identified and contributed to a future area of study.

Prior awareness of the research motive or objective by participants was another study limitation, as having advanced knowledge of research dynamics may have affected responses. However, interviews were successful, participants answered all questions thoroughly, and results reflected perceptions and views of study participants. Despite these limitations, the 10 interviews were detailed and exhaustive. Data provided insightful conclusions that could help in bridging the public health information gap regarding to young women's perceptions of EDs. The needs and experiences of those most at risk should inform and guide effective public health programs and the communities they serve (Cohen et al., 2010).

Recommendations

As with the reviewed literature (Fitzsimmons-Craft, 2011), I found young women to be knowledgeable of the existence of EDs in general—primarily AN and BN—citing media, family, and friends as their main sources of information. Additionally, participants knew that, although EDs can affect anyone regardless of demographics, race, age, or gender, disease prevalence, risk, and vulnerability were highest among young women, including those in junior and senior high school. Each participant described at least one painful memory from these years related to ED risks and factors.

However, these young women were unaware of tools for early ED screening and prevention. They expressed concern that EDs do not receive sufficient attention as serious diseases, as do mainstream illnesses such as breast cancer. Since teen and preteen girls are predominantly at risk and highly vulnerable, awareness programs geared toward this population are critical in the first line of ED prevention. As participants described, peer pressure and influence are high in the junior and senior high school years with, as P1 described, damaging effects that last a lifetime.

As Martino and Lester (2013) found, sociological factors such as media and peer perception are highly related to EDs in young women. In an earlier study, Bailey et al. (2011) reached the same conclusion, condemning the way young women are exposed to billboards, magazines, television commercials and series, films, and other media telling them how they should look, think, and act in regard to self-image, which often leads to a distorted sense of self. Public health program planners could partner with local school boards and staff to create ED awareness programs that speak to the target population.

Middle and high school principals may also draw on the results of this study as a source of disease understanding from young women's perspectives.

There is strong evidence that, in the case of behavioral diseases like EDs, primary prevention saves lives (Cohen et al., 2010). ED treatments do help, as shown by the full recovery of an AN sufferer (P10) in this study. However, she also described other young women who had relapsed several times, which implies the main and much-needed objective should be to prevent the disease from occurring at all. Disease prevention awareness programs should focus on the nature of EDs, disease severity, and access to screening tools and resources. Participants were surprised to learn that ED resources were available on the Internet and in different communities. Results from this study strongly indicate the need for more social support systems against EDs, along with awareness in schools and communities.

Young women struggle with and suffer from ED-related illnesses on a daily basis, with no idea where to get help. Along these lines, participants described friends who suffered silently from EDs; rather than seeking help in the early stages, they struggled with their disease until doctors made a secondary or follow-up diagnosis to another illness. Indeed, P10 had suffered in silence, not knowing what was wrong, until she finally received an AN diagnosis following suicidal behavior. EDs are preventable and these young women do need help, especially in their early school years, when vulnerability and risk for ED development is high. I will share the results from this study with local health program planners in South West Ohio Counties to help in understanding the needs of this population in relation to ED determinants.

While AN and BN were familiar to participants, they were unaware of EDNOS, the most frequently diagnosed ED in clinical and community samples (Smink et al., 2012). According to the *DSM-5* (APA, 2013), EDNOS is a heterogeneous group rather than a clearly defined set of EDs, and may consist of partial symptoms of AN and BN, purging disorder, and BED. Clear groups of EDs are not well known among this population, which lends support to Hoek (2012) on the complexity of EDs.

To improve disease prevention, young women, as well as their parents and family members, need education regarding the availability of screening tools, the majority of which are self-administered, such as the Eating Attitudes Test and the SCOFF Questionnaire (Austin et al., 2008). Another area demanding awareness is risk factors for EDs, especially with regard to individual perceptions of image and appearance. In this study, participants did not believe themselves at risk of suffering from disordered eating for reasons including practicing good eating habits, having strong family support systems, and exercising. More education on EDs is needed about other risk factors, such as age, gender, family history, stress, and mental health disorders.

As these findings showed, the media affects young women's perceptions of image and appearance, with social media named as the main cause of EDs. Previous researchers (Lindstedt et al., 2015; Wade & Tiggemann, 2013), shared similar observations, maintaining that all ED therapy work is geared to undoing the damage on self-image inflicted by social media. For this reason, successful therapy treatments are those focused on helping patients accept themselves for who they are (Lindstedt et al., 2015; Wade & Tiggemann, 2013), instead of what the media or society proclaims the "perfect" young

woman should look like (Nicely et al., 2014; NIMH, 2013). Patients must learn to develop a healthy body image, which begins with self-acceptance.

Participants revealed disappointment, frustration, and hopelessness toward media and the biased portrayal of beauty, expressing they want to be accepted for who they are right now, not how the media says they should look. Because of media's "skinny is beautiful" standard, these young women have endured a constant mental struggle to be accepted and to be who they are. This reveals a need for marketers to ensure advertisements include women of all sizes and body shapes. Additionally, groups concerned with young women's welfare should work to stop such sexual objectification, which would subsequently help reduce the obsession they have with their image and appearance.

Public health education programs should focus on helping young women appreciate themselves, empowering them to more positively use social media and to build internal character to reject the negative messages. Young women need education about self-esteem and diversity in society. Social comparisons lead to discontent and dissatisfaction, pointing to the need for self-acceptance. By learning the effects of peer pressure, young women equip themselves to neutralize or reject negative influences from their friends concerning image and appearance.

Eating disorders are serious illnesses that need attention, as shown in this and previous studies (Hoetzel et al., 2013). Behaviors, diagnostic criteria, and symptoms also reveal the gravity of EDs. While it is normal that people occasionally think about how they look and appear, for people with EDs, this attention to self-image is constant,

extreme, and obsessive. Criterion behaviors vary among EDs, and young females, regardless of race and ethnicity, show higher risk of ED behaviors than males (Becker et al., 2014; Dawson, 2014). Thus, there is a need for researchers to focus on understanding this gender imbalance by exploring and listening to the experiences of young women.

Researchers need to explore additional sociocultural factors of ED development. To produce appropriate preventive and treatment intervention programs, more research is needed regarding the interplay and interactions between sociocultural and environmental influences on a larger scale. Future researchers could repeat this study with participants from all Ohio counties to obtain a true representation of young female Ohioans' opinions on ED determinants.

Implications

Although the risks and conditions influencing the onset, development, and persistence of EDs have received considerable attention from researchers, their prevalence has remained the same over the past few decades, and even increased for female adolescents and young adults (Smink et al., 2012). This study's findings reduced the information gap identified from a literature review. Results showed that the type of relationships young women have with peers, family members, and society influence their perceptions of who they are, along with their senses of self-worth and personal beauty. If these relationships are positive, young women are often able to make constructive choices about their health and lifestyle, and withstand negative influences from social media and other external or internal forces.

One of the important implications for social change from this study is its contribution to and expansion of ED knowledge through the thoughts, opinions, ideas, perceptions, recommendations, and experiences of young women from the population most at risk for EDs. This study has brought about social change by contributing to knowledge that could help in reducing ED risk in Southwest Ohio, where few studies of this nature had previously taken place. Findings might inform and assist local public health program planners and inspire them to work closely with local communities, especially parents and school authorities, to come up with ED prevention programs. While ED treatment centers do help in recovery, this study revealed the risk of relapse for all ED sufferers; therefore, emphasis on the prevention of EDs can be a catalyst for social change.

Effective awareness and prevention programs focusing on the target population are needed. Eating disorders are preventable and treatable; however, awareness of diagnostic tools and intervention programs is limited. Information on ED programs and interventions should be widely available from a range of outlets, including public, local, and national television; weekly church bulletins and bulletin boards; messaging from hospitals and urgent care centers; and other community publications and resources.

There is a pressing need for awareness and education initiatives in junior high schools, high schools, and colleges. According to Fitzsimmons-Craft et al. (2014), the rate of EDs in young women increases during the college years. In the present study, I found ED risk peaks during junior and senior high school; therefore, prevention efforts in those earlier years may reduce or eliminate incidence of the disorder.

Public health departments at local levels need to partner with school officials, principals, and teachers to create ED awareness programs for junior high and senior high school students. These programs would help those at risk to learn about EDs as well as the available tools and resources, teaching them watch for ED symptoms in themselves and others. This study revealed stigma to be a main issue experienced by plus-size individuals and those with EDs; therefore, social relationships should focus on supporting and creating positive attitudes among young women. Such behaviors would help young women develop strong and positive images of themselves, and choose positive messages from social media to support personal development, not do harm.

Parents and guardians play a significant role in shaping these young women, revealing the need for programs to help parents with ED awareness, perhaps from religious organizations and community centers in collaboration with public health departments. Young women should receive encouragement to seek mentors and role models who will guide them and help build healthy relationships. Social customs of idolizing false standards of beauty are archaic and damaging to young women. There is a need to appreciate diversity and reject family, school, and social practices that lower young women's self-esteem. The media should seek to instill positive attitudes among young women (18 to 24 years old) toward their image and appearance by portraying all as equal.

Additionally, this study spurred social change on an individual basis, as participants vowed to make positive changes in their lives and the lives of family members and friends with regard to EDs. One participant (P9) vowed to combine her

background in physical education with the ED knowledge she gained from participating in this study to help other young women in her community become more fit and healthy; she planned to do this by opening a gym with affordable membership, along with a grocery store stocked with only natural produce. “This is a very important study,” stated P4, who said she was grateful for the research. Other participants (P7, P10, P4) expressed similar sentiments.

One of the implications for future research is social comparison in the development of EDs. My findings demonstrated that young women, both survivors and nonsufferers, strongly related the development of EDs to social comparison, which causes low self-esteem, poor self-image, and, ultimately EDs. Social comparison theory is one of three theories incorporated into the sociocultural model of ED in young women (Schaefer et al., 2015).

Subsequent researchers could replicate this study on a larger scale, using the same qualitative method but focusing solely on the social comparison theory to obtain in-depth information on young women’s understanding of EDs. The participants in this study stressed the influence of society on their image and the way they look at themselves, impacting their relationship with food to achieve a desired body image; as such, it is a worthwhile topic to investigate further.

In part due to lack of ED information and awareness, participants related that ED sufferers received diagnoses only as a secondary disease, something that has implications on health policies. According to the Eating Disorder Coalition (EDC; 2014), there is a need for health policy improvement benefiting ED patients. Public health researchers and

officials at local, state, and federal levels could help by disseminating existing ED policies to the public, as this study revealed young women are not aware of policies that benefit those with or at risk for EDs. Additionally, public health officials could partner with local, state, and federal lawmakers to create more beneficial ED health policies, especially ones that provide parents the ED education and support they need.

According to Becker et al. (2014), there is a need for public health studies to improve prevention, diagnosis, and treatment of EDs, as well as deliver more scientific findings and interventions rooted in community-based studies. This study helped close the gap by providing qualitative data on EDs that is of use to public health officials in devising programs that benefit the community. Risk reduction and disease prevention should be included in public health approaches addressing ED challenges. Public health involvement in EDs is necessary (Kostro et al., 2013) because, unlike clinical health settings focused on individuals (Patton, 2015), public health expands to large populations. This study could be a conduit to public health efforts and involvement in the fight against EDs.

Public health research is of value when communicated to the public; similarly, fellow researchers and editors, ED colleagues, and public health officials should disseminate this study's findings. The peer review process ensures objectivity, increasing the likelihood of findings reaching others interested in this area of study. I can also disseminate findings to local health professionals, the ODH, investigators, local church and youth program leaders, town hall meeting planners, and parents interested in learning about EDs. Other possible recipients include local media, quarterly public health

publications, and professional organizations devoted to the field of EDs among young women. (In fact, the church leader where I posted the flyer expressed interest in my published results to educate church youth on EDs.) I may also send a press release to media in Southwest Ohio, as it would provide an efficient mechanism to disseminate my results and educate the community on ED risk among young women.

Conclusion

Awareness of ED determinants among at-risk young women is a public health issue that must be thoroughly understood and addressed. Results from this study showed young women are fighting against external forces assaulting them daily with false images and standards of beauty. All 10 participants interviewed named social media as the main cause of EDs, not only among in adult women (18 to 24 years old), but especially among younger girls. One of the participants expressed ongoing trauma in the workplace, where she believes people look at and judge her because of her size.

These recommendations could lead to implementing effective public health programs at local, state, and federal levels to help ED victims get the social support they need. Study participants were young women who had recovered from EDs, as well as those who had not suffered from disordered eating. This study's findings can help program planners further understand differences in how women with and without disordered eating view EDs, including causes and development, which may reduce cognitive rigidity to treatment and lessen the tendency to stigmatize EDs in others.

Information gathered and analyzed relating to young women's perceptions of self-image and appearance was critical in the determination of how peer pressure, family

relationships, media, and social norms affect the development of EDs. Family relationships are important determinants of young women's views on eating behaviors and perceptions of weight and appearance, and in counteracting social influences of beauty. Strong parental relationships boosted the body image and body satisfaction critical for the prevention of EDs. Many young women look upon their mothers as role models concerning eating behaviors.

The media plays a significant role in defining social norms, which, in turn, affect the beliefs, eating behaviors, and perceptions of young women regarding body image (Fitzsimmons-Craft, 2011; Loth et al., 2014; Sanders, 2010). Previous researchers have shown the same struggle in helping young women fight against media's false standards to achieve body satisfaction and prevent EDs (Fitzsimons-Craft, 2011; Stephen et al., 2014). There is a need for media to present realistic, inclusive ideals (Glans et al., 2008) to help young women live healthy and positive lifestyles. As they seek to reduce the incidence of EDs among young women, public health program developers and policymakers should include the media as part of their strategies.

References

Allan, S., & Goss, K. (2014). Eating disorder beliefs and behaviors across eating disorder diagnoses. *Eating Behaviors, 15*(1), 42–44. doi:10.1016/j.eatbeh.2013.10.002

Alleva, J., Jansen, A., Martijn, C., Schepers, J., & Nederkoorn, C. (2013). Get your own mirror: Investigating how strict eating disordered women are in judging the bodies of other eating disordered women. *Appetite, 68*, 98–104. doi:10.1016/j.appet.2013.04.015

American Psychological Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Anderson, R., & Braud, W. (2011). *Transforming self and others through research: Transpersonal research methods and skills for the human sciences and humanities.* Albany, NY: State University of New York Press.

Angen, M. J. (2000). Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research, 10*(3), 378–395. doi:10.1177/104973230001000308

Arroyo, A. (2014). Connecting theory to fat talk: Body dissatisfaction mediates the relationships between weight discrepancy, upward comparison, body surveillance, and fat talk. *Body Image, 11*(3), 303–306. doi:10.1016/j.bodyim.2014.04.006

Attia, E. (2010). Anorexia nervosa: Current status and future directions. *Annual Review of Medicine, 61*, 425–435. doi:10.1146/annurev.med.050208.200745

Austin, S. B. (2012). A public health approach to eating disorders prevention: It's time for public health professionals to take a seat at the table. *BMC Public Health*, *12*, 854. Retrieved from http://www.biomedcentral.com/1471-2458/12/854

Austin, S. B., Ziyadeh, N. J., Forman, S., Prokop, L. A., Keliher, A., & Jacobs, D. (2008). Screening high school students for eating disorders: Results of a national initiative. *Preview of Chronic Diseases, 5*(4). Retrieved from http://www.cdc.gov/pcd/issues/2008/cot/07_0164.htm

Babbie, E. R. (2010). *The practice of social research*. Belmont, CA: Wadsworth.

Bailey, A. P., Parker A. G., Colautti, L. A., Hart, M. L., Liu, P., & Hetrick, S. E. (2014). Mapping the evidence for the prevention and treatment of eating disorders in young people. *Journal of Eating Disorders, 2*(1), 5. doi:10.1186/2050-2974-2-5

Becker, A. E., Fay, K. E., Agnew-Blais, J., Khan, A. N., Striegel-Moore, R. H., & Gilman, S. E. (2011). Social network media exposure and adolescent eating pathology in Fiji. *British Journal of Psychiatry, 198,* 43–50. doi:10.1192/bjp.bp. 110.078675

Becker, A. E., Grinspoon, S. K., Klibanski, A., & Herzog, D. B. (1999). Eating disorders. *New England Journal of Medicine*, *340*(14), 1092-1098. doi:10.1056/NEJM199904083401407

Becker, C., Plasencia, M., Kilpela, L., Briggs, M., Tiffany, S., & Stewart S. T. (2014). Changing the course of comorbid eating disorders and depression: What is the role of public health interventions in targeting shared risk factors? *Journal of Eating Disorders, 2*, 15. doi:10.1186/2050-2974-2-15

Best, J. (2004). *More damned lies and statistics: How numbers confuse public issues*. Berkeley, CA: University of California Press.

Blackburn, S. (2001). *Being good: A short introduction to ethics*. Oxford, UK: Oxford University Press.Blumenthal, D. S., & DiClemente, R. J. (2013). *Community based participatory health research* (2nd ed.). New York, NY: Springer.

Bogdan, R. C., & Biklen, S. K. (2007). *Qualitative research for education: An introduction to theories and methods*. Boston, MA: Pearson.

Bowlby, J. (1969). *Attachment and loss attachment.* New York, NY: Basic Books.

Brocki, J. J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health, 21*(1), 87–108. doi:10.1080/14768320500230185

Chan, M., & Kelly, H. (2014). Effectiveness of pilot trial of family meal support prior inpatient discharge. *Journal of Eating Disorders*, *2*(1), 14. doi:10.1186/2050-2974-2-S1-P14

Chao, A. M., Grilo, C. M., & Sinha, R. (2016). Food cravings, binge eating, and eating disorder psychopathology: Exploring the moderating roles of gender and race. *Eating Behaviors, 21,* 41–47. doi:10.1016/j.eatbeh.2015.12.007

Churruca, K., Pérez, J., & Ussher, J. M. (2014). Uncontrollable behavior or mental illness? Exploring constructions of bulimia using Q methodology. *Journal of Eating Disorders*, *2*, 22. doi:10.1186/s40337-014-0022-2

Cohen, D., & Crabtree, B. (2006). *Qualitative research guidelines project*. Retrieved from http://www.qualres.org/HomeThic-3697.html

Cohen, L., Chavez, V. & Chehimi. S. (Eds.). (2010). Prevention is primary: Strategies for community well-being. San Francisco, CA: Jossey-Bass.

Creswell, J. W. (2013a). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Los Angeles, CA: Sage Publications.

Creswell, J. W. (2013b). *Research design: A qualitative, quantitative, and mixed method approaches* (4th ed.). Thousand Oaks, CA: Sage Publications.

Dahlgren, C. (2014). A systematic review of cognitive remediation therapy for anorexia nervosa - Development, current state and implications for future research and clinical practice. *Journal of Eating Disorders, 2*, 26. Retrieved from http://www.jeatdisord.com/content/2/1/26/abstract

Dakanalis, A., Zanetti, M. A., Riva, G., & Clerici, M. (2013). Psychosocial moderators of the relationship between body dissatisfaction and symptoms of eating disorders: A look at a sample of young Italian women. *European Review of Applied Psychology, 63*(5), 323-334. doi:10.1016/j.erap.2013.08.001

Davidson, J. (2000). A phenomenology of fear: Merleau-Ponty and agoraphobic life-worlds. *Sociology of Health & Illness, 22*, 640-681. doi:10.1111/1467-9566.00224

Dawson, L. (2014). Review of the book *Treatment and recovery of eating disorders–edited*, by D. Stein and Y. Latzer. *Journal of Eating Disorders*, *2*, 4. doi:10.1186/2050-2974-2-4

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2000). *Handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Denzin, N. K., & Lincoln, Y. S. (2013). *Strategies of qualitative inquiry* (4th ed.). Thousand Oaks, CA: Sage Publications.

Ekeroth, K., Clinton, D., Norring, C., & Birgegård, A. (2013). Clinical characteristics and distinctiveness of DSM-5 eating disorder diagnoses: Findings from a large naturalistic clinical database. *Journal of Eating Disorders, 1*(31), 1-11. Retrieved from http://www.jeatdisord.com/content/pdf/2050-2974-1-31.pdf

Festinger, L. (1954). A theory of social comparison processes. *Human Relations, 7*(2), 117–140. doi:10.1177/001872675400700202

Fink, A. (2005). *Conducting research literature reviews: From the Internet to paper*. Thousand Oaks, CA: Sage Publications.

Fitzsimmons-Craft, E. E. (2011). Social psychological theories of disordered eating in college women: Review and integration. *Clinical Psychology Review, 31*(7), 1224–1237. doi:10.1016/j.cpr.2011.07.011

Fitzsimmons-Craft, E. E., Bardone-Cone, A. M., Bulik, C. M., Wonderlich, S. A., Crosby, R. D., & Engel, S. G. (2014). Examining an elaborated sociocultural model of disordered eating among college women: The roles of social comparison and body surveillance. *Body Image, 11*(4), 488–500. doi:10.1016/j.bodyim.2014.07.012

Flowers, P., Smith, J. A., Sheeran, P., & Beail, N. (1997). Health and romance: Understanding unprotected sex in relationships between gay men. *British Journal of Health Psychology, 2*, 73–86. doi:10.1111/j.2044-8287.1997.tb00524.x

Fox, A. P., Larkin, M., & Leung, N. (2011). The personal meaning of eating disorder symptoms: An interpretative phenomenological analysis. *Journal of Health Psychology, 16*(1), 116–125. doi:10.1177/1359105310368449

Frederick, D. A., Kelly, M. C., Latner, J. D., Sandhu, G., & Tsong, Y. (2016). Body image and face image in Asian American and white women: Examining associations with surveillance, construal of self, perfectionism, and sociocultural pressures. *Body Image, 16,* 113–125. doi:10.1016/j.bodyim.2015.12.002

Fredrickson, B.L., and Roberts, T.A. (1997). Objectification Theory: Toward Understanding Women's Lived Experiences and Mental Health Risks. Psychology of women quarterly. 21, 173-206. doi.org/10.1111/j.1471-6402.1997.tb00108.x

Gabriel C., & Waller G. (2014). Personality disorder cognitions in the eating disorders. *The Journal of Nervous and Mental Disease, 202*(2), 172–76. doi:10.1097/NMD.0b013e3181e4c6f7

Galman, S. C. (2013). *The good, the bad, and the data: Shane the lone ethnographer's basic guide to qualitative data analysis*. Walnut Creek, CA: Left Coast Press.

Gearhardt A. N., Boswell, R. G., & White M. A. (2014). The association of "food addiction" with disordered eating and body mass index. *The Journal of Eating Behavior, 15*(3), 427–433. doi:10.1016/j.eatbeh.2014.05.001

Glans, K., Rimer, B. K., & Viswanath, K. (Eds.). (2008). *Health behavior and health education: Theory, research, and practice* (4th ed.). San Francisco, CA: John Wiley & Sons.

Gleaves, D. H., Pearson, C. A., Ambwani, S., & Morey, L. C. (2014). Measuring eating disorder attitudes and behaviors: A reliability generalization study. *Journal of Eating*, *10*(2), 6. doi:10.1186/2050-2974-2-6

Golan, M. (2013). The journey from opposition to recovery from eating disorders: Multidisciplinary model integrating narrative counseling and motivational interviewing in traditional approaches. *Journal of Eating Disorders 1*, 19. doi:10.1186/2050-2974-1-19

Griffiths, S., Mond, J. M., Murray, S. B., Thornton, C., & Touyz, S. (2015). Stigma resistance in eating disorders. *Journal of Social Psychiatry Psychiatric and Epidemiology, 50*(2), 279-87. doi:10.1007/s00127-014-0923-z

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods, 3*(1). Retrieved from http://www.ualberta.ca/~iiqm/backissues/3_1/pdf/groenewald.pdf

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Thousand Oaks, CA: Sage Publications.

Haines, J., & Neumark-Sztainer, D. (2006). Prevention of obesity and eating disorders: A consideration of shared risk factors. *Health Education and Research*, *21*, 770–782. Retrieved from http://her.oxfordjournals.org/content/21/6/770.short

Harrison, C., Mond, J., Bentley, C., Gratwick-Sarll, K., Rieger, E., & Rodger, B. (2014). Loss of control eating with and without the undue influence of weight or shape on self-evaluation: Evidence from an adolescent population. *Journal of Eating Disorders, 2*, 31. doi:10.1186/s40337-014-0031-1

Hepworth, J. (1994). Qualitative analysis and eating disorders: Discourse analytic research on anorexia nervosa. *International Journal of Eating Disorders, 2*, 179–185. doi.org/10.1002/1098-108X

Hilbert, A., Pike, K. M., Goldschmidt, A. B., Wilfley, D. E., Fairburn, C. G., Dohm, F., Weissman, R. S. (2014). Risk factors across the eating disorders. *Psychiatry Research, 220*(1–2), 500-506. doi:10.1016/j.psychres.2014.05.054

Hiles, D. R., & Čermák, I. (2007) Narrative psychology. In C. Willig & W. Stainton-Rogers (Eds.), *Handbook of qualitative research in psychology*. London, UK: Sage Publications.

Hoetzel, K., Brachel, R., Schlossmacher, L., & Vocks, S. (2013). Assessing motivation to change in eating disorders: A systematic review. *Journal of Eating Disorders*, *1*, 38. doi:10.1186/2050-2974-1-38

Hudson, J. I., Hiripi, E., Pope, H. G., Kessler, R.C. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological Psychiatry*. *61*, 348–358. doi:10.1016/j.biopsych.2006.03.040

Hughes, K. E., Allan, E., Le Grange, D., & Sawyer S., (2013). "It depends who you ask": Perceptions of the family environment of adolescents presenting to a specialist eating disorders program. *Journal of Eating Disorders, 1,* O56. doi:10.1186/2050-2974-1-S1-O56

Issel, M. L. (2013). *Health program planning and evaluation: A practical, systematic approach for community health* (2nd ed.). Sudbury, MA: Jones & Bartlett Learning.

Jauregui-Lobera, I. (2011). Electroencephalography in eating disorders. *Neuropsychiatric Disease and Treatment, 8,* 1–11. doi:10.2147/NDT.S27302

Jones, A. (2001). Some experiences of professional practice and beneficial changes from clinical supervision by community Macmillan nurses. *European Journal of Cancer Care, 10*(1), 21–31. doi:10.1046/j.1365-2354.2001.00209.

Kass, K.E., Kolko, R.P. and Wilfley, D.E. (2013). Psychological Treatments for Eating Disorders. *Current Opinion in Psychiatry* 26(6): 549–555. doi:10.1097/YCO.0b013e328365a30e

Kaye, W. H., Bulik, C. M., Thornton, L., Barbarich, N., & Masters, K. (2004). Comorbidity of anxiety disorders with anorexia and bulimia nervosa. *American Journal of Psychiatry, 161*, 2215–2221. doi:10.1176/appi.ajp.161.12.2215

Kelly, C. A., & Carter, J. C. (2014). The current status of suicide and self-injury in eating disorders: a narrative review. *Journal of Eating Disorders, 2*(2), 19. doi:10.1186/2050-2974-2-2

Kim, S. Y., Seo, Y. S., & Baek, K. Y. (2014). Face consciousness among South Korean women: A culture-specific extension of objectification theory. *Journal of Counseling Psychology, 61,* 24–36. doi:10.1037/a0034433

Klump, K. L., McGue, M., & Iacono, W. G. (2000). Age differences in genetic and environmental influences on eating attitudes and behaviors in preadolescent and adolescent female twins. *Journal of Abnormal Psychology, 109*(2), 239–251. Retrieved from http://www.apa.org/pubs/journals/abn/

Kostro, K. Lerman, J. B., & Attia, E. (2014). The current status of suicide and self-injury in eating disorders: A narrative review. *Journal of Eating Disorders, 2*(1), 19. doi:10.1186/s40337-014-0019-x

Kvale, S. (1996). *InterViews: An introduction to qualitative research interviewing*. London, UK: Sage Publications.

Kvale, S. (2009). *Doing interviews: The Sage qualitative research kit.* Thousand Oaks, CA: Sage Publications.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, *3*(2), 102–120. doi:10.1191/1478088706qp062oa

Lasalvia, A., Zoppei, S., Van Bortel, T., Bonetto, C., Cristofalo, D., Wahlbeck, K.,Thornicroft, G. (2013). Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: A cross sectional survey. *The Lancet, 381*(9860)*,* 55–62. doi:10.1016/S0140-6736(12)61379-8

Leedy, P. D., & Ormrod, J. E. (2005). *Practical research: Planning and design*. Upper Saddle River, NJ: Merrell Publishing.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Thousand Oaks, CA: Sage Publications.

Lindstedt, K., Neander, K., Kjellin, L., & Gustafsson, S. A. (2015). Being me and being us - Adolescents' experiences of treatment for eating disorders. *Journal of Eating Disorders,* 3(1), 9. doi:10.1186/s40337-015-0051-5

Loth, K. A., MacLehose, R., Bucchianeri, M., Crow, S., & Neumark-Sztainer, D. (2014). Predictors of dieting and disordered eating behaviors from adolescence to young adulthood. *Journal of Adolescent Health, 55*(5), 705–712. doi:10.1016/j.jadohealth.2014.04.016

MacGregor, M. W., & Lamborn, P. (2014). Personality assessment inventory profiles of university students with eating disorders. *Journal of Eating Disorders, 2,* 20. Retrieved from http://wwwi.jeatdisord.com/content/2/1/20

Malterud, K. (2001). Qualitative research: Standards, challenges, and guidelines. *The Lancet, 358*(9280), 483–488. Doi:10.1016/S0140-6736(01)05627-6

Martino, S., & Lester, D. (2013). Menarche and eating disorders. *Psychological Reports: Disability and Trauma, 113*(1), 315–317. doi:10.2466/15.02.PR0.113x15z5

Maxwell, J. A. (2012). *A realist approach for qualitative research*. Thousand Oaks, CA: Sage Publications.

Minkler, M. (2004). Ethical challenges for the "outside" researcher in community-based participatory research. *Health Education & Behavior, 31* (6), 684–697. doi:10.1177/1090198104269566

Mitchell, J. E., Roerig, J., & Steffen, K. (2013). Biological therapies for eating disorders. *International Journal of Eating Disorders, 46*(5)*,* 470–477. doi:10.1002/eat.22104

Monell, E., Högdahl, L., Mantilla, E., & Birgegård, A. (2015). Emotion dysregulation, self-image and eating disorder symptoms in university women. *Journal of Eating Disorders, 3*(44), 1–11. doi:10.1186/s40337-015-0083-x

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2), 13–22. doi:10.1177/160940690200100202

Moskowitz, D. S., & Young, S. N. (2006). Ecological momentary assessment: What it is and why is it a method of the future in clinical psychopharmacology. *Journal of Psychiatry Neuroscience, 31*(1), 13–20. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1325062/

National Institute of Mental Health. (2013). *Eating disorders*. Washington, DC: U.S. Government Printing Office.

Newton, M., Boblin, S., Brown B. D., & Ciliska, D. (2006). Understanding intimacy for women with anorexia nervosa: A phenomenological approach. *European Eating Disorders Review, 14*, 43–53. doi:10.1002/erv.669

Nicely, T. A., Lane-Lonely, S., Masciulli, E., Hollenbeak, C. S. & Ornstein, R. M. (2014). Prevalence and characteristics of avoidant/restrictive food intake disorder in a cohort of young patients in day treatment for eating disorders. *Journal of Eating Disorders, 2*, 21. Retrieved from http://www.jeatdisord.com/content

Nowakowski. M., McFarlane, T., & Cassin, S. (2013). Alexithymia and eating disorders: A critical review of the literature. *Journal of Eating Disorders, 1*(21), 1–14. doi:10.1186/2050-2974-1-21

Ohio Department of Health. (2013a). *Adolescent health–Ohio*. Retrieved from http://www.odh.ohio.gov/odhprograms/chss/ad_hlth/adhlth1.aspx

Ohio Department of Health. (2013b). *Adolescent health–Ohio youth risk behavior survey*. Retrieved from http://www.odh.ohio.gov/en/odhprograms/chss/ad_hlth/youthrsk/youthrsk1.aspx

Patton, M. Q. (1989). *Qualitative research and evaluation methods* (4th ed.). Thousand Oaks, CA: Sage Publications.

Patton, M. Q. (2015). *Qualitative research and evaluation methods* (4th ed.). Thousand Oaks, CA: Sage Publications.

Phan, T., & Tylka, T. L. (2006). Exploring a model and moderators of disordered eating with Asian American college women. *Journal of Counseling Psychology, 53*(1), 36–47. doi:10.1037/0022-1067.53.1.36

Pike, K. M., Walsh, B. T., Vitousek, K., Wilson, G. T., & Bauer, J. (2003). Cognitive behavior therapy in the posthospitalization treatment of anorexia nervosa. *The American Journal of Psychiatry, 160*(11), 2046–2049. doi:10.1176/appi.ajp.160.11.2046. PMID 14594754

Polivy & Herman. (2002). Causes of Eating Disorders. *Annual Review of Psychology* 53:187-213 https://doi.org/10.1146/annurev.psych.53.100901.135103

Rakhkovskaya, L. M., & Warren, C. S. (2016). Sociocultural and identity predictors of body dissatisfaction in ethnically diverse college women. *Body Image, 16,* 32–40. doi:10.1016/j.bodyim.2015.10.004

Reid, K., Flowers, P. & Larkin, M. (2005). Exploring lived experience: An introduction to interpretative phenomenological analysis. *The Psychologist, 18*(1), 20–23. Retrieved from https://www.researchgate.net/profile/Paul_Flowers/publication/

221670347_Exploring_lived_Experience/links/0922b4f57ab3ca3a29000000/Exploring-lived-Experience.pdf

Rikani, A. A., Choudhry, Z., Choudhry, A. M., Ikram, H., Asghar, M. W., Kajal, D., . . . Mobassarah, N. J. (2013). A critique of the literature on etiology of eating disorders. *Annals of Neuroscience, 4*(20), 770–782. Retrieved from http://her.oxfordjournals.org/content/21/6/770.short

Roulston, K. (2010). *Reflective interviewing: A guide to theory and practice*. Thousand Oaks, CA: Sage Publications.

Rudestam, K. E., & Newton, R. R. (2007). *Surviving your dissertation: A comprehensive guide to content and process* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Salafia, E. B., Jones, M., Haugen, E., & Schaefer, M. (2015). Perceptions of the causes of eating disorders: A comparison of individuals with and without eating disorders. *Journal of Eating Disorders, 3*(32), 1–10. doi:10.1186/s40337-015-0069-8

Sanders, L. D. (2010). *Discovering research methods in psychology: A student's guide*. Malden, MA: British Psychological Society/Blackwell.

Saunders, M., Lewis, P., & Thornhill, A. (2007). *Research methods for business students*. (6th ed.). New York, NY: Pearson Education.

Schaefer, L. M., Thibodaux, L. K., Krenik, D., Arnold, E., & Thompson, J. K. (2015). Physical appearance comparisons in ethnically diverse college women. *Body Image, 15*, 153–157. doi:10.1016/j.bodyim.2015.09.002

Schmidt, U. (2017). Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA). In T. Wade (Ed.), *Encyclopedia of feeding and eating disorders*, pp. 508–513. Switzerland, AG: Springer. doi:10.1007/978-981-287-104-6_83

Schooler, D., & Trinh, S. (2011). Longitudinal associations between television viewing patterns and adolescent body satisfaction. *Body Image, 8*(1), 34–42. doi:10.1016/j.bodyim.2010.09.001

Schulte, E. M., Grilo, C. M., & Gearhardt, A. N. (2016). Shared and unique mechanisms underlying binge eating disorder and addictive disorders. *Clinical Psychology Review, 44*, 125–139. doi:10.1016/j.cpr.2016.02.001

Scott, N., Hanstock, T. L., & Thornton, C. (2014). Dysfunctional self-talk associated with eating disorder severity and symptomatology. *Journal of Eating Disorders*, *2*(1), 14. doi:10.1186/2050-2974-2-14

Serpell, L., Stobie, B., Fariburn, G. C., & van Schaick, R. (2013). Empirically-supported and non-empirically supported therapies for bulimia nervosa: Retrospective patient ratings. *Journal of Eating Disorders*, *1*, 41. doi:10.1186/2050-2974-1-41

Shenton L. L. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*, 63–75. Retrieved from https://www.iospress.nl/journal/education-for-information/

Silverman, D. (2006). *Interpreting qualitative data: Methods of analyzing talk, text and interaction* (3rd ed.). London, UK: Sage Publications.

Silverman, D. (2013). *Doing qualitative research: A practical handbook* (4th ed.). London, UK: Sage Publications.

Smart, R., & Tsong, Y. (2014). Weight, body dissatisfaction, and disordered eating: Asian American women's perspectives. *Asian American Journal of Psychology, 5*(4), 344–352. doi:10.1037/a0035599

Smeets, E., Tiggemann, M., Kemps, E., Mills, J. S., Hollitt, S., Roefs, A., & Jansen, A. (2011). Body checking induces attentional bias for body-related cues. *International Journal of Eating Disorders, 44,* 50–57. doi:10.1002/eat.20776.

Smink, F. R. E., van Hoeken, D., & Hoek, H. W. (2012). Epidemiology of eating disorders: Incidence, prevalence and mortality rates. *Current Psychiatry Reports, 14,* 406–414. doi:10.1007/s11920-012-0282-y

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology & Health, 11*(2), 261–271. doi:10.1080/08870449608400256

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretive phenomenological analysis: Theory method and research. An interpretative phenomenological analysis*. Thousand Oaks, CA: Sage Publications.

Soh, L. N., & Walter, G. (2013). Publications on cross-cultural aspects of eating disorders. *Journal of Eating Disorders*, *1*(4). doi:10.1186/2050-2974-1-4

Steiner, H., & Lock, J. (1998). Anorexia nervosa and bulimia nervosa in children and adolescents: A review of the past ten years. *Journal of the American Academy of Child and Adolescent Psychiatry*, *37*, 352–359. doi:10.1097/00004583-199804000-00011

Stein. (2006).Stephen, E. M., Rose, J., Kenney, L., Rosselli-Navarra, F., & Weissman, R. (2014). Adolescent risk factors for purging in young women: Findings from the national longitudinal study of adolescent health. *Journal of Eating Disorders, 2*(1), 1–9. doi:10.1186/2050-2974-2-1

Stringer, E. T. (2007). *Action research.* Thousand Oaks, CA: Sage Publications.

Striegel-Moore, R. H., & Bulik, C. M. (2007). Risk factors for eating disorders. *The American Psychologist, 62*(3), 181–198. doi:10.1037/0003-066X.62.3.181

Substance Abuse and Mental Health Services Administration. (2011). *Brief interventions for substance abuse-KAP keys based on TIP 34*. Retrieved from http://store.samhsa.gov/product/Brief-Interventions-and-Therapies-for-Substance-Abuse/SMA01-3601

Surgenor, L., & Maguire, S. (2013). Assessment of anorexia nervosa: An overview of universal issues and contextual challenges. *Journal of Eating Disorders, 1*(1), 29. doi:10.1186/2050-2974-1-29

Tchanturia, K., Davies, H., & Campbell, I. C. (2007). Cognitive remediation therapy for patients with anorexia nervosa: preliminary findings. *Annals of General Psychiatry, 6,* 14. doi:10.1186/1744-859X-6-14

Tetley, A., Moghaddam, N.G., Dawson, D. L., & Rennoldson, M. (2014). Parental bonding and eating disorders: A systematic review. *Eating Behaviors, 15*(1), 49–59. doi:10.1016/j.eatbeh.2013.10.008

Teusch, M, & Fielding, E. J. (2013). Rediscovering the core of public health. *Annual Review Public Health, 34*, 287–299. doi:10.1146/annurev-publhealth-031912-114433

Thamotharan, S., Hubbard, M., & Fields, S. (2015). Delay discounting, but not disinhibition or inattention, partially mediates the effects of neuroticism on disordered eating in adolescents. *Eating Behaviors, 18*, 91–96. doi:10.1016/j.eatbeh.2015.04.005

Thomas, R. M., & Brubaker, D. L. (2000). *Theses and dissertations: A guide to planning, research, and writing.* Westport, CT: Bergin & Garvey.

Thornicroft, Rose, Kassam, & Sartorius. (2007). Stigma: ignorance, prejudice or discrimination? *British Journal of Psychiatry,* 190, 192-193. doi:1 0 .119 2 / bjp. bp.106.025791 2007

Treasure, J., & Schmidt, U. (2013). The cognitive-interpersonal maintenance model of anorexia nervosa revisited: A summary of the evidence for cognitive, socio-emotional and interpersonal predisposing and perpetuating factors. *Journal of Eating Disorders*, *1*, 13. doi:10.1186/2050-2974-1-13

Vann, A., Strodl, E. & Anderson, E. (2013). Thinking about internal states, a qualitative investigation into metacognitions in women with eating disorders. *Journal of Eating Disorders*, *1*, 22. doi:10.1186/2050-2974-1-22

Vogt, W. P., Gardner, D. C., & Haeffele, L. M. (2012). *When to use what research design*. New York, NY: Guilford Press.

Wade, T. D., Keski-Rahkonen A., & Hudson J. (2011). Epidemiology of eating disorders. In M. Tsuang & M. Tohen (Eds.), *Textbook in psychiatric epidemiology* (3rd ed., pp. 343–360). New York, NY: Wiley.

Wade, T. D., & Tiedemann, M. (2013). The role of perfectionism in body dissatisfaction. *Journal of Eating Disorders 1*, 2. doi:10.1186/2050-2974-1-2Waldman, A., Loomes, R., Mountford, V. A., & Tchanturia, K. (2013). Attitudinal and perceptual factors in body image distortion: An exploratory study in patients with anorexia nervosa. *Journal of Eating Disorders, 1*(1), 17. doi:10.1186/2050-2974-1-17

Ward, R. M., & Hay, M. C. (2015). Depression, coping, hassles, and body dissatisfaction: factors associated with disordered eating. *Journal of Eating Behavior, 17*, 14–18. doi:10.1016 /j.eatbeh.2014.12.002

Wingfield, J.C. (2013). Ecological processes and the ecology of stress: the impacts of abiotic environmental factors. Journal of Functional Ecology. 27(1): 37-44. doi.org/10.1111/1365-2435.12039

Yoo, H., Steger, M. F., & Lee, R. M. (2010). Validation of the subtle and blatant racism scale for Asian American college students (SABR-A2). *Cultural Diversity & Ethnic Minority Psychology, 16,* 323–334. doi:10.1037/a0018674

Zhao, Y., & Encinosa, W. (2009, April). *Hospitalizations for eating disorders from 1999 to 2006.* (HCUP Statistical Brief #70). Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from http://www.hcup-us.ahrq.gov/reports/statbriefs/sb70.pdf

Zwickert, K., & Rieger E. (2013). Stigmatizing attitudes towards individuals with anorexia nervosa: An investigation of attribution theory. *Journal of Eating Disorders, 1*(1), 5. doi:10.1186/2050-2974-1-5

Appendix A: Interview Guide

Interview Location:_____ Date: _____

Time Interview Started: Time Interview Ended:

_____ _____

Name of Researcher: Participant Name and Code:

_____ _____

1. Can you tell me what you understand or know about eating disorders?
2. Can you tell me what place (if any) eating disorder has in your life and/or family right now?
3. Can you share with me what and who is your role model for physical beauty? And how you see or view yourself?
4. How would you describe yourself as a person?
5. Can you share with me if you have had any experiences with EDs? (Have you been diagnosed with EDs? Do you know anyone with EDs?)
6. Can you share with me your experiences in relation to body image?
7. Are you aware of any ED screening tools accessible to you? Please explain.
8. Do you see yourself as at risk of developing EDs? Please explain.
9. How do your family and friends influence the way you see yourself?

10. How, if any, have any of your family, friends, school, church, social media comments, attitudes, et cetera, influenced your eating habits?
11. What would you say is the main cause for body dissatisfaction in young women?
12. Please tell me what body dissatisfaction means to you.
13. What do you think about fast food and EDs?
14. What role does social perception of beauty play on ED development in young women?

Appendix B: Interpretive Phenomenological Data Analysis Steps

Step	Step Goal	Description
1	Transcript reading	After setting time aside (at least 3 hr) for data analysis, I began by reading all interview transcripts in general, and making notes of my first impressions from the data. Then I went back, reading the transcripts again, this time one by one, looking for any ideas that may have come up. I reread, line by line, the data as reported by the participant.
2	Coding or labeling relevant information pieces	Using Microsoft Word, in this step I was looking for pieces of information (words, actions, concepts, etc.) relevant to the research questions of this study, and then labeled or coded them. Deciding on what information to code could come from any of the following: • Repeated information or information shown in a number of places in the transcript. • Information that may have been surprising to me. • Information to which the study participant may have drawn attention by stating that it was important. • Information that may have resonated with any of the ED theories/or frameworks in this study. There is no set rule in IPA for analyzing data (Reid, Flowers & Larkin, 2005; Smith, 1996; Smith, 2011) because the goal is to let the data speak for itself. Therefore, in this data analysis, I continually reminded myself of any preconceived notions, ideas, or judgments and set those aside (bracketing). I

Step	Step Goal	Description
		thus coded data with an open, unbiased mind, so that data coding or themes created from the data were as close to the interview transcript as possible. I reminded myself constantly to make sure that data coding represented the experiences of the participants—hence, examples of what to look for were examples only. This initial coding may have generated multiple themes, depending on the transcripts.
3	Categorizing or looking for emerging themes (conceptualizing the data)	The goal in this step was to conceptualize the data; unlike in the second step, here I was looking the data on a more abstract and general level, still with an open-minded and unbiased approach, staying close to the data (transcript). I reviewed the data from Step 2, closely inspecting all codes, line by line, reading and rereading the codes and looking for themes by bringing similar codes together. In this step, I categorized the data according to the most important codes as identified by the participant's descriptions and experiences. I also reminded myself that my goal in this section was to work intensely and closely with the text, looking for relevant insights that would take me into the interviewee's views and experiences (Smith et al., 2009) on ED. Eventually, I cataloged the resultant codes, and then looked for patterns or themes in the important codes. Categories may have been of different types (differences, objects, etc.), depending on what the data revealed. IPA data analysis is done with no preconceived notions (Reid et al., 2005) to see the world in the eyes of the participant.

Step	Step Goal	Description
4	Labeling the categories (study results)	Labeling study results entailed looking for how the themes and categories are connected to each other:I described the connections between the categories. I repeated the above steps for each of the interview transcripts (data) until all data analysis was completed. Eventually, these categories and the connections were the main results of my research, providing new knowledge about the world, society, etc., from the perspective of these young women 18 to 24 years old from Southwest Ohio.
5	Hierarchy: Looking for some sort of order in the data	This step included looking for a hierarchy in the data (across the entire study), and then putting it either into a table or another graphical way of easily communicating results.
6	Results write-up	According to Smith, Flowers, and Larkin (2009), the best IPA analysis is of no value unless the reader can make sense of what the researcher finds. Therefore, the results write-up is a critical part of the IPA data analysis procedure. In line with this, I summarized the results of my study in the Results section (Chapter 4) of the dissertation. In Chapter 5, the discussion section, I revealed my interpretation of the data and suggestions regarding future studies in connection to the research findings.