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A Qualitative Study of Women's Attitudes and Experiences Regarding Body Image and Disordered Eating Behaviors

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A Qualitative Study of Women's Attitudes and Experiences Regarding
Body Image and Disordered Eating Behaviors

Natalie Ann Kirtley

A dissertation submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy

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ABSTRACT

A Qualitative Study of Women's Attitudes and Experiences Regarding Body Image and Disordered Eating Behaviors

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Doctor of Philosophy

The current research study is responding to recent findings wherein, Fischer et al. (2013) report a risk rate based on EAT-26 scores in the range of 9.2% to 10.8% at BYU in comparison to the 15% they found reported in the literature using samples from other college campuses. Risk rates based on BSQ scores were reported in the 27.2% to 31.1% range, which was on par with a risk rate of 28.7% reported at a comparable university (Fischer et al., 2013). Fischer et al. (2013) conclude that while body shape concerns were estimated to be equal to or lower than reports at other universities, the level of eating disorder risk was not what would have been expected based on the estimates of other universities of the correlations normally found between EAT-26 and BSQ scores.

This qualitative study investigated the experiences of 14 women who were identified as exhibiting high body shape dissatisfaction as determined by the Body Shape Questionnaire (BSQ) and did endorse having disordered eating attitudes or habits as determined by the Eating Attitudes Test (EAT-26). The In-depth interviews and data analysis were conducted using an Interpretative Phenomenological Analysis method and aimed at exploring the experiences of these women and what they believe keeps them healthy. Seven themes emerged from the data: Control, Social, Spiritual, Priorities, Exposure to Information, Avoidance, and Food Relationship. The first four themes were further conceptualized as having both a positive, or protective, impact and a negative, or counterproductive, impact on the participants. These four themes contributed to the participants overall Self-concept. The latter three themes, although likely having the same dual potential conceptualization were less compatible with an overall model despite being themes that were emphasized in the transcripts. The theme Control was further conceptualized to depict how the positive/protective impact functioned through a perception of choice and empowerment and how the negative/counterproductive impact functioned through a perception of no choice and disempowerment. Each of these possibilities yielded two potential outcomes for the participants, (a) enforce desired behaviors; or (b) do not enforce desired behaviors. What appears to be most protective against allowing body dissatisfaction to lead to disordered eating attitudes and behaviors is having a sense of self that is accepted by both oneself and by others. Ultimately, the results are a first step in the exploration of protective factors for women with a risk of developing an eating disorder. The results provide potential implications for future research and hint at potential clinical uses, both of which are discussed.

Keywords: body image, disordered eating, control, spirituality, priorities, social, avoidance, food relationship, self-acceptance, BYU, religion, body shape questionnaire, eating attitudes test, interpretative phenomenological analysis, qualitative

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Chapter 1: Introduction

Theories on the origin of eating disorders (ED) are many and varied, and are being used as the basis of treatment plans and prevention programs. Prevention programs are appearing in community, school and medical settings to curb the incidence rates and improve identification efforts. Research efforts are working to understand the etiology of EDs and how best they respond to treatment. Naturally, research efforts have begun to focus on prevention efforts to reduce the need for treatment and recovery. Interestingly, most ED research has concentrated on exploring individuals who report disordered eating as source for understanding ED risk and prevention, leaving a large untapped resource of ED risk and prevention information that could be gleaned from individuals who report healthy or well-ordered eating. The current study takes into account research conducted on risk and prevention factors in ED development. It also explores recent findings reported by Fischer et al. (2013). Those findings identified a group of women that are at high risk for developing an eating disorder based on body dissatisfaction but do not have elevated eating disordered attitudes. This study aims to explore the experiences of those women and what they believe keeps them healthy.

Prevalence

Eating disorder (ED) diagnoses, behaviors, and attitudes have been reported to be on the rise for decades, plateauing in more recent years (Hoek, 2006). Bulimia Nervosa (BN) is estimated to have a lifetime prevalence rate of 1.7% to 2.3% among women using DSM-5 criteria (Keski-Rahkonen et al., 2009, as cited in Smink, Van Hoeken, & Hoek, 2012). Prevalence rates for disordered eating now diagnostically in the category *Feeding and Eating Disorders Not Elsewhere Categorized* has been estimated to be as high as 11.5% (Le Grange, Swanson, Crow, & Merikangas, 2012; Stice, Marti, & Rhode, 2013).

Wilfley, Agras, and Taylor (2013) reported on ED symptoms that did and did not qualify for a strict diagnosis but were still disordered. They indicated that it would be expected that in a college sample of 1,000 women, if screened for ED, risk rates would be expected to yield prevalence rates of 1-2% clinical, 2-5% subclinical, 20-25% high risk, and 68-77% as low risk. Overall, ED research reports a lifetime prevalence rate of 11%-12% for women situating EDs. With a lifetime prevalence rate over 10% and with others struggling with undiagnosed EDs, understanding the development of EDs becomes a clinical focus to formulate prevention and treatment plans. With clinically significant prevalence rates, risk factor identification has become increasingly meaningful.

Risk

To date, ED prevention and treatment programs have been founded on research identifying risk factors. Identifying ED development risk factors is difficult because it insinuates a reliable and for some a causal relationship. A risk factor is “a characteristic (e.g., allele), event (e.g., teasing), or experience (e.g., growing up in a culture that values extreme thinness) that precedes the onset of the outcome of interest” (Striegel-Moore & Bulik, 2007, p. 183). ED research has attended to identifying risk factors but admittedly risk factors do not reliably predict (Jacobi et al., 2011; Keel & Forney, 2013).

A recent qualitative literature review conducted by Keel and Forney (2013) surveyed the ED research for the most commonly identified risk factors. Their findings indicated the following as common and significant risk factors: being female and an adolescent or young adult; internalization of idealization of thinness; weight concerns; personality traits such as negative emotionality and perfectionism; and peer interactions. For the purposes of the current study, risk factors have been categorized into four domains: demographics such as ethnicity,

gender and age; personality traits and affect including negative emotionality and perfectionism; social factors such as peer commentary and social comparison; and body specific concerns like thin ideal internalization, weight concerns and body dissatisfaction.

Protective Factors

The goal of risk factor research had given rise to research on protective factors. The goal of risk factor research is to understand elements that contribute to the development of disordered eating. Some researchers argue that disordered eating develops in the presence of risk factors; meanwhile, others argue that disordered eating develops in the absence of protective factors. Protective factor research is sparse and attempts to explore what prevents ED development are divergent and problematic (Cordero & Israel, 2009; Gustaffson, Edlund, Kjellin, & Norring, 2009). Some approaches point to factors that are negatively correlated with EDs as protective factors and others assume protective factors are the opposite of risk factors. There is very little, if any, research attempting to identify unique protective factors with independent origins.

Another conceptual approach to protective factor research is called resiliency. While resiliency research is also scrutinizing what protects individuals from developing EDs, the research mainly addresses resilience after ED recovery. Very few of the studies investigating protective factors and resiliency target women who are at high risk but are not engaged in full ED criteria. Rather they typically sample from groups that meet ED criteria or are at such high risk that a portion of the sample meets ED criteria; this in turn, leads to a sample that yields a spectrum of ED engagement and thus a range in the presence and absence of risk and protective factors. While this approach is valuable and positively contributes to our understanding of ED etiology, eliminating the ensuing confounds of such an approach could lead to greater understanding of resiliency experienced by high risk individuals avoiding full ED criteria.

Protective factors being explored in the literature include demographics such as gender, age and ethnicity; personality traits and affect such as mental skills and perfectionism; social factors such as family support; and body image flexibility. Another possible protective factors worth investigation are spirituality and religiosity.

BYU Risk Factors and Recent Research

The current research proposal is responding to recent findings regarding a population considered to be highly likely to develop eating disorders based on common risk factors. Fischer et al. (2013) conducted a study on ED risk and behavior at Brigham Young University (BYU), an environment assumed to have heightened rates of EDs or at least ED risk. Fischer et al. (2013) attribute this assumption to common risk factors applicable to BYU student population. Specifically, they list: academic achievement/achievement orientation, competitiveness, religiosity and being Caucasian.

Risk factors pertinent to the BYU student populace include ethnicity, gender, age, perfectionism, and peer social environment. Body specific concerns such as thin ideal internalization, weight concerns and body dissatisfaction are also risk factors likely to affect the BYU student populace.

Demographics

Ethnicity. BYU reported for the 2012 academic school year that of the student population 86% were Caucasian. Research indicates that Caucasians have higher ED rates than Blacks and Asians, an equal ED rate as Hispanics and a lower ED rate than Native Americans (Jacobi, Haward, de Zwaan, Kraemer, & Agras, 2004). Demographic risk factors are easy to confirm or deny with basic statistics. Some research suggests that the risk rates associated with ethnicity are more accurately attributed to exposure to Western ideals and culture accounts

(Streigle-Moore & Bulik, 2007). Streigle-Moore and Bulik (2007) argue “sociocultural models of eating disorders have emphasized ‘Western’ culture’s female beauty ideal of extreme thinness and objectification of the female body as specific risk factors for the development of an eating disorder” (p. 184). Ninety-four percent of the students enrolled at BYU in 2012 were from the United States, which offers a rough estimate of the student population’s exposure to Western ideals and culture. It is unknown if students who declared other nationalities are likely to have come from other Western cultures, or environments were exposed to Western culture is occurring. It can, however, be assumed that to some degree they are being exposed to Western ideals and culture currently due to their attendance at the university.

Gender. In a meta-analysis of the ED literature, mixed ratios of female to male prevalence were reported; however, a generally accepted ratio is 10:1 (Smink et al., 2012). Overall, ED detection is female dominant. BYU reported for the 2012 academic school year that of the student population, 48% were female.

Age. While prevalence rates to this point have been reported on general populations, research is showing that women in college experience ED symptoms at higher rates than the general population (Favaro, Ferrara, & Santonastaso, 2003; Hoek, 2006). Hoek (2006) found “The most substantial increase [in ED prevalence rates] was among females aged 15–24 years, for whom a significant increase was observed from 1935 to 1999” (p. 389). It has been suggested that higher prevalence rates among female college samples is due to the critical developmental period of female college students (Berg, Frazier, & Sherr, 2009).

Social Environment

Two social factors are considered as risk factors in the review of the literature for this study: peer commentary and social comparison. Herbozo, Menzel, and Thompson (2013)

reported that positive and negative weight and shape commentary was significantly correlated with body dissatisfaction for women. Furthermore, for women considered underweight and normal weight, even commentary about general appearance was significantly correlated with body dissatisfaction. Pokrajac-Bulian, Ambrosi-Randić, and Kukić (2008) conducted a study on the internalization of the thin ideal and comparison processes in the development of disordered eating. They reported the following observations:

Higher level of social influences (criticism or teasing, modelling of dieting, and investment in thinness) increased the probability for internalization of a thin ideal and with mediation of internalization, the probability also increased of restrictive behaviour, dieting, weight awareness and fear of fatness, which became a potential risk factor for the development of clinical eating disorders. (Pokrajac-Bulian et al., 2008, p. 237)

While research does not exist to compare rates of peer commentary on body and weight and rates of social comparison with other populations it can be assumed that these behaviors are occurring on BYU campus. Aside from a university policy code of conduct banning the use of alcohol and illicit drugs, premarital and extramarital sexual relationships and modest dress and grooming standards, the social environment of BYU is comparable to that of other universities offering university sponsored social events as well as on-campus and off-campus married and unmarried same-gendered housing.

It could be argued that the LDS religious structure that permeates BYU and the immediate social environs actually increases the social exposure of the students to one another by increasing the amount of time spent together in religious meetings and activities outside of academic routines. BYU reported for the 2012 academic school year that of the student population 98.5% declared religious affiliation with The Church of Jesus Christ of Latter-day

Saints (LDS). Of the 1.5% of non-LDS students the majority declared a religious affiliation other than LDS. Interacting within a religious framework as well as a university code of conduct could increase social pressures and self-critiquing tendencies leading to the increased likelihood of social comparison and peer commentary. Some of the assumptions made about the ED risk or prevalence rates at BYU may be generated in consideration of this information.

Perfectionism

Craddock, Church, Harrison, and Sands (2010) described the social pressures involved in a religious situation in their study on general dysfunctional perfectionism's relation to religious dysfunctional perfectionism:

It has been suggested that clinically significant perfectionism has as its defining feature '... overdependence of self evaluation on the determined pursuit (and achievement) of self imposed personally demanding standards of performance in at least one salient domain, despite the occurrence of adverse consequences' (Shafran, Cooper, & Fairburn, 2002, p. 773). The findings of the present study reveal religious activity as one such salient domain. Furthermore, perfectionism as a spiritual and religious concern has been identified as a significant issue for distressed University students seeking help at a University counseling center (Johnson & Hayes, 2003, p. 214)

Despite this argument, research recently published at BYU on perfectionism rates indicated that BYU has lower perfectionism rates than other religious and non-religious college samples based on data collected in 1995 (Tenney, 2013).

Achievement is sometimes viewed synonymously with perfection. Yanover and Thompson (2008) reported a significant correlation between GPA, as measure of achievement and perfectionism ($r=.09, p < .01$). The academic rigor and competitiveness of BYU is indicated

by the average ACT and high school GPA scores upon admissions which for the 2012 academic year was reported as an average ACT score of 28.4 and average GPA of 3.81 (Fischer et al., 2013; BYU, 2013).

Risk Rate for Eating Disorders at BYU

Given the rumors and variations in risk factors present at BYU, Fischer et al. (2013) undertook the task of determining risk rates at BYU by administering the EAT-26 and BSQ to three cohorts of incoming freshman, consisting of 1800 randomly selected female students. Each cohort was sent the measures each fall and winter semester over the course of four years. Using the EAT-26 and BSQ measures, Fischer et al. (2013) targeted information on eating attitudes and behaviors, and concerns about weight and body shape, respectively. These two measures were used as the sole determinants of risk.

Fischer et al. (2013) report a risk rate based on EAT-26 scores in the range of 9.2% to 10.8% in comparison to the 15% they found reported in the literature using samples from other college campuses. Risk rates based on BSQ scores were reported in the 27.2% to 31.1% range, which was on par with a risk rate of 28.7% reported at a comparable university (Fischer et al., 2013). Fischer et al. (2013) conclude that while body shape concerns were estimated to be equal to, and in some cases lower than, reports at other universities, the level of eating disorder risk was not what would have been expected based on the estimates of other universities in consideration of the correlations normally found between EAT-26 and BSQ scores.

Protective Implications for Eating Disorders at BYU

This is an interesting finding especially in response to the number of potential risk factors that apply to the BYU population. Fischer et al. (2013) enumerate a number of factors that may be responsible for this finding. The article lists the on-campus Student Life prevention efforts,

the religious social structure that offers almost immediate social support for incoming freshman, and the teachings of the religious doctrine espoused the LDS affiliated university. These suggestions are reasonable; however, they were more speculative than declarative given that data was not available to support them.

More can be done to discover the protective factors experienced by women at BYU with high body dissatisfaction and low disordered eating attitudes. As previously indicated, the literature on protective factors among the general population has been lacking. Exploring the experience of women in this unique group could offer great insight into protective factors and motivators for avoiding disordered eating attitudes and behavior, which could inform future research on protective factors, prevention efforts and treatment programs. The enticing essence of the proposed study is that instead of researching factors that are negatively correlated with EDs as protective factors or assuming protective factors are the opposite of risk factors, a qualitative explorative methodology will be used to identify unique protective factors independent of risk factors.

Statement of Problem

Eating disorders research is ever growing and expanding and great advances are being made in our understanding of etiology, symptomology, prevention and treatment. Research to this point has mostly focused on such research from the perspective of individuals engaged in eating disordered behavior. However, little attention has been given to the motivations of individuals who do not engage in eating disordered behavior even when their risk for developing eating disordered behaviors and attitudes is comparable to others who do. Exploration of those motivations could lead to more informed and applicable prevention and treatment programs.

Statement of Purpose

The purpose of this research is to approach an old question from a new perspective by attempting to ascertain the motivations and experiences of individuals who do not engage in eating disordered behaviors and attitudes. A qualitative approach will allow for greater exploration of potential and emerging themes relevant to the research question. The goal is to explore the experiences of individuals with high body dissatisfaction and low disordered eating attitudes and behaviors to gain insight into the emotional and cognitive behaviors that protect/prevent them from developing disordered eating. It is expected and hoped that emerging themes could potentially be incorporated into future research, prevention programming and treatment plans.

Research Questions

What is the experience of women that are at high risk for developing an eating disorder based on body dissatisfaction but do not have elevated eating disordered attitudes? What do these women believe keeps them healthy?

Chapter 2: Review of Literature

Eating disorder (ED) diagnoses, behaviors and attitudes have been reported to be on the rise for decades, plateauing in the last decade (Hoek, 2006). Even with slowing rates it is believed that ED prevalence rates are underestimated due to limited detection (Smink et al., 2012). Furthermore, ED research has focused more on prevalence rates among women since detection is more common in women (Keel & Forney, 2013). More recent research is including incident and lifetime prevalence rates for men (Smink et al., 2012). Theories of ED etiology are many and varied, and act as foundations from which treatment plans are derived. Prevention programs are appearing in community, school and medical settings to curb the incidence rate and improve identification efforts. Recent changes to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V) have expanded the feeding and eating disorder diagnoses to more appropriately include individuals who previously have not met criteria for an eating disorder, or a well specified eating disorder despite obvious indication that their eating and feeding behaviors are harmful and maladaptive (APA, 2013; Hudson, Coit, Lalonde, & Pope, 2012; Smink et al., 2012; Stice et al., 2013).

As would be expected, research in the mental and behavioral health fields has concentrated efforts on exploring disordered eating, leaving a large gap in our knowledge on ordered eating. This literature review will discuss the prevalence of eating disorders, risk factors associated with disordered eating, and identified protective factors. A recent study was conducted at Brigham Young University, identifying a group that has a disparity between risk factors and disordered eating behaviors suggests a number of possible protective factors. The current research question will then be outlined and discussed within the context of current literature.

Prevalence and Diagnostic Criteria

Published eating disorder prevalence rates vary on a number of factors, sample location, SES, ethnic make-up, gender proportions and as of late the criteria used for determining diagnosis of an eating disorder. Recent changes in the Diagnostic and Statistical Manual of Mental Health Disorders have redefined the criteria and expanded the usable diagnoses (APA, 2013). Reported prevalence rates are determined by the set of diagnostic criteria used and because criteria changes are recent, a review of the literature at this point will have to cover prevalence rates based on both.

The current study will be focusing on ED behavior in women and thus the literature review will report on the prevalence among women. In a meta-analysis of the ED literature, mixed ratios of female to male prevalence were reported (Smink et al., 2012). A ratio of 10:1 was reported by some studies while others reported a smaller ratio. Smink et al. (2012) suggest that methodology could be responsible for the mixed results or lack of results on male prevalence but assert that some research is showing that ED are more prevalent in males that previously assumed. Due to the nature of this project males will not be included in the sample and therefore will not be discussed in the literature review. The prevalence rates of eating disordered behavior in college samples will also be reported.

DSM-IV diagnostic criteria. DSM-IV TR delineates between Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Eating Disorder Not Otherwise Specified (EDNOS). In research, Atypical BN and AN are often included in the EDNOS category, although individually they are not recognized as DSM-IV diagnostic categories. Favaro et al. (2003) conducted a study to ascertain the prevalence of eating disorders in a general population. The study reported the following lifetime prevalence rates: AN - 2.0%, BN - 4.6%, BED - 0.6%, Atypical AN - 2.6%

and Atypical BN - 3.1%. It reported an overall lifetime prevalence rate of 11.0%. In a meta-analysis of the prevalence literature, Smink et al. (2012) identified lifetime prevalence rates of 3.5% among adult women and 2.3% among adolescent girls for BED, 0.6% for AN and 2.0% for broad AN in women by the age of 20, and 1.7% for BN among women. Interestingly

DSM-5 diagnostic criteria. DSM-V delineates between Avoidant/Restrictive Food Intake Disorder; Anorexia Nervosa (AN); Bulimia Nervosa (BN); and Binge-eating Disorder (BED) and Other Specified Feeding and Eating Disorders including: Atypical Anorexia Nervosa, Bulimia Nervosa low frequency and duration, Binge-eating Disorder low frequency and duration, Purging Disorder, and Night Eating Disorder; and Unspecified Feeding and Eating Disorders (APA, 2013). The increased spectrum and reduced rigor of the criteria has been predicted to increase the prevalence of some eating disorders (Hudson et al., 2012; Smink et al., 2012). In a study conducted prior to the DSM-5 release prevalence rates were reported based on the DSM-5 criterion and diagnoses (Stice et al., 2013). Stice et al. (2013) used a community sample over an eight year period from which lifetime prevalence rates were reported as follows: AN - 0.8%, BN - 2.6%, BED - 3.0%, FED-NEC - 11.5% and Other Specified Feeding and Eating Disorders ranging from 2.8%-4.4%. Furthermore, onset for all the eating diagnoses ranged from age 16 to age 20. The study claims that a slightly higher prevalence rate of eating disorders was obtained using DSM-5 criterion as opposed to DSM-IV criterion. An overall summed lifetime prevalence of developing any eating disorder is 12%. Stice et al. (2013) also took into account impairment level and if new criterion offer diagnoses to those with a lower level of impairment; however, due to larger effect sizes for DSM-5 diagnoses as opposed to DSM-IV diagnoses, it can be argued that the DSM-5 criterion do not simply take in less impaired individuals but rather more accurately identifies equally impaired individuals.

The lifetime prevalence rates reported by Favaro et al. (2003) of 11% using DSM-IV criteria and Stice et al. (2013) or 12% using DSM-5 criteria would suggest that broadened criteria has not led to greater ED detection. Instead what may be more accurate is enhanced categorization within the ED diagnostic categories, shifting the prevalence rates from EDNOS to AN or BN. Keski-Rahkonen et al. (as cited in Smink et al., 2012) reported a rise in the lifetime prevalence of BN among women from 1.7% to 2.3% when the DSM-5 criteria was adopted. Furthermore, Le Grange et al. (2012) reported a EDNOS lifetime prevalence rate of 4.64% in adults while the “new” EDNOS” category FED-NEC outlined in the DSM-5 has yielded lifetime prevalence rates of 11.5% (Stice et al., 2013). Le Grange et al. (2012) report that DSM-5 changes have limited the reliability of the EDNOS category but admittedly the EDNOS category outlined by DSM-IV criteria is hugely problematic. Overall, the lifetime ED prevalence rate of 11%-12% makes ED prevention, treatment and research a necessity.

Eating disordered behaviors. While prevalence rates to this point have been reported on general populations research is showing that women in college seem to experience ED symptoms at higher rates than the general population. Favaro et al. (2003) found that urbanization contributed to higher ED prevalence rates which may attribute to the higher rates seen in college populations since colleges tend to have a more urban demographic. It has been suggested that higher prevalence rates among female college samples is due to the high-risk developmental period of traditional female college students (Berg et al., 2009). Whatever the reason may be the rates in such samples are elevated. Moreover, it is often that case that a woman does not develop a clinically significant set of ED behavior qualifying her for diagnosis or treatment. However, the presence of disordered eating is still a concern that put women at risk of escalating. Berg et al. (2009) conducted a study on change in ED attitudes and behaviors in college women. They

found in their sample that 49% of their sample had at least one eating disorder symptom with a frequency of at least one a week. Wilfley et al. (2013) included in their recent article on ED prevention and treatment on university and college campuses that it would be expected that in a college sample of 1,000 women, if screened for ED risk rates would be expected to yield ED rates of 1-2% clinical, 2-5% subclinical, 20-25% high risk, and 68-77% as low risk. While some have pointed to the developmental period of most college aged women as the risk factor responsible for the increased rates Berg et al. (2009) argue that women in the same developmental period that are not attending a college or university do not report engaging in eating disorder behaviors such as binge eating at the same rate. Common or likely risk factors are explored in the following section.

Risk Factors

Identifying risk factors for developing an ED is difficult because it insinuates a reliable and for some a causal relationship. A risk factor has been defined as “a characteristic (e.g., allele), event (e.g., teasing), or experience (e.g., growing up in a culture that values extreme thinness) that precedes the onset of the outcome of interest” (Striegel-Moore & Bulik, 2007, p. 183). Research in the field of ED has given a fair amount of attention to identifying risk factors but admit that the risk factors identified to this point do not lend to reliable prediction (Jacobi et al., 2011; Keel & Forney, 2013). A recent qualitative literature review conducted by Keel and Forney (2013) surveyed the ED research for the most commonly identified risk factors. Their findings indicated the following as accepted and significant risk factors: being female and an adolescent or young adult; internalization of idealization of thinness; weight concerns; personality traits such as negative emotionality and perfectionism; and peer interactions. In a study of risk factors represented in the literature, Jacobi et al. (2004) extracted many of these

same risk factors and included them in more general categories. Outlining the research on risk factors is not straightforward and the number of risk factors considered in the research continues to increase. To inform the literature review for this project, risk factors enumerated in the article by Fischer et al. (2013) were used as a reference point. Fischer et al. (2013) list the following as considerable risk factors pertinent to the sample population: achievement/competition, academic or otherwise; religiosity; and ethnicity, specifically being Caucasian. Other risk factors pertinent to the population from which the sample was obtained for Fischer et al.'s (2013) study and the current study are gender, social factors and Western ideals. These risk factors have many different names in the research and much of the research findings are quite circular; however, a linear attempt will be made using these general categorizations of risk factors research: demographics; personality concerns, social factors, body specific concerns.

Demographics. Demographics such as ethnicity, gender and age are commonly referred to in the literature as risk factors. This section will take a brief look at each of these three categories and their status as a risk factor.

Ethnicity. It is often thought that EDs are a Caucasian problem; an opinion being informed by cultural ideas regarding the body. Usually higher prevalence rates are reported among Caucasian research participants (Hoek, 2006; Jacobi et al., 2004). However some research makes such claims by comparing prevalence rates between Caucasian and Blacks without taking in to consideration of what more may differ such as nationality, culture and exposure to similar societal ideals (e.g., Eisenberg, Nিকেlett, Roeder, & Kirz, 2011).

Furthermore, there are elucidating dynamics to such findings; for example, Striegel-Moore et al. (2007) reported that in the United States Black women are not as dissatisfied with their bodies

and have fewer weight concerns in comparison to a Caucasian sample; however, they pulled even on bingeing behaviors.

Including a number of ethnicities, research indicates compared to Caucasians, Hispanics have equal ED rates, Native Americans have higher ED rates, and Blacks and Asians have lower ED rates (Jacobi et al., 2004). Ethnicity as a risk factor, therefore, is hard to confirm and since ethnicity is a fixed variable it is more a marker than a risk factor (Jacobi et al., 2004).

Gender. The proposition of gender as an ED risk factor is derived from prevalence rates, which have already been discussed in a previous section. A review of the research shows that men report lower prevalence rates of AN and BN in all cases, pulling even on prevalence rates in some studies for Binge-Eating Disorder (BED) (Striegel-Moore & Bulik, 2007). Critiques have been offered to explain this relatively consistent finding, such as, the etiology of EDs is socially situated to affect only females, ED criteria are gender biased since body dissatisfaction for men is not always about weight reduction, stigma leads to under-reporting by men and associated affective disorders such as anxiety and depression are more prevalent in women than men (Jacobi et al., 2004; Striegel-Moore & Bulik, 2007). Given that gender is usually a static characteristic some researchers consider it a fixed marker instead of a risk factor for developing an ED (Striegel-Moore et al., 2007).

Age. Age as an ED risk factor is difficult to explain. While never directly stated, simply having a birthday is not the inclusion criteria for risk but something about that period of time. Much of risk factor research surrounding the development of EDs is aimed at determining what about adolescence and early adulthood that lends to the development of an ED; is it biological factors, social factors, environmental factors, lifestyle changes, exposure to adulthood, increased stress, etc. Prevalence research has demonstrated that most individuals develop EDs during

adolescence and yearly adulthood, development at a later age point is highly uncommon for AN and BN, but not for BED (Striegel-Moore & Bulik, 2007). The strength this risk factor has not been determined due in part to how highly dependent the results are on the age groups used for comparison (Jacobi et al., 2004). Nevertheless, research to this point has clearly identified women in adolescence and early adulthood as most at risk (Delinsky & Wilson, 2008). A similar critique is offered here as was for gender; there is a notable increase of psychological changes, concerns and affective disorders with age. The next section will discuss these generally categorized personality aspects (Striegel-Moore & Bulik, 2007).

Personality traits and affect. It is common for studies in the area of ED risk factor research to investigate more than one possible risk factor at a time. Usually this leads to a report on a number of findings about not only the relationship between each risk factor and the incidence of an ED but also the relationships between risk factors. While this information is helpful it also lends to a messy untangling that can lead to questions about the exclusiveness of risk factor constructs and their individual potency. The perfect example of this is illustrated in the research on personality traits and affect as ED risk factors. This section will cover research on negative emotionality and perfectionism.

Negative emotionality. As indicated in the gender and age sections, reports of affective concerns also increase with age and appear to be more often reported by females; affective concerns such as depression and generalized anxiety (Cooper & Proudfoot, 2013; Eisenberg et al., 2011; Evers, Adriaanse, de Ridder, & de Witt Huberts, 2013; Jacobi et al., 2004; Keel & Forney, 2013; Kelly & Carter, 2013; Pike et al., 2008; Pokrajac-Bulian et al., 2008). Jacobi et al. (2004) indicate that comorbidity studies have made arguments that the cause of EDs might have more to do with association with another mental or behavioral health concern such as depression,

anxiety, personality disorders and substance abuse. Such arguments insinuate that EDs are not the primary causing diagnoses. As such it would be pertinent to ascertain if the ED occurred prior to or after other diagnoses. Jacobi et al. (2004) indicate that very little research has been conducted to clarify this point. The research often refers to the idea of negative affect or emotionality as an associated ED risk factor (Keel & Forney, 2013). In the midst of so many risk factors, some of which are yet to be discussed, personality traits and affect are being argued as the difference explaining why some women have body image issues and develop eating concerns while others do not (Keel & Forney, 2013; Striegel-Moore et al., 2007).

The construct of negative affect or emotionality, although referred to in a number of studies, has been defined or outlined as including a range of concepts. Keel and Forney (2013) described the concept as including “tendency to experience dysphoria, negative self-evaluation, and low self-esteem” (p.436). They reported in their review of the literature that depression and negative emotionality (as well as body dissatisfaction, ineffectiveness and poor interoceptive awareness) predicted the risk and eventual onset of disordered eating pathology as reported in a study by Leon, Fulkerson, Perry, Keel, and Klump (as cited in Keel & Forney, 2013; see also Jacobi et al., 2004) over a four-year study. In another study described by Keel and Forney (2013) results indicated negative emotionality as a significant predictor of bulimic symptoms. In a review of the literature, Jacobi et al. (2004) concluded, after looking at seven longitudinal studies, that results were mixed for concurrent psychiatric concerns and negative emotionality. In four of the seven studies negative emotionality and concurrent psychiatric disorders were not found to be a reliable predictors. Much of this could have to do with the broad inclusions of constructs like ineffectiveness and body dissatisfaction which may confound efforts to predict onset since body dissatisfaction is often considered in ED research under the construct of weight

concerns as well leading to a double dipping effect in the research results (Jacobi et al., 2004; Keel & Forney, 2013). Pokrajac-Bulian et al. (2008) reported that negative affect, which they described as anxiety and depression, was significantly related to thinness ideal internalization and restrictive eating behavior. They also found that thinness ideal internalization was linked with self-esteem and perfectionism both of which have been found to be associated with disordered eating attitudes and behavior. Pike et al. (2008) found the negative affect and perfectionism were significantly higher in a group of AN diagnosed participants in comparison to a psychiatric control group suggesting that these constructs no matter how they are defined are unique to disordered eating pathology (Keel & Forney, 2013).

Perfectionism. Perfectionism, as a personality trait, tends to be a significant standout construct in the research results on ED risk factors (Keel & Forney, 2013; Kelly & Carter, 2013; Pike et al., 2008; Pokrajac-Bulian et al., 2008; Striegel-Moore et al., 2007). Perfectionism refers to a characteristic inclination towards performing and being flawless (Keel & Forney, 2013). Perfectionism has yielded similar results as negative emotionality which is somewhat expected since they are often reported on as if part of the same construct. Achievement is sometimes viewed synonymously with perfection and the research has little to say in disagreement. There is limited research on the idea of achievement orientation and eating disorders, especially without the inclusion of athleticism. Yanover and Thompson (2008) reported a very mild yet significant correlation between GPA, as measure of achievement and perfectionism ($r=.09$, $p < .01$). Gustafsson et al. (2009) found the while adolescent females with disordered eating had competitively enforced a high personal standard, having a perfectionistic personality did not appear to be a predisposing ED risk factor. This same finding was reported in a study conducted by Wojtowicz and von Ranson (2012) in an adolescent female sample. They report, “Contrary to

expectation, weight-related teasing, thin-ideal internalization, and perfectionism were not significant predictors... The results suggest that self-esteem and BMI are relevant variables for helping to identify middle-adolescent girls who may be at risk for subsequent increases in body dissatisfaction” (Wojtowicz & von Ranson, 2012, p. 26). Body dissatisfaction as it turns out is a robust risk factor that will be discussed in a later section.

Luo, Forbush, Williamson, Markon, and Pollack (2013) conducted a study to ascertain more about the relationships between eating disorder behaviors and perfectionism. The findings are interesting because they link claims previously discussed in this literature review to perfectionism. Luo et al. (2013) found that maladaptive perfectionism was attributable to a tendency to experience negative emotion. This finding prompts the question if perfectionism is a separate construct or rather a residual reaction to negative emotionality. Luo et al. (2013) indicate that other research findings suggest that failing to reach a perfectionistic standard may lead to increased negative affect which may lead to an increase in body dissatisfaction. This is a perfect illustration of the muddled research on risk factors. Despite the interdependent matrix of risk factor findings understanding these relationships offers insight into common themes of ED concerns.

Social factors. Social factors to be included in this section are peer commentary, family relationships, and social comparison theory. Peer commentary and Social Comparison Theory will be discussed as contributors to ED risk.

Peer commentary. An interesting connection exists between social factors and weight concerns that has best been captured by Herbozo et al.’s (2013) study on body dissatisfaction and eating disturbances in college women as related to appearance-related commentary by others. They even further specified the results by differentiating the women by weight categories. They

reported a number of results that were intriguing. To start, negative weight and shape commentary was significantly correlated with eating concerns for all weight groups and dietary restraint in the overweight group. It would be expected perhaps that positive weight and shape commentary would decrease these correlations; however, it was reported instead that for all weight groups positive weight and shape commentary was significantly correlated with body dissatisfaction. Furthermore, for women in the underweight and normal weight groups, even commentary about general appearance was significantly correlated with body dissatisfaction.

In coordination, Jacobi et al. (2011) noted that individuals with ED more often reported that other people commented about their body shape, weight and eating behaviors than those in healthy control groups. In their study on the risk factors in a sample at high-risk of developing a subthreshold or full syndrome eating disorder, they found two factors to be most potent predictor of ED incidence: having received a critical comment about their eating from a teacher, coach or sibling and having a history with depression. They reported an ED prevalence rate of 39.1% for participants that endorsed having received critical comments as opposed to a prevalence rate of 7.8% for participants who did not endorse receiving critical comments. In regards to having a history of depression they reported an ED prevalence 30.4% as opposed to a prevalence rate of 4.2%. These results suggest that development of an ED may be highly influenced by direct or perceived social pressures around eating and body image. It may even incentivize the internalization of the thin ideal being portrayed to them through a number of portals.

Pokrajac-Bulian et al. (2008) conducted a study on the internalization of the thin ideal and comparison processes in the development of disordered eating. They reported “higher level of social influences (criticism or teasing, modelling of dieting, and investment in thinness) increased the probability for internalization of a thin ideal and with mediation of internalization,

the probability also increased of restrictive behaviour, dieting, weight awareness and fear of fatness, which became a potential risk factor for the development of clinical eating disorders” (Pokrajac-Bulian et al., 2008, p. 237). Rodgers, Paxton, and Chabrol (2009) combined these many elements into one study with the aim of investigating the effects of commentary on body dissatisfaction and eating disturbances. They looked at three kinds of commentary, positive, negative and importance/comparison comments. They conducted a CFI and correlated importance/comparison comments (path coefficient=.25, $p \leq .01$) and negative comments (path coefficient=.17, $p \leq .05$) with appearance comparison/internalization of media ideals. Appearance comparison/internalization of media ideals was significantly correlated with body dissatisfaction (path coefficient=.57, $p \leq .001$). Body dissatisfaction was correlated with drive for thinness (path coefficient=.39, $p \leq .001$) and drive for thinness was correlated with bulimia (path coefficient=.65, $p \leq .001$). In the end the model was a moderate fit ($\chi^2(10)=24.4$, $p < .007$, RMSEA=.09, CFI=.96) but what they did suggest based on the findings is that parent commentary of any kind is mediated by internalization of media ideals and appearance comparison (Rodgers et al., 2009). This gives a lot of power to comparison and media ideal, also referred to thin ideal, internalization.

Social comparison theory. Halliwell (2012) linked body image issues to social comparison theory, which posits that people evaluate themselves through comparison with others. In the review of the literature Halliwell (2012) concludes that the research indicates that after viewing same sex models both men and women report increased body dissatisfaction. While every social context is an opportunity for upward and downward social comparison, college campuses as a context compound this opportunity by increasing the concentration of same-age peers available for viewing and interaction. Zalta and Keel (2006) even have gone so

far as to claim that boarding schools and colleges in themselves might be environmental risk factors.

Body dissatisfaction as a risk factor has been researched often in college populations with interesting results. Berg et al. (2009) conducted a study on the changes in eating disorder attitudes and behaviors in college women. First, they reported a decrease in the number of participants that reported engaging in at least one disorder eating behavior from 49% to 40% over a two-month period. Next, more specifically, they reported a significant decrease in purging behavior as well as bulimic attitudes. Interestingly, however, while participants reported less body dissatisfaction at the follow up it was not statistically significant. This is noteworthy because of connections drawn between body dissatisfaction as a risk factor and eating disordered behavior.

While body dissatisfaction seems to be present for individuals engaged in disordered eating it does not appear to be absent in those who do not engage in disordered eating. Furthermore, the fairly stable body dissatisfaction report was coupled with decreased reports of not only eating disorder behaviors but eating disordered attitudes as well. In a survey of the literature Berg et al. (2009) found that overall studies were reporting higher body dissatisfaction in association with higher levels of eating disordered symptoms. Thus, it appears that while it has been established as a risk factor the gap in the research remains explaining how women are managing to not engage in eating disordered symptoms while reporting high body dissatisfaction. After asserting that when a change is reported it is more likely a decrease than an increase in eating disorder behaviors, attitudes and associated risk factors despite reports remaining mostly consistent throughout college, the authors asserted the following acknowledging the gap:

Thus, in addition to studying risk factors, researchers should begin to study the factors that protect women from developing eating disorders in college or that are associated with decreases in eating disorder behavior. Protective factors may not simply be the opposite of risk factors (e.g., high self-esteem, and low body dissatisfaction), but may be variables not generally considered in the risk factor literature (e.g., presence of a mentor, vocational interests; Berg et al., 2009, p. 141).

Others have come to same conclusion about the power of unseen protective factors.

Striegel-Moore et al. (2007) conducted a study looking at risk factors involved in the development of Binge-eating disorder. Their analysis suggests elevated perceived stress was linked with binge eating. In their discussion they point out that of those defined as “at risk” not all exhibited binge eating. They ask “This raises the question of possible protective factors; that is, were there protective factors in the lives of these participants that prevented development of an eating disorder or, for that matter, another psychiatric disorder?” (Streigel-Moore et al., 2007, p. 486).

Body specific concerns. Body specific concerns are most frequently referred to as thin ideal internalization, weight concerns and body dissatisfaction. The research often reports on all three or includes all three in one category.

Thin ideal internalization. Keel and Forney (2013) reported on the idealization of thinness and weight concerns as risk factors. Other research has reported body dissatisfaction as a risk factor for developing an ED as well (DeLeel, Hughes, Miller, Hipwell, & Theodore, 2009; Fischer et al., 2013; Forney, Holland, Keel, 2012; Herbozo et al., 2013). While it is not hard to imagine that these factors are related to risk of developing an ED it is interesting to note the dynamic relationships between each factor and ED risk. Keel and Forney (2013), for example,

argue that over the course of the 20th century idealization of thinness has intensified and the impact is notable in the rising prevalence rates of AN and BN throughout that same specified time frame. However, they readily admit that increase in the prevalence rates could reflect changes in diagnostic criterion, increased screening and education, etc. Furthermore, causation is not a claim that can be supported.

Research conducted in cross-cultural formats, however, is offering more evidence to suggest there may be a causal relationship or at least a strong correlation. Studies on the influences of Western ideals of thinness in cultures that traditionally value a more robust female figure suggest that there is connection. Keel and Forney (2013) outline two studies that looked at this influence. In a study conducted by Becker, Burwell, Gilman, Hergoz, and Hamburg (as cited in Keel & Forney, 2013) it was concluded that internalization of the thin ideal depicted in Western media occurred when Fijian girls were exposed to the media. This contributed to increases in weight concerns and disordered eating. Hoek et al. (as cited in Keel & Forney, 2013) conducted a study on the prevalence of EDs in Curacao. Keel and Forney (2013) point out that 64% of the individuals diagnosed with AN also has traveled abroad increasing the likelihood of exposure to Western media. Despite these examples, Keel and Forney (2013) indicated that their survey of the literature indicated mixed results on exposure to Western idealization of thinness and the development of and ED except in the development of BN. They claim that cases of BN were only found in cross-cultural studies in the presence of exposure to Western influences. They also point out that internalization of the thin ideal is most often manifested by increases in weight concerns.

Weight concerns. Weight concerns are so closely linked to the risk of developing an ED that it is actually included in the diagnostic criterion for EDs, criterion that did not sustain any

alterations during edition revisions (APA, 1994, 2013). The DSM-5 criterion includes the following for AN: “Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight,” and “Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight” (APA, 2013, “Anorexia Nervosa” para. 1). The DSM criterion includes the following for BN: “Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as...” and “Self-evaluation is unduly influenced by body shape and weight” (APA, 2013, “Bulimia Nervosa,” para. 2). Keel and Forney (2013) suggest that weight concerns are the most robust predictors of EDs according to their review of the literature. Jacobi et al. (2004) asserted that weight concerns are one of the most often assessed factors in longitudinal studies of ED and predicted disordered eating most consistently. Weight concerns include a number of different issues such as fear of gaining weight, body dissatisfaction and dieting behaviors.

Body dissatisfaction. Body dissatisfaction was defined by Hill, Musado, and Lutzman (2013) as “the negative evaluation of one's physical appearance; specially, the discrepancy between ideal and perceived body size and shape” (p. 336). Berg et al. (2009) conducted a study among college women about change in eating disorder attitudes and behaviors over time. They reported that over time increases in body satisfaction were associated with decreases in bulimic attitudes and bingeing behaviors. Jacobi et al. (2004) reported similar findings in their meta-analysis of the ED literature. They reported that body dissatisfaction was associated with constructs of negative affect, which predicted risk of developing an eating disorder. Body dissatisfaction appears to be closely related to other identified risk factors. Which prompts the question, are we sure of the constructs currently employed in ED research? To support this line

of thinking consider the research of Van Diest and Perez (2013) who published that thin ideal internalization and self-objectification was predictively correlated with body dissatisfaction and ED symptomology. Yet other studies report very direct and solid results confirming body dissatisfaction as a well-defined and useful risk factor.

An example is the research of Stice, Marti, and Durant (2011) who found that body dissatisfaction was the most potent predictor of risk of developing an eating disorder in adolescence. A qualifying critique about body dissatisfaction research was offered in a recent meta-analytic publication on research results on thin ideal internalization and body dissatisfaction. Ferguson (2013) concluded that although anywhere from 40% to 50% of women harbor body dissatisfaction the common attempt to link it with media exposure or messages is weak. With all the multidirectional connections outlined in the research findings there still appears to be a gap in the explanation, something just does not quite jibe; perhaps it is an unidentified risk factor or perhaps it is the counteracting forces of potential protective factors but for all our attempts to predict and account for the phenomenon there still confusion about the big picture.

Protective Factors

Risk factor research is attempting to understand elements that contribute to the development of disordered eating. Some results suggest that disordered eating develops in the presence of risk factors; meanwhile, another branch of research on eating behaviors is suggesting that disordered eating develops less often in the presence of protective factors. Protective factor research is relatively sparse and there are divergent attempts to explore what prevents the development of an eating disorder (Cordero & Israel, 2009; Gustaffson et al., 2009). Some approaches merely mention factors that are negatively correlated with eating disorders as

protective factors, others indicate protective factors as the opposite of researched risk factors while other avenues are attempting to identify unique protective factors. Resiliency is also a vein of research attempting to get at what protects individuals from developing EDs; however, a large portion of the resiliency research is about resilience after ED recovery. Furthermore, very few of the studies currently investigating protective factors and resiliency target women that are at high risk but are not engaged in full criteria EDs, rather they target groups that are usually at high risk and get a sampling of the spectrum of risk and protective factors. While this approach is valuable and positively contributes to our understanding of ED etiology, research using high risk samples that do not screen positive could lead to greater understanding of the experience of keeping high risk from becoming incident. Protective factors that should be discussed include demographics such as gender, age and ethnicity; personality traits and affect such as mental skills and perfectionism; social factors such as family support; and body image flexibility. Another possible protective factor is spirituality.

Demographics. Demographics such as gender, age and ethnicity were discussed as risk factors. Research indicates that at-risk individuals are Caucasian, female and of adolescent and early adulthood age (Delinsky & Wilson, 2008; Hoek, 2006; Jacobi et al., 2004; Striegel-Moore & Bulik, 2007). Some research therefore is arguing gender, age and ethnicity as protective factors. For example, Warren, Gleaves, Cepeda-Benito, del Carmen Fernandez, and Fernandez (2005) found a positive relationship between thin ideal internalization and body dissatisfaction as well as awareness of cultural pressures and thin ideals and internalization of the thin ideal. They also found that thin ideal internalization mediated the relationship between awareness of cultural pressures and thin ideals and body dissatisfaction. Ethnicity was also found to be a moderator on these relationships finding a stronger relationship for European American women than Spanish

or Mexican American women (Warren et al., 2005). They argue that ethnicity is a protective factor inasmuch as the cultural ideals about body image stereotypically associated with the culture of these ethnicities. Striegel-Moore et al. (2007) reported that in the United States Black women are not as dissatisfied with their bodies and have fewer weight concerns in comparison to a Caucasian sample; however, statistically they reported equally engaging in bingeing behaviors. Ethnicity as a risk factor was difficult to confirm and it is even more difficult to argue ethnicity as a protective factor since.

Age is rarely discussed as a protective factor in the literature; however, gender is just beginning to appear in the research. Prevalence rates indicate that EDs are primarily found in females and therefore the majority of the research has been conducted on females. Ferreiro, Seoane, and Senra (2012) conducted a study to begin to address this concern. They looked at risk and protective factors in men and women to see how they differed. They asserted that gender disparity has not really been recognized in the protective factor literature to this point because ED research has primarily focused on women. Their results indicate that prevention efforts should be directed at both girls and boys. These results and others contentions with current ED criteria suggest that gender may not be a protective factor at all.

Personality traits and affect. Risk factor research indicated that negative affect and specific elements of personality like perfectionism have the potential to play a role in the development of an eating disorder (Cooper & Proudfoot, 2013; Eisenberg et al., 2011; Evers et al., 2013; Jacobi et al., 2004; Keel & Forney, 2013; Kelly & Carter, 2013; Pike et al., 2008; Pokrajac-Bulian et al., 2008). While research on negative affect includes mood states such as depression and anxiety, positive affect factors research are less organized. This section will discuss research on mental skills considered the antithesis of negative affect factors and

perfectionism which has been implicated as both a risk and protective factor (Keel & Forney, 2013; Striegel-Moore et al., 2007).

Mental skills. Mental skills have been discussed as a protective factor. Interestingly, the research on mental skills employs these skills as coping skills suggesting that they are useful in combating the risk factors. Estanol, Shepard and McDonald (2013) asserted that positive coping skills may have a protective effect. They indicate that positive coping skills have been shown to be employed more in ED recovered individuals (Estanol et al., 2013). They also point out that there is little to no research on resiliency against ED development due to positive coping skills. Estanol et al. (2013) conducted a study among a high ED risk group, dancers, to ascertain possible protective factors. The Athletic Coping Skills Inventory - 28 was used to tap into mental skills such as “coping with adversity, peaking under pressure, motivation, and coachability” (p. 215). Results showed a negative association between mental skills and reported ED symptomology. Estanol et al. (2013) also looked at the relationship of negative affect and ED symptomology. They found a positive relationship between the two. They also found a mediating effect on the relationship by mental skills such as coping with adversity, freedom from worry and confidence/achievement motivation. In fact the authors claim it is a fully mediating effect (Estanol et al. 2013).

The most significant protective factors that arose from the results are coping with adversity freedom from worry and confidence, however these arose in confrontation to negative affect factors. These findings are a great starting point for further research. Further research should consider looking at mental skills and coping skills not associated specifically with athletics. Snapp, Hensley-Choate and Ryu (2012) did address this in a freshman college sample of women. Snapp et al. (2012) indicate that coping strategies are aimed at processing and

channeling negative affect. The study yielded results that suggest that positive coping skills beat positive body image as a contributor to wellness. However, this study defined coping skills as an active confrontation of one's problems.

Perfectionism. Perfectionism is often accused in ED development and while there is sufficient research to back those assertions perfectionism may have two sides. Interestingly, it has been reported that perfectionism may not always be a risk factor (Keel & Forney, 2013). Some research has actually reported higher rates of perfectionism for non-ED participants than ED participants (Striegel-Moore et al., 2007). Keel and Forney (2013) report that “clinical and maladaptive perfectionism has been theorized as most relevant to eating disorder risk” (p. 436). The distinction of maladaptive perfectionism opens the possibility for perfectionism to function in more than one way. Other studies have also found differences in the relationship between perfectionism and ED development. For example McVey, Pepler, Davis, Flett, and Abdolell (2002) conducted a study on the development of ED in adolescent female populations. They distinguished between self-oriented perfectionism and socially prescribed perfectionism. Self-oriented perfectionism was designated as perfectionism oriented to very high standards set by the individual and socially prescribed perfectionism, which is the perception that others require perfection from them (McVey et al., 2002). Their results found that self-oriented perfectionism was correlated with disordered eating while socially prescribed perfectionism was not. These results do not go on to suggest that socially prescribed perfectionism is a protective factor but the results do open up a debate on how perfectionism and/or its substrates are connected to the development of disordered eating (Gustaffson et al., 2009). Luo et al. (2013) further supports this line of arguing given their reported findings that maladaptive perfectionism levels associated

with EDs are more accurately accounted for by negative emotionality. Luo et al. (2013) expounds:

The association between maladaptive perfectionism facets and binge eating is intriguing, particularly given prior research suggesting that binge eating disorder is not associated with elevated levels of perfectionism...Research that has sought to explain these complexities indicates that negative affect, caused by failure to achieve one's maladaptive perfectionistic standards, may increase one's body dissatisfaction, which by interacting with low self-esteem, leads to counterproductive behavior. (p. 294)

Family support. Family support is appearing more often in the ED protective factor research. Most pathologies arise within a context and disorder eating is no different. Given the typical age of onset, adolescence and early adulthood, family dynamics can be less than stable as young girls begin to gain independence while still being engaged in the family system. As women make the transition to college, the relationship previously established with parents and the changes in those relationships as they leave home can play a large role in their development especially during a time with peer interaction increases and family interaction decreases. Cordero and Israel (2009) designed a study to look at parents as protective factors in the development of disordered eating among college women. More specifically they assumed that parents could act as protective factors and set out to figure out how. They reported a number of ways parents might possibly contribute to protection against the development of disordered eating. First, they found that messages about weight and shape from parents are related to problematic eating. More specifically they indicated that women who heard less about body shape and weight reported less unhealthy eating. Unfortunately, Cordero and Israel (2009) discovered that awareness of cultural expectations regarding body shape and weight and an internalization of these ideals overpowered

the possible protective effect of reduced body shape and weight messaging from parents. This study did not consider the effects of positive messaging made a difference; however, research conducted by Herbozo et al. (2013) did explore that and found that both positive and negative commentary can have detrimental effects. Second, Cordero and Israel (2009) reported that parental acceptance and emotional availability did not correlate to eating habits reported by the participants. This finding contradicts other findings that suggest that positive relationships with the mother and father can have a mediating effect. While this study did not find a significant relationship between well-ordered eating and parental relationships it did find a relationship between parental acceptance and emotional availability with self-esteem.

As previously mentioned, protective factors are sometimes assumed as the opposite of risk factors. However, not even the opposites of risk factors have been researched yet in regards to family support. For example, Pike et al. (2008) found that family discord and higher parental demands for individuals with identified AN in comparison with a control group. However, research has not been conducted to see if these factors work as protective factors. Their mere absence or decreased frequency is not sufficient criteria for being a protective factor.

McVey et al. (2002) reported a finding that does not follow this pattern. They found that parental support moderates the relationship between disordered eating and negative events that are school related. They, like others, found that parental relationships were linked with disordered eating. Furthermore, it was reported that maternal support was not correlated with disordered eating. McVey et al. (2002) also reported that, the quality of the father/daughter relationship, namely the degree of involvement and of the conditionality of support on the part of the father, might have an additive influence on girls' eating behavior for those facing stressful circumstances. It would appear that high levels of involvement and unconditional support from

fathers is the most optimal to help reduce the negative impact of stress (p. 90). Such findings need further research to back them up and to expound on the nature of the impact these family relationships have on the development of eating disorders.

Body image. Body image research associated with EDs has focused primarily on the risk factors such as body shape dissatisfaction, internalization of thin ideal, weight concerns, etc. Literature on the protective factors is sparse. Hill et al. (2013) are pioneering work in this area by focusing on body image flexibility. Body image flexibility refers to the general ability to experience body dissatisfaction in such a way that yields value-congruent behavior (Hill et al., 2013). Their study looked at the relationship between body image flexibility and disordered eating in low, average and high BMI female groups. Their results indicated a significant negative association between body image flexibility and disordered eating ($r=-.41, p<.01$) (Hill et al., 2013). Furthermore, there was a significant interaction effect between body image flexibility and BMI. Body image flexibility was associated with reduced levels of disordered eating for low BMI individuals; however, in for those with average and high BMIs, body image flexibility was not associated at all with disordered eating. The authors conclude “body image flexibility may function as a protective factor against disordered eating behavior only for those with lower BMI” (p. 339). These findings require further research about ability to cope with body dissatisfaction and maintain healthy eating behaviors.

Body image flexibility as a concept argues for a degree of self-awareness and ability to process well information about oneself and their behavior. Some research, however, is suggesting that the opposite option may be protective. This protective factor is called self-deceptive enhancement, which is defined exactly how its verbiage would suggest. In a study conducted by Tester and Gleaves’ (2005) self-deceptive enhancement (SDE) was explored as a

moderator in the relationship between body dissatisfaction and thin ideal internalization. Interestingly, women who reported lower SDE levels also reported less strength in the relationship between thin ideal internalization and acknowledgement of the ideal. Tester and Gleaves (2005) assert that SDE may therefore function as a protective factor against thin ideal internalization.

Perhaps SDE is really a form of self-compassion to deal with the resulting emotions of body dissatisfaction. Research on EDs and shame suggest that shame is a huge proponent of ED development and maintenance (Ferreira, Pinto-Gouveia, & Duarte, 2013). Ferreira et al. (2013) aimed to get at the nature of the relationship between self-compassion, shame, body dissatisfaction and strive for thinness. As could be predicted, lower self-compassion levels were associated with higher shame and psychopathological symptoms such as anxiety, depression, and strive for thinness. This relationship was found in ED and an opposite relationship was found in a nonclinical sample; however, the correlations in the ED sample were stronger than those found in the nonclinical sample. Results also indicated that the relationship between shame and strive for thinness was fully mediated by self-compassion ($p=.001$); the relationship between body dissatisfaction and strive for thinness was not (Ferreira et al., 2013). The author claims “self-compassion may be an antidote for ... feeling of inferiority” (p. 209). More research is needed to substantiate this.

Spirituality. Spirituality is an emerging branch in the ED research. It is being incorporated into treatment plans, prevention programs, case conceptualization and the research is working alongside to make sense of the role of spirituality. Homan and Boyatzis (2010) investigated the protective role of attachment to God as it pertains to the development of an ED. Attachment research focuses on attachment style, which is usually dichotomized into a secure

attachment style and an anxious attachment style. Results indicated that having a secure relationship with God moderates the internalization of the thin ideal. Thin idea internalization and body dissatisfaction have a weaker relationship when a woman has a secure relationship with God (Homan & Boyatzis, 2010). Furthermore, women who had a secure attachment to God did not internalize the thin ideal as much as women with an anxious attachment suggesting that a secure attachment to God may act as a protective factor against internalizing negative feelings about one's body and societal expectations or ideals. The authors assert that overall their results indicate "women who feel loved and accepted by God are protected over time from the harmful effects of sociocultural pressures on body image and eating" (Homan & Boyatzis, 2010, p. 252). Interestingly, Homan and Boyatzis (2010) indicate that a protective factor may work by offsetting or reducing risk factors, which an attempt at defining how a protective factor works, something the research on protective factors has yet to define.

Chapter 3: Method

The study was conducted on the campus of Brigham Young University (BYU). Screening measures were administered online via a Qualtrics survey. Face-to-face interviews were held in a room allocated for research conducted by the Counseling Psychology and Special Education Department faculty in the McKay School of Education building on BYU campus.

Participants

Participants were sampled from the BYU student population. To address the research questions, purposive sampling was required. Males were excluded yielding an all female sample. Potential participants were screened for high risk of manifesting an eating disorder using the Eating Attitudes Test (EAT-26) and clinical elevations on a closely related concern using the Body Shape Questionnaire (BSQ). To target participants that are consistent with the research question, women with EAT-26 scores under 20 and BSQ scores of at least 110 were selected for interviewing.

Participants were recruited using the BYU Psychology Research Participation System called Sona. Sona is an online interface for recruiting and scheduling. This BYU psychology research participation system allows enrolled BYU students to participate in research usually for extra credit being offered in undergraduate psychology courses. Female students who wish to participate opted to do so through Sona and were redirected to Qualtrics to complete the EAT-26 and BSQ measures. Participants with elevated BSQ scores and non-elevated EAT-26 scores were asked to participate in follow up interviews. Those who elected to participate in follow up interviews were contacted by email and asked to schedule an interview time through Sona. Participants who completed the Sona screening process were compensated with extra credit for

their psychology courses. Those who participated in interviews were compensated with a \$20 BYU gift card.

The final sample included fourteen female BYU students. They ranged in age from 18 to 23. Twelve of the participants identified as either white or Caucasian. One participant identified as White and Asian. One participant identified as Latina as well as being an international student. All of the participants identified religious with The Church of Jesus Christ of Latter-day Saints (LDS). One participant indicated she was in a committed dating relationship, one participant indicated at the time of the interview she was engaged to be married and one participant was married. All other participants identified as single.

Instruments

Eating Attitudes Test. The Eating Attitudes Test (EAT) is a self-report measure of eating attitudes and behaviors (Garner & Garfinkle, 1979; Garner, Olmstead, Bohr & Garfinkle, 1982). There are two versions of the EAT, the EAT-40 which has a total of 40 questions and the EAT-26 which is a subset of the 40 original questions. Correlation between the EAT-40 and the EAT-26 is reported at $r=0.98$ (Garner et al., 1982). Of the 26 items 9 are reported to measure disordered eating behaviors (Hill et al., 2013). Items are rated from 0 to 3 indicating frequency from *rarely* to *often*. Scores range from 0 to 78 with a clinical cutoff score of 20 (Fischer et al., 2013; Koslowsky et al., 1993). An accuracy rate of .90 was reported for distinguishing between clinical and nonclinical profiles in a college age sample. In a study conducted by Koslowsky et al. (1993) it was concluded that the EAT-26 is best at screening for mild EDs and fails to perform well at screening for severe EDs.

Body Shape Questionnaire. The Body Shape Questionnaire (BSQ) is a self-report measure of factors that tend to correlate with EDs (Cooper, Taylor, Cooper, & Fairburn, 1987). It

hones in on concerns about body shape, for example believing one is fat. The measure contains 34 items, scaled on a 6-point response system ranging from 1 (*always*) to 6 (*never*) regarding body shape and appearance concerns (Delinsky & Wilson, 2008). A score of at least 110 is considered clinically elevated (Fischer et al., 2013). In screening individuals with diagnosed BN a correlation of $r=.66$ was reported between the BSQ and the Body Dissatisfaction - Eating Disorders Inventory (BD-EDI) subtest (Cooper et al., 1987).

Procedures

A proposal was submitted to the BYU Institutional Review Board for Human Subjects (IRB). Once permission to proceed with the research project was obtained, data collection commenced. A description of the research project was set up with scheduling slots in SONA so that students looking to participate in research studies could arrange to participate. Students read and completed an informed consent form online through Qualtrics. Participant selection procedures were followed as outlined in the Participant section. Once students qualified to participate in the interview portion interview times were scheduled through SONA. Interviews commenced in accordance with the following procedures.

The interviews were approximately 1-2 hours combined total in length and were video recorded to allow for transcription at a later date. The interviews were recorded using a personal laptop computer and cataloged for transcription. The primary researcher on this project, Natalie Kirtley, conducted interviews and completed the data analysis. The interviews were conducted using an interview guide with questions targeting participants' experience with body satisfaction/dissatisfaction, eating behaviors, and protective influences in accordance with a phenomenological qualitative approach to the research questions. Interview question starters included the following:

1. An introduction to the selection process for interviewing with a follow up question about personal insights as to why she qualified as an interviewee.
2. How do you experience/feel about your body?
3. How do you manage your experience/feelings about your body?
4. How do you experience/feel about food?
5. How do you manage your experience/feelings surrounding food?
6. Tell me times when you have had a strong reaction to the way you have eaten.
7. How do you personally experience the pressure put on women about physical appearance and how do you respond to it?
8. What do you experience the difference to be between how you manage body image and how other women might manage body image?
9. What is your experience with disordered eating?
10. What is your experience with healthy body image and healthy eating?

The interviews were unstructured; however, these questions were used to guide the interview. While these inquiries were used, the interviews were at times spontaneous and fluid (Finlay, 2011). At the conclusion of the interview the participant was debriefed on the research experience. After completion of the interviews, the recordings were transcribed for data analysis.

Confidentiality was maintained by assigning a participant number to each individual when they took the EAT-26 and BSQ through Qualtrics. Identifying information was collected by SONA for allocation of extra credit based on participation. The participants' first name was used during the interviews and therefore will be in the recordings of the interviews. Pseudonyms were assigned to each participant and used in the transcriptions. Some other identifying

information was changes such as the names of friends and family, places of employment or locations. Recordings have been maintained in an encrypted format that is password protected.

Research Design and Data Analysis

This study utilized a qualitative methodology for data collection and analysis. Specifically, a phenomenological approach was employed to allow for an informed exploration of general experience and emerging themes. Data analysis also utilized Interpretative Phenomenological Analysis (IPA) methods.

Phenomenology as a qualitative approach. Edmund Husserl originally developed a qualitative approach known as Phenomenology that was conceptualized specifically to investigate the human experience (Wertz, 2005). His philosophies have greatly contributed to research in psychology. Wertz (2005) described Husserl's contributions as "protest against dehumanization in psychology" claiming that he "offered original research and theory that faithfully reflects the distinctive characteristics of human behavior and first-person experience" (p. 167). Focusing on the human experience and reducing the investigation to the psychological realm of human being is referred to by Husserl as the phenomenological psychological reduction (Finlay, 2011; Wertz, 2005). A phenomenological approach therefore allows researchers to hone in on the psychological lived experience taking it beyond a mere history of events or thoughts to a living experiential history. Finlay (2013) outlined five components of a phenomenological study: (a) the phenomenological attitude, (b) focusing on the lifeworld, (c) dwelling on meanings, (d) holistic explication of the phenomenon, and (e) frame of reference integration.

The phenomenological attitude focusing on the human experience and reducing the investigation to the psychological realm of human being is referred to by Husserl as the phenomenological psychological reduction (Wertz, 2005). The phenomenological attitude refers

to a sense of wonder, curiosity and suspended judgment or as Finlay (2012) describes, an attitude of “noninterference” (p. 175). To accomplish this attitude it is important to bracket (i.e., bringing into awareness and then setting aside or encapsulating) previously formed biases, knowledge and assumptions.

The concept of lifeworld is central to Husserl’s philosophies. Lifeworld or *Lebenswelt* is defined as the everyday experienced world of the interviewee (Kvale & Brinkermann, 2009; Wertz, 2005). Finlay (2013) described it as “the matrix of meanings inherent in our ongoing relations with our world” (p. 180). The goal of phenomenology is to obtain access to the lifeworld through descriptions and narratives. Finlay (2013) indicated that one element of a phenomenological research approach is dwelling in the data and in the meanings underneath the words. Dwelling may on occasion be confused with immersion by the novice researcher; dwelling is in a way immersing oneself in the experiences of the interviewee but it is not the same as getting lost. This portion of the phenomenological process is part of the analysis and is aimed at making sense of and deepening the understanding of the data.

Finlay (2011) suggests that the primary researcher transcribe the interviews as part of the process of dwelling in the data. After the analysis portion of the research, it becomes essential to then communicate the findings in a holistic way that retains as much meaning as possible. How to accomplish this, Finlay (2011, 2013) points out, boils down to phenomenology arguably being both a science and an art. Perhaps it is best illustrated by the idea of unpacking the meaning (Finlay 2011, 2013; Wertz, 2005). Finally, it becomes essential to reframe the meaning and anchor it to other reference points, which is not merely about creating a context for the information but also to be congruent with the idea of the lifeworld as a matrix. This does not

refer only to the context of the research project but a philosophical context as well (Finlay, 2011, 2013).

Interpretative phenomenological analysis. The analysis procedure for this study more specifically utilized Interpretative Phenomenological Analysis (IPA). IPA is a hermeneutic phenomenological approach to qualitative data analysis. IPA employs a double hermeneutic approach. The single hermeneutic refers to the meaning making of the interviewee. The double hermeneutic refers to the meaning making of the researcher in response to the meaning making of the interviewee (Finlay, 2011). This concept is simplified by envisioning hermeneutics or meaning making occurring at two different levels; level 1 being the single hermeneutic (interviewee) and level 2 being the double hermeneutic (interviewer). IPA incorporates the researcher as part of the instrumentation not measurement error like quantitative research. IPA is more focused on process than outcomes and therefore is best described as being comprised of three methodological imperatives as outlined by Finlay (2011): “1) a reflective focus on subjective accounts of personal experience; 2) an idiographic sensibility; 3) the commitment to a hermeneutic approach” (p. 140).

A commitment to these three imperatives was included throughout the current research project in a number of ways. First, paying heed to the subjective personal experiences of the women to be interviewed is reflected in the research questions, the potential interview questions and in the method of analysis still to be discussed. Second, the screening methods and even the setting of the study are in response to a commitment to idiographic sensibility. Third, interviews and analysis were conducted by one individual, despite the size of the task, to retain meaning as it is elicited and to integrate the researcher as part of the hermeneutic approach.

Integrating the researcher/interviewer may have introduced potential confounds in unfavorable ways. To acknowledge this potential, a balance was navigated between engaging in reductions as explicated by Husserl and a process of reflections (Wertz, 2005). As the primary researcher it was important to unpack my expectations, biases, and knowledge about the experiences I am attempting to explore as an effort to bracket but also to inform a reflective process. Finlay (2011) argues that as researchers we need to examine how our personal experiences, values and behaviors impact the research process as well as the findings. In a deliberate and purposeful way, examining my own position in the research was to hopefully and ethically pay heed to the principle of double hermeneutics. To engage in this process I wrote about my experiences prior to and concurrent with the study. I also allowed myself to journal during the interview process as needed.

An IPA framework was used for analysis. This method was chosen because it adheres to phenomenology's philosophical tenets which match the research questions but also because IPA offers some structure for analysis. The following is a seven-step outline for analysis that was adhered to in the analysis process of this research project. This outline is taken from Finlay's (2011) book on phenomenological qualitative research and is based on an outline originally published by Smith & Eatough (as cited in Finlay 2011):

- *Step 1* Reading and re-reading - immersing oneself in the original data.
- *Step 2* Initial noting - free association and exploring semantic content (e.g., by writing notes in the margin).
- *Step 3* Developing emergent themes - focusing on chunks of transcript and analysis of notes made into themes.

- *Step 4* Searching for connections across emergent themes - abstracting and integrating themes.
- *Step 5* Moving to the next case - trying to bracket previous themes and keep open minded in order to do justice to the individuality of each new case.
- *Step 6* Looking for patterns across cases - finding patterns of shared higher order qualities across cases, noting idiosyncratic instances.
- *Step 7* Taking interpretations to deeper levels - deepening the analysis by utilizing metaphors and temporal referents, and by importing other theories as a lens through which to view the analysis. (p. 142)

Research results have been reported at the level of higher order themes or categories and unpacked using specific illustrative examples or lower order groups as well. Both convergent and divergent findings will be reported as well as insights considered to be more experiential on the part of the primary researcher.

Chapter 4: Results

This study was undertaken to investigate the experience of women who are at high risk for developing an eating disorder based on body dissatisfaction but who also do not have elevated eating disordered attitudes. The secondary goal was to consider what these women believe keeps them healthy, or in other words what prevents or protects them from developing disordered eating attitudes and behaviors.

Based on an Interpretative Phenomenological Analysis a number of themes emerged from participant data. The highest order theme, (1) *Self-concept*, connects with four general themes including, (1) *Control*, (2) *Social*, (3) *Priorities*, and (4) *Religion/Spirituality*. These four themes were determined to have two modalities, positive and negative, that describe a couple of general differences of the participants' experiences. The positive modality accounts for data that illustrates protective qualities as well as empowering or other effects associated with positive emotion, cognition and behavior. The negative modality accounts for data that describes destructive qualities as well as disempowering or other effects associated with negative emotion, cognition and behavior such as fear and guilt. The nuances of these two modalities will be discussed in the explanation of each theme. The two modality organizational structure is most clear in *Control*. Outside of the structure shown in Figure 1, three more themes will be discussed: (5) *Information/Exposure*, (6) *Avoidance*, and (7) *Food Relationship*.

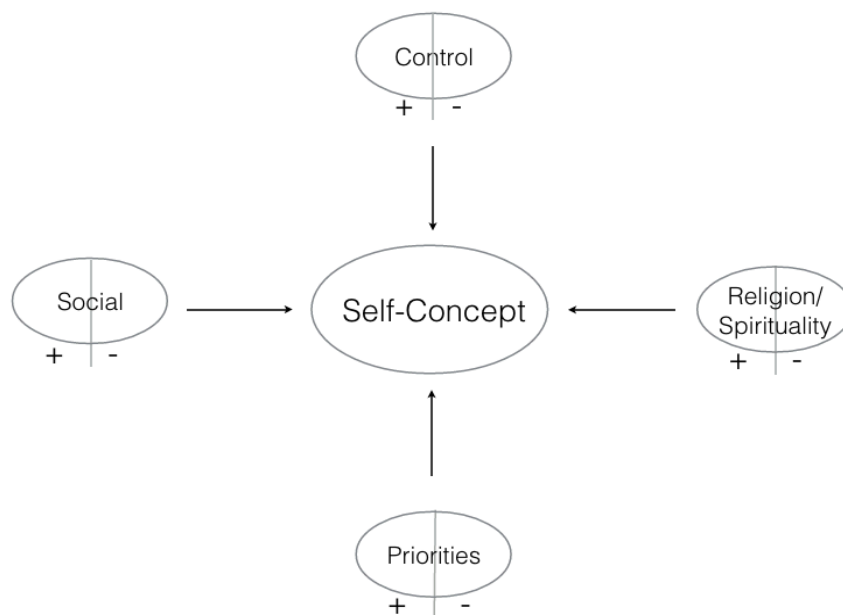


Figure 1. Organization of the first four themes, Control, Social, Religion/Spirituality, and Priorities, including positive and negative modalities, around the higher order theme, Self-concept.

Control

Control is a particularly interesting theme that emerged from the narratives of every participant. The development of this theme began by taking note of reoccurring glorifying responses of the control and willpower attributed to women with eating disorders as perceived by the participants. At times this was expressed by participants commenting on their own lack of willpower to more positively manage their body image or associated behaviors. Libby offers an example wherein she hypothesizes that perhaps her lack of willpower was responsible for protecting her from risk of developing an eating disorder. She shared,

So...I've never, I don't know if it's that I lack the willpower [*laughing*] to have an eating disorder cause I feel, cause sometimes I feel like I would. I like, there's sometimes I even think 'I almost wish I had an eating disorder.' I've caught myself thinking that but, and

I'm a rational enough person that I'm like 'no, I don't really wish that' but..."

She reiterated this idea during her second interview, "Cause I always just laughed and said it was my lack of willpower but I just like food too much and wouldn't be able to stay away from it..." Later, when asked to reflect on what she believes is the difference between herself and women with an eating disorder she stated, "Um, first, I think, I am less self-sacrificing..." and then laughed it off and offered an alternative explanation. Susan also provided self-deprecating jokes about her willpower, "No, but, um, I'm just kind of laughing [*crying*] because I was just, well not the other day but I would think, because, I would jokingly, I just almost feel like I'm a bad candidate because I'm like, 'man I wish I had the willpower to be anorexic' joking!" However, later, when questioned if she would seriously consider disordered eating behaviors if she had the willpower she wished for, she affirmed she would. Even though these participants indicated their comments were not serious the idea exists for them in some capacity. Volunteering that perspective suggests they have spent time considering the conditions necessary to sustain disordered eating habits like extreme restriction.

The last two examples spoke of willpower, other participants used the word "lazy," and expressed that they were not in the athletic shape or physical shape they desired because they were lazy about exercise and diet. Vivian even shared that laziness nullifies intelligence and intent. One participant grappled more with the dual nature of control likely experienced by women with eating disorders. Adrianna recounted an experience that colluded with the perception of increased control as a requirement for disordered eating but also recognized that women with eating disorders may not necessarily have control. The story describes a time in high school when she attempted to develop an eating disorder after reading a book about a woman who did.

Um yeah, I have been tempted to try them...like throwing up. Actually, it was after I read a book about a girl's horrible experience with it and I wanted to try it. It was when I was in high school... Well, it was written so that girls... it was, like, a Jack Weyland book and I remember thinking that maybe I would... I wouldn't get to the point where it was out of control...that I would feel in control and I would know what to do then. But I never actually went through with it, I just thought about it sometimes.

When asked to surmise why she had not followed through she said, "Um, because well there was part of me that said 'I could try it and stay in control' but that's probably what every girl thinks and so I didn't try it." Adrianna saw past the illusion of control and considered the less appealing result of loss of control. While the perception of control is an illusion a number of participants idealize the control they view as necessary to engage in an eating disorder, especially in restrictive eating and exercise based compensatory habits. Having a sense of control is enticing. It is easy to see the appeal of behaviors that appear to offer control and willpower, especially if one is consistently feeling dissatisfied with one's body. Ultimately Jane summarizes the reality of both the illusion and the desire for control, "There's a reason it's a disorder, you know. It's not glam...or it shouldn't be glamorous, like, I feel, like, sometimes it is."

Control framework. Not all of the discussion surrounding control, however, glorified eating disorders. The majority of the participant responses referred to their own sense of control and how it affects their behavior and self-concept. The participants described a variety of approaches to emotional coping in regards to their body shape dissatisfaction and the behavioral results. Some reported making no efforts to address their body shape through emotional coping strategies or diet and exercise, which for some seemed to further push them into dissatisfaction with their body while another portion seemed forgiving and unconcerned. Others expressed

making efforts to cope with the emotions or eat healthy and/or exercise, which for some seemed to further push them into dissatisfaction with their body while another portion seemed contented by their efforts. To understand these differences the narratives were relied upon to build and interpretative framework (illustrated in Figure 2). Examples will be provided for each of the two modalities (positive/protective and negative/distressing) of the framework.

Closer analysis of the data revealed a framework to explain a variety of conceptualizations and behaviors reported by the participants. The two modalities that resulted were further developed into a framework that is comprised of two branches. The first branch accounts for data that describes a sense of control, having options and being capable and allowed to make choices, which leads to feeling at liberty. These experiences ultimately left participants feeling empowered. The other branch accounts for data that describes a sense of stuck-ness (lack of choice) and restriction. These experiences ultimately left participants feeling disempowered. Associated with each of these branches were two categories that illustrated cognitive, affective and behavioral outcomes.

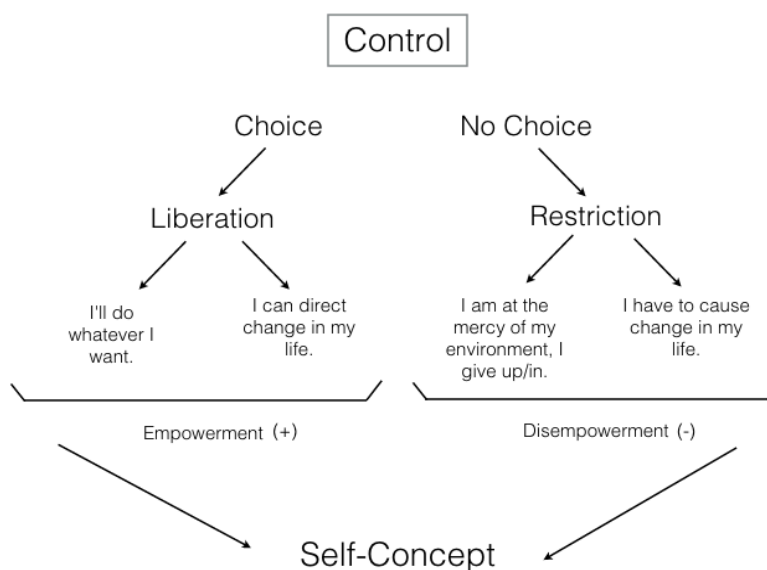


Figure 2. Detailed framework of the positive and negative modalities within the theme of *Control* and the connection with *Self-concept*.

Prior to clarifying the categories and presenting supporting data it is important to explain that these categories are not intended to categorize the women themselves but rather the ideas they expressed. Many of the women expressed a number of ideas that were descriptive of more than one category. Women and their experiences with body dissatisfaction and coping strategies are varied and cannot be not so neatly allocated to one category. They often contradicted themselves or would vacillate between feeling empowered and disempowered. None of the participants seemed to be settled in any one place, rather they wandered in and around aspects of control. Individuals are better described as mosaics, collections of pieces, each piece being real but not being the whole reality. In this way each individual is both unique and alike. This is true of the participants in this study. They exhibited their mosaic of experiences in combinations

unique to themselves. Each category will be explored with data. The data will illustrate the contradictions and collections of categories described by the participants.

I'll do whatever I want. The first category has been summarized as *I'll do whatever I want*. Generally, this category refers to experiences demonstrating acknowledgment of having a choice, change being available and therefore a sense of liberation to consider one's options. Ultimately, in this category the decision may be to not take any type of action to alter their situation such as instituting a diet or exercise plan. The result, however, is an approach of acceptance and leads to reduced concern.

The participant who speaks most to this category is Susan. Susan uses class time to look up restaurant menus, says that she drinks soda because, "I'll think is this worth it, is it worth drinking this right now? And I would say that in the moment it always is or else I wouldn't do it," and considers eating with friends more of a priority than dieting or exercising. She offers up our first illustration in response to considering the self-talk she employs to help her with her negative body shape experiences. "... I think it's just a matter of, like, I've, I definitely know I have the capability to, like, be healthy and eat right and exercise because I use to. I was, like, on varsity swim and club swim when I was in high school so I was really in shape." Susan's historical body shape and ability to change her body shape gives her a feeling of control and choice. This sense of option and ability protects her from feeling trapped or stuck with a body shape she feels poorly about at times.

Julietta narrates how she manages negative emotions about her body shape. As she talks about her approach having options and control to make a choice about dieting emerge. She goes on to describe how this also was a part of her experience as a teenager. She starts with an explanation of how she copes with negative emotions about her body, she explained,

I think about food and then I'm better... Yeah, when I was little I was super fat, well not like super super fat, but I was fat and my mom took me to be in sport and right now she thinks I'm still following my diet but I'm not. When I think of my diet I think 'no thank you.'”

Later, she was asked how her feelings about her body affect the way she eats. “ I don't think that it affects ...like if I want pizza I eat pizza.” She does what she wants. At least, she does what she wants when she can. Julietta tells about being part of an upper class family in Mexico where appearance and social politics are part of daily life, even school.

In Mexico we don't have, um, we have paid schools...there are different kinds, levels. Um, I was in the highest level but I needed to be like, the perfect, the perfect girl because in that school it's very selective. In my class it was seven girls and one boy and I didn't like that school because there were no boys. So I went level down, and because I went from the highest level they thought that I was perfect...It was nice but you had to have the perfect body and the perfect hair and I was like, I don't have to be so much that way. It was liberating. I don't have to do...

This transferred to other periods of her life that took her away from home and her culture, which are nearer the source of pressure. One such period is her attending college. Consider the following interview segment for comparison of the two environments:

Julietta: But there [Mexico] it was like, today I'm going to the house of the governor and the next day... it was a lot of pressure to look nice ...and be in the newspaper and then here they don't worry...

Interviewer: So it feels more relaxed?

Julietta: Yeah. And I love it. And I think that's why I'm not worried about my body, I'm happy, I don't have pressures. I don't have that pressure. I just eat the food.

Interviewer: What do you think it is about being here that makes it relaxed so that you don't have to worry about how you look?

Julietta: Cause they don't know who I am and no one cares... they are not interested in what I do for you, what can you do for me ...

Interviewer: Do you feel like people here care as much about the way you look as the people do where you're from?

Julietta: I don't think that they do.

Interviewer: So it feels manage...it feels like not a big deal to you in comparison?

Julietta: If they try to make me feel bad about myself here I would not care but if somebody would try to make me feel bad in Mexico I would be like, 'ah!'

Interviewer: So when you feel badly about your body in Mexico, do you think that has a bigger impact on your eating?

Julietta: Yes.

Interviewer: And here not as much?

Julietta: Yes.

This excerpt not only illustrates the liberating option of choice associated with *I'll do whatever I want*, but also a bit of the fear motivated choices more illustrative of the fourth category, *I have to cause change in my life*, which will be discussed later. Perhaps the most illustrative comment is what Julietta shared in regards to her trips home. "When I go to Mexico, I go for two weeks. The first week nobody knows that I am there and the second week people know. I can be myself but not myself the second week."

Julietta's story greatly elucidates the role social pressures play in women's experiences of their bodies and in their choices of food, exercise, clothing and other appearance related choices. What is specifically pertinent to this section of the results, however, is that in an environment perceived to be less encumbered by these pressures, Julietta elected to do whatever she wanted including not adhering to her diet, worrying less about her hair, and even dismissing social commentary.

It would appear that a sense of control over one's situation allows for a more relaxed approach to food and body image or at least a more self-guided approach. It may also afford a more relaxed approach to behaviors associated with body image. And in some cases it may even allow a space for one to react against pressures and choice restrictions felt at other times and in other arenas of one's life.

I can direct change in my life. The second category has been summarized as *I can direct change in my life*. This category also refers to experiences demonstrating acknowledgement of having a choice, change being available and therefore a sense of liberation to consider one's options. However, in this category the decision is to institute behavioral goals such as dieting or exercise, or to employ emotional coping strategies. The result of which leads to a decrease in distress and an increase in positive outlook.

Susan described being an athlete in high school, which has left her with knowledge of how to physically train and change her body shape. She claims that knowing she could make changes eases her body image dissatisfaction at times when she is feeling distressed. Heidi shares the common experience of having competed in athletics in high school and then not maintaining the same level of physique and athletic ability in college. The distinction between

Susan and Heidi, however, is that Heidi elects to eat selectively and seeks out physical activity and exercise. She stated,

I...I think I kinda just tell myself that I can, you know, I can achieve it again if I work hard enough and if I don't like, you know, it's not really that, you know, life...impeding, like it's not gonna ruin my life if I'm not. Um. I think that...Sometime, like sometimes, I'll try...I'll tell myself like 'oh it doesn't matter,' but in the back of your mind you're like 'no it does matter!

Alyssa grew up training in ballet. The further she progressed into puberty the more she was told that her body was no longer suited for continued training. She eventually discontinued her ballet studies. Alyssa considered what self-critical thoughts she experiences and how she combats them. In this example we see that she feels empowered to make choices and seeks to implement choices that attribute to a sense of health.

They're usually like 'you need to better,' or like, 'you're little but chunky; you've got some tires.' Um, I just push them away. [*laughing*]. I don't know if that's a good thing or bad thing. I push them away...I, I'll do something about it, like, like I said I like to feel healthy, so I'll probably go on a bike ride or I won't drive to work, or I'll do something else. I'll try to acknowledge that it's there but I don't want it to control me so I don't, I don't want it to fester because after going through the ballet experience I don't want it to ever feel like that again, or to feel like I can't be good enough because I wasn't good enough to go on to point kind of a thing. Like, I don't wanna be the person that holds me back from being good enough for anything. So, I think with that mindset and because of ballet I want to be good enough for me...

Her sense of motivation is not one of fear but a desire to be healthy and enough for only herself. There is not a sense of fear but rather a good faith effort to do right by herself. She solidifies these ideas when she explains,

And think that's just always been in my head: as long as you're healthy you're fine kind of a mindset. If I'm being active and I'm eating right, I'm going to be healthy and just trusting in that, what science tells us and things that that should be the way to go and that I shouldn't feel too bad about what I look like because as long as I feel good and I'm healthy and not wheezing when I walk up steps that I'll be okay kind of a thing. Just reminding myself you can still do lots of things.

While these participants described action, exercising, dieting, etc. others described using their sense of control or choice to choose non-action. Three of the participants discussed plastic surgery. One of the three elected to have plastic surgery performed. Libby shares how the option of plastic surgery was introduced to her, how she reacted and why:

My father is a plastic surgeon and my mother was, *sigh*, my mother was always telling me that um, she would always say, 'well, you can go get implants from your dad' or whatever... My mother, well, my mother did but she was big before that. And my sister is huge anyway. And I never wanted that, I, and all the stuff that comes with it. But having my mom tell me 'you should go, you should go' or 'you could get this fixed' or 'you could get Botox' or that kind of stuff has contributed. And definitely they made me consider it and think about like 'well maybe if I just went and got lipo then I'd feel better.'

Libby, however, rejects the offers and suggestions. Which points out that *I'll do whatever I want* and *I can cause change in my life* are not just about what women choose to do but also

about what they choose not to do. While Libby opted to not have surgery, Julietta elected to have surgery. Julietta described believing her mother was joking about the suggestion and within days found herself in the operating room. Julietta believes that she will have surgery in the future to reverse the physical effects of having children. While she may have been swept up in her first encounter with plastic surgery, her future plans seem self-directed and voluntary. It could be argued that despite their divergent decisions, having the ground to make a decision at all may function in similar ways in regards to empowerment. However, does plastic surgery really leave women feeling empowered? Consider Julietta's experience with the first two plastic surgeries, wherein she did not play an initiative role. Perhaps, that experience speaks more to the qualities of the third category.

I am at the mercy of my environment, I give up/in. The third category has been summarized by *I am at the mercy of my environment, I give up/in*. This category refers to experiences demonstrating a lack of acknowledgment of having a choice and therefore a sense of restriction wherein one does not have options. Despite the illusion of there not being a choice, ultimately the decision is to not take any type of action to alter their situation such as instituting a diet or exercise plan, rather they submit to their conditions and changes are not considered. The result is an approach of resignation and leads to increased concern or at least sustains concern.

Vivian speaks to this category quite a bit. Vivian shares that her mother was always actively concerned about her weight and appearance. Like Julietta and Libby, her mother suggested that she seek surgery to have her jaw split and narrowed to achieve a face shape more typical of Europeans and, therefore, less Korean looking. She shared that her mother's side of the family, all Korean, also commented on her style being too androgynous and her voice too deep. When this example is considered, it is true that she did not give in and have the plastic surgery as

might be expected given the category under discussion. Perhaps the decision to not go along with the suggestions of plastic surgery is more illustrative of the second category, *I can direct change in my life*, similar to Libby's experience with rejecting suggestions to receive plastic surgery. Or it could be that Vivian did not consent to the surgery because she has given in to her dissatisfaction and was unmotivated to act deliberately to change the situation surgery or otherwise. What is important in this example is the attitude Vivian expresses about her reaction to these experiences. They exude the *give up/in* feel that is missing from Libby's experience.

Vivian describes,

My understanding is that they are very concerned about their appearance. Um, when I visited Korea, they have always been very thin. They always care a lot about how they look, even going to the grocery store they dress like they're going to an interview. Um, even the boys get perms and dye their hair. Um, and all the girls wear designer clothes. They're very appearance conscious. And everywhere you go there are ads for plastic surgery. And it's actually pretty normal. A parent sometimes as a birthday present will give them plastic surgery as a gift. My mom even one time said if you just got a shot right here in your nose and got a nose bridge you'd be pretty, and that's completely normal... Um, I guess I'm just used to it. I, I do feel self-conscious all the time and it's created a conflict but I guess you just kind of learn to deal with it.

This is where text fails the rich quality of face-to-face interactions. The feeling in the room when Vivian said, "I'm just used to it. I, I do feel self-conscious all the time and it's created a conflict but I guess you just kind of learn to deal with it" was one of defeat and discouragement. She seemed depleted and without energy to deal with anything. She goes on to say,

I personally don't want plastic surgery but, and her friends also suggested, because my face is a little bit round like an Asian's, they like to restructure their skulls, like split their jaws and get it narrowed like a European's and they suggested that once. But again, I don't really care. What's more hurtful to me is my body weight. Again, it's just the culture. And in Korea it's, not many people are fat. So, to them I do look really fat. They're, they're, to them I'm fat and I'm not sure if I would be considered obese but when I do go to Korea I stand out a little bit because most people have a healthier diet and they travel a lot and they're just thinner.

What, perhaps, will help illuminate the defeated nature of Vivian's comments are examples of her behavior.

Like, I don't know if this important but when I was younger because my mom was always concerned about my weight she would, um, really micromanage what I ate. And so whenever I got the chance, like when I was out at a party, I would eat everything I could that was sweet. And I think that instinct has just stayed with me. Whenever I see something I eat it, even if I don't want to and I think that's part of it.

It could be argued that when Vivian was faced with a choice, she seized the sense of empowerment and ate whatever she wanted. This interpretation would be more descriptive of *I'll do whatever I want*. However, if we consider that her decision to eat everything at the party was more a function of feeling disempowered and not having a sense of control the behavior suddenly feels more a desperate act of feeling at the mercy of her environment. Given that this behavior, or mentality has continued into her independent adult years, it suggests that Vivian still feels the pressure of being restricted even when she is not.

Vivian stated that she first started feeling badly about her body in the fourth grade. She was asked if she feels like she is getting an edge on it. “No. [*laughing*]. Not really. It’s more like I’ve just given up.” She states that while she still cares she feels defeated, she expounds,

Pretty much. Yes. That’s kind of an attitude I’ve had for a lot of things actually. Um like whenever we have to write something, I think ‘well I’m never going to, I’m not that smart and I’m never going to be that good anyways so...um, what’s the point?’ But I’m still a perfectionist so I take forever on papers. It’s just kind of with everything. It’s the discipline and self-control. To me intelligence is a really nice thing but if you don’t have the drive to do anything with it then it’s pretty useless.

She then reasserts that she is “lazy.” A challenge is offered for her to reconsider the use of this particular word. “It’s the word I use with myself. It’s the word my sister uses with herself. Uh...I...maybe it’s anxious. Maybe it’s just afraid of failure but it’s still kind of laziness to me.” Vivian feels defeated in way that feeds back into her distress.

While Vivian was able to quite adeptly explain her thoughts, feelings and experiences, Betty was not. Betty began crying in her first interview right out of the gate in a way that conveyed her emotions on the topic of body image were tender and close to the surface. She struggled to generate content as she choked back tears. What is certain is Betty spoke as though she was at the mercy of her environment. Aside from ignoring her body she struggled to identify any coping behaviors for her negative emotional experience around food. When directly questioned about dieting as a response to negative body image she said,

Like, I usually do it for like a week, then I don’t see results and, like, I don’t intentionally give up but I, like, I kinda give up, day by day, kind of thing. Kinda like, like, a month

goes by and I'm, like, 'crap,' like, 'I could be somewhere else right now if I kept with it.'
[crying].

It may have been the lack of Betty's ability to verbalize her experience but it seemed that she felt like a pawn in her own experience.

I have to cause change in my life. The fourth category has been summarized by *I have to cause change in my life*. This category refers to experiences demonstrating a lack of acknowledgment of having a choice and therefore a sense of restriction wherein one does not have options. Despite the illusion of there not being a choice, ultimately the decision is to acquiesce with expectations and institute behavioral goals such as dieting or exercise, or to employ emotional coping strategies. The result is an approach fueled by fear and leads to increased concern or at least sustains concern.

Trina illustrates this idea and how the pressure, how the "I have to," came to exist for her. Trina confides that her mother is overweight and has paid above average attention to the health and fitness of her children for fear they will also become overweight. Trina also participated in beauty pageants, athletics and clogging growing up. Trina was asked to reflect on her responses to pressures from these sources. She offered the following response:

That I need to change. That I can change. And then it's just like, but not over doing it. Like, there's limits. Like, I'm always a person that's just like 'I...' I don't know, it's just like a 'you can do it.' If it's like running a certain distance then I was like 'oh I just need to work on it to get to it.' But, if it was like trying to lose like certain weight in a certain area... sometimes I would be like 'okay, what do I have to do to get there? What goals do I need to set? Do I even want to do it? Do I think it's possible?' Things like that. And

then when I fail at it, that's when it makes it worse, I guess, like when I try to do something and I don't get there it makes it worse.

When asked if she ever has a different reaction she responds with confusion, "What would be other options maybe I just don't know what they are?" Perhaps this suggests there is one mode of operation, make changes or... "Mhmm. I think with sports it's like 'I can do it.' But, like, for example on my mission when I couldn't control anything it was always like the defeated reaction." It would seem that the other reaction is to give up. She continues, "And things like that. Sometimes, sometimes I do feel defeated just like, I've tried in the past so many times and I'm never going to get there. So I have, like, them both, the proactive and the defeated." Trina, however, remains focused on being proactive in causing change in her body. She offered the following response:

Because, like, I want to be the best that I can, and I want to be the best that I can be and obviously... I'm not the best because not everyone, because we're not perfect but because of that I just am trying to do all the things I can, all the things I know how to do to be able to do that and I know that the eating disorder is not going to help me. Like, if I don't get enough sleep, if I don't drink enough water, if I don't get all those nutrients in my body I'm not going to be able to do well in school, I'm not going help my future family. I think a lot of what helps me is thinking about the future, maybe...my goals, my drives...

While Trina has some great ideas about imperfection that could buffer the intensity of the pressures she feels the weight of the responsibility she hold seems to be in the forefront of her mind, that change is possible but she doesn't really have a choice about whether or not to make it happen, because, well, she should make it happen, "... I do expect a lot out of myself, so that's

where the dissatisfaction comes into play, I think. I guess I have such high expectations that I'm like 'I need to be this, this, this, and my body is not fitting this, this, this,' right?' Perhaps the important difference is need versus want.

An experience from Trina's mission shows us what it is like when an individual who "needs to be, this, this, this" is not in a situation to enforce the behaviors required to conform.

Um...I can give you a really good example. When I served my mission in Chile I didn't have a lot of control over a lot of things. Like, I couldn't exercise as much, I couldn't control the food that I was intaking, so naturally I gained like twenty pounds or something like that. And, so when I would look in the mirror it was just like... there was feelings of anger, like, why is this happening? Parts of it were sadness because I couldn't do anything about it and things like that. And so when I got home from my mission I was like don't go crazy, you know don't, like...lose the weight at a slow pace but...and so as I've been like in this process of trying to get back to the way I was before my mission it's been a lot of like, like, hopelessness I guess. Not feeling like I'll ever get back to the way I looked before, or. There's feelings of just um, I don't wanna say regret, sometimes it's regret, just cause...that. So my mission was a lot like the anger sadness but now it's just like hopelessness, just thinking like 'oh, I'm never going to get there,' or things like that.

The shift for Trina from a situation where she felt control over her actions to a period of time where there was less liberty was demolishing. What never seemed to change for her was the pressure of needing to cause change, a fear that continued to fuel her concerns.

On her mission Trina began to combat some of the restricting concepts that reinforce the pressures that have helped her fixate on body image and weight loss. It was this process that Trina actually attributes as the most protective experience for against disordered eating.

When I was going to counseling, he, he asked me what is the truth? Like, what is real beauty? And, like, I always had that question, but I was just like, ‘well, you know, it’s this or that,’ but it really stuck out to me. So every time after that when I saw a picture... like, I would think, is that real beauty? And it actually completely changed how I thought about it. That’s when I actually started seeing the success of my mind changing is when I started questioning, like, I would look at a picture and I would be like ‘is that really beautiful?’ Like, ‘is this person in this magazine, is that really beautiful or is it just a bunch of lines with a bunch of colors?’ You know? So it was just like the moment when I started questioning what was beautiful and then just looking around at the people and saying ‘well, why wouldn’t they be beautiful?’ So, it, like, took from taking it down to the ‘what’s really beautiful?’ to seeing the beauty in other people...so that now, as I’m continuing this process I can finally kind of see the beauty in myself. So it’s, like, slowly coming inward, I’m slowly figuring it out. I just like, [*snaps fingers*] what really is beautiful? What makes it, that you get to decide what beautiful is. And that goes back to like anthropologic idea of like who, who has power. A lot of times people who have power decide what is truth, you know. But...but you can question that! And that’s what helped me start the process. Mhmm exactly. I think that’s actually where it started, when I started... [*snaps fingers*] that would be my success story right there. I pinpointed it.

This may have been Trina’s first glimpse into feeling empowerment within the realm of body image. The powerful effect and the perpetuation of feeling liberated that resulted from questioning power, her power, the power of others is what she decides is the changing catalyst that relieves her from the fear of “having to,” to be, to look or to behave in certain ways to deserve peace and acceptance of her body. Having returned home from serving a mission, Trina

admits that she is still, “just trying to fight that body image thing.” She continues to work through the struggle,

Um, I feel like for most of my life it was just like tunnel vision. It was, like, this is what you have to be and if you're not this then you're not good enough. And just these last couple years, I feel like I'm tired of thinking like that. I'm tired of trying to conform, I feel like I'm just never going to be happy with it if I don't just be happy now, you know? So, I've started to try and figure out and change the way I think about things. Cause I don't wanna think about things... I don't wanna be this person that's never happy with the way they are ...Like, I don't wanna be this person forever because for one, I don't want my kids to be like that. I want my kids to have a confidence that I never had.

In conclusion, the framework provided is general. The examples provided show that clear categorizations are impossible. Elements of each idea can be found in various ways along the stories of the participants. The difference between feeling empowered and disempowered is almost palpable in the tenor of their voices and visible in their facial expressions. But, it is a mixed bag and no one participant was in anyway completely empowered or disempowered but rather a mosaic of both.

Social

The narratives of the participants were saturated in social elements. They spoke about the impact of having friends that were critical or supportive. They explained how their body image concerns affect their social life. They even contemplated how social food really is in their daily life. More than any of these elements the participants spoke about comparison. Within the idea of comparison they spoke often about the ideals and standards they believe exist in society. It might be assumed that the participants feel crushed under societal and familial enforcement of these

ideas, and while that is sometimes the case, it was also evident that at times the enforcers were the participants themselves. Amidst this unhelpful and distressing social dynamic participants also seemed extremely calmed and healed by the positive affirmation offered in social contexts. The *Social* theme, like other themes, can be organized into two modalities. The positive modality accounts for data that illustrates reductions in distress about body shape and eating while the negative modality second accounts for data that illustrates increases or the sustaining distress regarding body shape and eating. Most participants took note of social standards or ideals but some spoke about them more directly. Gina is a perfect example of internalizing perceived expectations about body shape and enforcing them even if the social environment around her was not. She recounts an experience she had at the gym.

... When I go workout and stuff it's just, like, I try to, like, ignore people in a way. Like, I'm like, um, like I'll be like, 'just don't look at them just get through this and then you can just go home and you don't have to,' you know, like, 'deal with people, like, looking at you' type deal. And like, um, like I used to go down to UCLA and, like, there was, like, a class where you just, like, workout at the fitness center. And like, one time, ah, this guy, he, like, came over and asked me out on a date and I said no because I was just like, 'I'm here working out. I'm not in the right shape. I'm not...you know, I can't do that.' And so, like, it's kinda weird but it's just, like, I felt like I was so, like, crumby. Even though apparently he didn't think so. I couldn't, you know, I didn't want to, like, go out and, I don't know, with someone that, you know...didn't, I don't know how to explain that. Like, I just didn't want to, I don't even like people talking to me while I'm working out cause it's just, like, I feel like crap and so it's just like why deal with, you know,

other people while doing that. And so to like get him away I just said no and just had him go.

An inquiry was made into whether or not she feels there is a certain way she needs to look to go out with men, “Oh yeah. You know that, you know, you should be like healthier, like, like kinda fit type deal. Cause, you know, it always seems like the guys, you know, want the skinner type girls, you know, kinda, you know, like, I don’t know, like prettier and like that kind of way.” This excerpt illustrates a variety of social elements that play out in body shape dissatisfaction. She notes the desire to socially isolate or disconnect, her perception of social rules about good body shapes and bad body shapes, her perception of social rules about who is worthy of receiving romantic interest and the exacerbating effect of social presence on her body awareness and dissatisfaction.

Many other social elements were discussed and supplemental data can be viewed in Appendix D. However, another example that speaks to cultural, socioeconomic, and sociopolitical facets of this concept was offered by Julietta and is worth adding to the conversation.

I think like I was saying, well, cause like in America, the people I see in T.V. shows are as equally as pretty as anyone you might see in the street. But in Mexico whenever I see people in shows they are very plastic, they are like really really rich people. And this normal people are made to look like these fake people. Here, in America, it’s more because everyone is pretty [inaudible segment] but in Mexico... and also, one thing that I’ve found here, in America, is you can dress however you want and still get respect. In Mexico there is a minimum... Like [here] when you go to a house if there are different kind of styles in the same house that will be good, but in Mexico if there are different

styles in your own house that will be like very, something is not right ... Maybe in Mexico there is more pressure, because here I think, I don't know if I'm right but your teachers, your entrepreneur, your elected, whatever you do, it is fine. Where in Mexico, if you are a teacher it's something bad. Or if you're elected it's something good. So, it's a lot of labels. And if you're a teacher you will not have a good income and [inaudible]. But if you're elected then you have a house, and you have a car and you have family. How do you eat healthy if you have no money? How do you go to a gym if you don't have money to go to a gym because you can't go running in the street...

In summation she indicates that it seems if you can manage to have the right overall image, the right status, "And if you are that, you are "happy." If you don't have it then you are not." These examples suggest that the most effective pressures are those from communities individuals belong to and those communities that are nearest them. For Julietta that includes her Mexican community and culture. For all of the participants it means their religious community as well as university community and culture. For Vivian it includes her Korean community and culture. For some it includes their dance, pageant and athletic communities and culture. Each of these communities has a culture, which offers with it a set of expectations and norms and complimentary pressures to conform.

Jane was asked to reflect on how she perceives and reacts to the societal pressures that pertain to her. She shared,

You know, like, I know... it's a problem with me because I have a logical side and then I have my emotional side. So, logically, I know those people in those magazines don't look like that, they don't. That's totally fake, but the other side of me is like 'why don't you look like that? You could if you just did this, this or this, or...' you know?

When asked what helps her through those feelings she identifies the following,

It helps when people tell me, you know. It's like 'oh Jane, you're beautiful.' It's shallow but I love being told that I look okay. That helps a lot. ... Um, I joke with my roommate, I'm big on positive affirmations, you know, like... I'll just be like 'Hannah you're beautiful. You are awesome. You are smart. You have a sense of humor and I love it.' And I don't have very many people to do it to me but... when I find someone I'm like 'awww, thank you!'

However, it turns out that receiving a compliment is not always simple. Jane points out how some people have a difficult time internalizing affirmations from others.

... Like I know there's a lot of people who you compliment them and they're like 'Oh! Well let me tell you how I'm not that...' you know, 'you think I'm pretty? Well, no, look at me!' So, you know, I know it's a pretty common thing so I wouldn't be surprised if I were pretty similar.

Penny's responses echo Jane's desire for affirmation. She starts by stating how affirmations help ease the distress of not being satisfied with her body. "I guess other people affirming that I'm not, not ugly or out of shape." Even though she does not believe she receives affirmation that often she says, "but when I do it's like 'oh, thank you, that means a lot to me.'" But then, Penny throws in a condition that may void such affirmations. "Yeah, like, when sometimes, when they are talking like in a joking sort of voice, then I am more dismissive of it but when they sound sincere then I'll take that for what it's worth." Even Jane endorsed responding like that,

I was talking to my friend, I can't remember what we were talking about, but he was like 'you look like you slimmed down since...' you know, it's pointed out and I'm like

‘thanks’ (1/2 sarcastic) Like, you know, ‘thank you and by the way I didn’t look good then?’ Sort of thing.

It would appear that participants, although desiring external affirmation are quick to dismiss affirmations or distrust the intentions of the individual offering them. It would also seem that for these participants, affirmations can easily turn on them and feel like a comparison that functions more like an insult than a compliment.

Comparison was an event that no participant managed to escape. They compared themselves to family members, friends, strangers, celebrities, ideals and even their past selves. They compared athletic abilities, physical attributes, body shape, clothing style, as well as exercise and eating behaviors. No stone went unturned. In all cases it seems two outcomes were allowed. Either the comparison left the participant feeling like they were better off than the counterpart or like they were worse off than the counterpart. It is not surprising that more often participants believed they were worse off.

Some data of comparisons have already been provided in this section, such as Zoey comparing herself to the women in pornographic materials. Additional examples are provided. Libby was a Musical Theater student prior to the semester in which the interviews were held. She indicated that in the music and theater industry comparison is constant and harsh. She shares how a losing comparison can be made even in the smallest of moments.

...You’re taught to compare yourself to others because that’s the way you judge where you are and how good you are. So when you’re in that mindset of comparing yourself to others constantly then you see a girl eat a salad and you’re like ‘I’m fat’ even though you aren’t and you eat salads all the time. She’s not the only one who eats salad but you see

that and you're like 'I shouldn't have had that pizza' you know, 'I'm fat I better start cutting stuff out of my diet.'

Finally, Heidi provides, possibly, the purest example.

And then, yeah, and I also tell...I usually...I'll think of...I don't know, I'm so bad but...I'll think of people who are like...who can't do what I can do. Or that aren't, ah... like, are in a worse shape than me and then I'm like 'ok well...it's...like it could be worse, I could not even have use of my legs. I can go that extreme. Or just like, I can still run and play and do all these things and just be happy with that.

Heidi seems uncomfortable with the result of these comparisons. She dances around saying it, "it could be worse" because that means someone is worse than she is and she decided they were.

With such data in mind it is worth considering how often society and self are pitted against one another, creating an uncomfortable and distressing dissonance. If affirmations help reduce feelings of body dissatisfaction then perhaps body dissatisfaction is a product of perceiving that one's positive and accepting self-evaluation of one's body is wrong. Heidi narrates a common experience that may be evidence of women seeking others to confirm that their self-evaluation is not wrong, or at least they are not alone in feeling they do not match societal norms about body image. Heidi points out,

I feel like it's almost a social norm to have that bad image of yourself as a woman, because you don't wanna be the one saying 'oh, I'm so perfect.' ...I've felt this way, if someone's been like 'oh does this...' like 'I look SO fat in this!' Or, 'this makes me look ugly.' You're like 'NO!' And then you say something back that is like negative about yourself so they, to try to empathize, so you're not the only one. So I feel like that's kinda

become the social norm for women. Like, we kinda help each other but it's kinda this negative way instead of... uplifting each other... Yeah putting yourself down instead of just like... I feel like I do this with my roommates.

It turns out Heidi's hesitation to feel like she is better off than someone else is rooted in not wanting to feel too positively about herself, for fear of what that may look like to others, or perhaps for fear of knowing what it feels like to be the individual that is worse off. She points out a social norm, or at least tradition, to hold roasting sessions where everyone is responsible for roasting only themselves while simultaneously reassuring others. The goals include being empathic about the dislikes and concerns of others, creating a closeness and bond by helping them understand they are not alone in their dissatisfaction, and to elicit social affirmations contrary to the critical content expressed. While positive affirmations from others appear to have a protective effect, self-deprecating remarks do not. They put individuals at odds with themselves and with their community. What may be most protective for women with increase body dissatisfaction overall is a lack of dissonance between self-concept and community culture.

Spirituality

Spirituality and religion emerged as a noteworthy theme. This theme was mentioned to some degree by every participant except one, Gina. There is robust research on the difference between the constructs of spirituality and religion, which will not be covered here. For the sake of brevity, both constructs will be combined and referred to as Spirituality.

Analysis of the participants' disclosures about spirituality suggests that spirituality functions in general modalities. For the most part, spirituality was reported to be comforting, reassuring, supportive and forgiving. However, significant, although not as frequent, mention was made of spirituality functioning as a source of fear, discipline, and guilt.

Comforting spiritual concepts included divine identity, body gratitude, unconditional love, acceptance of mistakes/imperfections and eternal perspectives on goals and individual value. Most commonly referred to in terms of fear, discipline and guilt was The Word of Wisdom. In fact The Word of Wisdom was only mentioned as a source of guilt or standard to which obedience was required. In the LDS faith, The Word of Wisdom is a doctrine concerning diet. It instructs what best practices should be followed as far as diet content and quantity while strictly prohibiting the use of specific substances such as tobacco, coffee/tea, alcohol and any other illicit drugs. Examples of each will be demonstrated in consideration of the responses of the participants.

Heidi first introduces the idea in her interview when she states, “Um, well, I guess from a religious perspective like I’m very grateful for my body.” She later expands her acknowledgement of spirituality by sharing,

So, um, I don’t know, other protective things probably, um, just religious views. Because growing up in LDS culture we focus a lot on our divine nature and that is, like, something you can hold on to is, you know, I’m more than just this mortal body. And so, but at the same time this body is a gift for us and we need to do the best to take care of it so no matter what we are give we protect it. So that responsibility almost to your body and then at the same time knowing that there is more than just the body.

Heidi tells about a small poem her cousin gave her as child that she keeps pinned on her mirror that says, ... ‘nothing is more attractive than having the Holy Ghost.’ She concludes, “So that, you know, just reminded me that there is more to people than just physical appearance and yeah those thought help when you are feeling negative.” Heidi indicated that when she is feeling

poorly these spiritual concepts do run through her mind and help her address the emotional experience as well as guide any resulting decisions based on those experiences.

She also speaks to the self-criticism from the second modality based more on fear, discipline and guilt. She says,

...I think also, sometimes though its almost like a guilty like 'oh, I shouldn't be... thinking badly because, like, we're not supposed to. [*laughing*]. Almost like it's a sin. [*laughing*]." She indicated coupled with the guilt is a space for self-compassion to not be so self-critical. "And then like religiously there is pressure to like accept yourself always and not judge yourself so you feel guilty if you do..."

The rest of her comments are more mixed. There are the complications of what is more about religious social tradition and how it meets up with spiritual beliefs. However, for Heidi, the positive modality of protection and empowerment more often seems to win out.

Um, I think...good it's been, I think there's been overall more pressure to look, look, like, more look more pressure to look good and skinny and look...and be like super healthy here cause I just, I think there's a lot of social pressures here and for some reason there is extra in the Mormon culture because of The Word of the Wisdom and we think that if you're too big you're not following the Word of Wisdom and I've heard a lot of people say things like that. But, at the same time I think that there is also a lot of support here from girls cause we also have the same religious beliefs and we can be in environments where we're uplifting to one another.

She concludes on the matter, "...there is all of the opposite pressures that we talked about that are driving us towards not being satisfied and so we have to kind of counter act that with... I

mean I think different things work for different people but for me it was helpful to have those religious views...”

Penny also feels spiritual aspects of her life have been protective. She was questioned about how her spiritual beliefs have been a comfort in situations characterized by body dissatisfaction.

Definitely yeah they have. In that I think whatever I've gone through I'm not alone in that. Yeah, the atonement has definitely made me think about that because it's like if I put myself in pain then I'm not the only one I'm putting in pain, so. Thinking about that and thinking I don't want to cause any more pain than I have to, so.

This example is also illustrates the negative/distressing modality of spirituality. On the one hand she reports feeling supported, even accompanied through difficult times, on the other hand, she shies away from doing anything harmful because Christ would suffer as well. The idea of causing anyone pain, let alone Christ, is grounds for feeling fear or guilt. In the end, however, whether she is protected from distressing body dissatisfaction through feeling supported or through feeling fearful, potentially harmful developments of sustained body dissatisfaction or developments of disordered eating behaviors are avoided. Therefore, while the mechanisms vary they both offer a protection. Ultimately Penny was asked if spirituality in this area of her life has made enough of a difference for her, in keeping her safe. Penny stated, “Um, it's kept me alive, so yeah, without it I would not be alive.”

Trina also references God in explaining how she combats negative thoughts about her body. She attempts to consider what God would think.

Um, so I would say there's like the negative thoughts, the bad things about it and sometimes I just have to say like stop, in my mind or, um...I don't know, or get to the

point where I have this two way conversation in my mind thinking, ‘is this really true? Why are you doing this to yourself?’ And a lot of, and part of it is my religion... like being LDS it’s like, ‘well, what does God think about this?’

Later Trina explained how big a role spirituality plays for her.

I feel like it’s the only thing that keeps me, like, really, it just helps me think on a higher level. And I don’t think if I had that I would be able to think at a higher level or get out of the ... Yeah, or like a different perspective about yourself, I guess that’s the thing.

Because if I didn’t have that other perspective I would just have the perspective of what the world would say. I wouldn’t have anything else to go off of. And so, like, the religion helps me have a different perspective. Just knowing that, um, that God loves me, that we can’t be perfect in this life. I think that’s a big one. It’s just, like, perfection isn’t attainable in this life. And also that... just that, I think love is a huge factor, that He loves me no matter what I do, not matter what I look like, so.

Trina served as a missionary for the LDS church during which time she did not feel like she could not control all the food she ate since other church members often fed her, nor did she feel she could exercise how and when she needed to. She struggled with weight gain and emotionally reacted to the conditions. She explains how she ultimately reconciled with the situation. Things for Trina were,

To the point where I, I actually like broke down. And, so, I had to actually, like, go see a psychologist to learn other coping. Like, every night I had to look at the day and, like, give myself a pat on the shoulder and say like, ‘hey you did what you could.’ It was kind of like the ‘well, we’ll try again tomorrow’ comes into play. Or I had to look for reasons to be grateful everyday. Like, there was one time I just decided to be grateful and just

pray to thank God for everything. Then I got really sick, so I just prayed ‘thank you God for my body. Thank you that I have it.’ And I actually, like...instead of seeing my body that was just something weak and imperfect I saw it as a gift. Just like being grateful was another way.

In summation, she concludes, “So based on, off of what I have had, what just helps me deal with things is just...*sigh* is, it would have to be my religion. It really helps me just, um, not go get too consumed or be like whatever.” For Trina, in spirituality, comes the ultimate balance of not too much and not too little. It narrows the gap between how she views herself and how another views her. It is another source of acceptance and another set of standards for her to compare herself to, which may, like previously discussed in the section on *Social* factors, offer her a more forgiving set of community norms that are more closely aligned with her self-concept.

Susan’s understanding of her spiritual beliefs supports such an interpretation. She arrives at one spiritual concept that she perceives can protect her and others during negative self-critique.

...I’m a huge believer in... helping people understand where their worth comes from.

And I know just as a missionary, and in general, I am convinced that I purposely got like the most insecure [*laughing*] companions purposely so that, like I could help them because I think that’s something I’ve always been really good at is understanding I’m a child of God. And understanding that my decisions in general, including about food, don’t determine who I am, or how successful I am, or if God loves me, or if other people love me. And, I don’t know, and I think it’s easy to feel hopeless if you don’t have people telling you that, if you don’t have people that love you, and you’re going to look for any way to make people like you. I just think anyone who has an eating disorder, in my mind,

they just don't understand where their true value comes from and no one's praising them or giving them a reason to feel like they're successful or doing a good job... And so, I think we just put so much pressure on ourselves and all we have to do is just try our best and we mess up every single day like I do with food everyday... whatever. *[laughing]*.

It would seem that spirituality has the potential to offer support and comfort to women who are distressed about their body image. It could even be said that it affords them mercy, mercy from God or even permission for self granted mercy. It also has the potential to incite guilt and fear for non-compliance, like justice. Interestingly, concepts viewed as more global and eternal or fixed such as a divine identity and the body being a gift were mentioned more often and were significantly more protective than concepts that were punitive, specific or event bound such as a reckoning day or the do's and don'ts of health. It would be worth considering how an internalization of justice and mercy concepts affect self-critique and coping in times of distress, especially in relation to religious individuals experiences with body image dissatisfaction.

Priorities

One theme that seemed to be a source of consistent relief for the participants is their focus on priorities. While narrating their stories of body shape dissatisfaction some of the women coped by focusing on or refocusing their priorities. Most explicitly discussed their priorities. Others, while not naming them priorities also outlined what they value most. In some ways, the examples for this theme could be seen more as illustrations of the motives and motivators the participants value. In many of the examples a hierarchy is detectable, a hierarchy that helps them make decisions for how to behave and how to emotionally and cognitively process their experiences. For this reason they are being considered priorities.

Adrianna is most overt about how her priorities play into her body image dissatisfaction, “I just think that I have different priorities maybe. Like, being skinny isn’t a priority...I just, I’m just basing it off of like what I spend more time doing or thinking about...I, I don’t know. I spend more time like trying to be fit rather than just skinny.” When asked if there are other priorities that take precedence she responds, “Um, yeah, like being a good friend. And like, the relationships, like, that are important to me.”

She even takes note of other’s priorities and how it helps them, “Yeah, actually I had one friend who I’ve never heard her talk bad about her body, I mean like she’d say ‘I’m so out of shape’ but that’s all. I think I respect her because I can tell she cares about herself, that her intelligence is more important to her than her looks.” Adrianna is not the only one to note the reinforced false either-or flavor of physical attractiveness and intelligence.

Vivian’s thoughts on the priorities she perceives as standards for women are discouraging. ... I know they do put pressure on men but I think for women the appearance is even more important. Intelligence is more of a supplement.... Um, well I don’t really like it but I just live with it. Um... I, I do kind of wish that women were more than just how they looked. And, um, um, I’m not really sure. Um, I guess frustrated, because I wish I could look like that but I don’t.

Whether or not her perception is correct she feels the burden of those priorities. Interestingly, her priorities do not match those she views society have for women, which could likely be causing some dissonance for her. In fact, her priorities are so different that when presented with a way to get closer to the standards of society she still does not engage. Vivian shares that she was diagnosed with Attention Deficit/Hyperactivity Disorder and for a while was taking medication to manage the symptoms. One of the side effects was weight loss. She

described being pleased with her body during that time but experiencing less comfortable side effects. She ultimately elected to discontinue taking the medication. When asked whether or not she had ever taken diet pills she disclosed the following,

I've thought about it and the ADHD pills do take away your appetite but I stopped taking those because I didn't like how I felt and I didn't take it only for weight loss, I took it for ADHD. They just made me really panicked and nervous and my mind would race too, um... Yeah. I never took any pills for weight loss... Well, maybe it was because of the experience with the ADHD pills that I, I think those pills would have a similar effect and I just don't like that feeling so I don't wanna do it.

Each participant had a unique combination of priorities. What is consistent across most cases is that priorities reorient them in a positive self-loving direction, which is a helpful buffer against negative emotions and pressures regarding body image. Priorities also seem to intervene in behavioral reactions and decision-making. For those who felt at odds with the priorities they perceive to be valued by society, the impact of self-loving priorities was less helpful. The reconciliation of differences may not buffer from negative emotions and may not intervene in behavioral reactions and decisions in the same way. Either way, the participants acknowledged that if they were to have priorities aligned with having the perfect body or caring about being skinny above all else they expect they would not be healthy in their choices.

In conclusion, what seems to emerge from the examples provided is the participants actively seek to maximize the quality of their life and reduce distress. What functions to achieve those goals appears to differ for each of the participants, nevertheless, a focus on self-improvement, social connection, self-worth and value/goal congruency seem to play a major role in consideration of priorities that act in a protective fashion.

Self-Concept

Self-concept was a theme all the participants discussed. They did so indirectly as they considered their priorities, spirituality, social environment and their sense of locus of control. Each experience, feeling and idea they shared contributed to the building of a unique self-concept. In this way each participant came alive in the research making the data rich and robust. Inherent in their disclosures was a narrative telling the story to the question, “who am I?” All of the data from the four previously mentioned themes support this theme as well; however, there are other responses that share a bit more about elements these women considered in their self-concept. For example, Jane shares something she did to her physical appearance to individuate and express herself. She shares,

Another thing, this is kind of like going back to what helps me with my body image actually, um, I dyed my hair recently and it's, it's a stupid thing but it just really helped like when, like, cause, it used to be way more bright (red), it's kind of faded a little bit but I just, like 'I don't like how my body looks but man my hair looks great!' You know, and so that helped, you know, to have that.

She goes on to point out that while she can continue to critique her body she knows for sure her hair is great. It is an attempt to compliment herself or to own her look. Jane spoke to this same idea when she considered how she sometimes compares herself to other she believes to be more beautiful or more closely aligned with what she perceives as acceptable appearance in society. She states,

Well, just, um, you know, just the whole self image thing; I hated myself, hated how I looked... It's gotten a little better now, like, um, I can recognize it's just the way I am, you know. Like, it's in my genes to be a little but heavier but you know...like I have

really really tiny friends some of ‘em; they’re like this big *uses hands to illustrate a small size*. You know, for a while I was like ‘Whoa I wanna look like Anna.’ But, you know, now I’m like ‘I wouldn’t look good like Anna. [*laughing*] I’m just the way I am. It wouldn’t work.

Jane recognizes that she would not look good as Anna because that is not who she is or how she was meant to look. There is something relieving her statement “I’m just the way I am.” Alyssa echoes this idea when she shares how she struggled to find her self-concept again after the physical changes of puberty that left her rejected from her ballet studies and unsure in her own skin. She shares, “ And then, I grew into it and I’m not as awkward as I was. I have a little bit more control of what my movements are like and I’ve noticed that my family, like, I look a lot like my mom.” The sense of being connected in physical appearance and knowing oneself and accepting it as it is seems to be of great importance in protecting women who feel poorly about their bodies. What also seems apparent is that body dissatisfaction is particularly distressing for women when what they know and accept about themselves does not align with what they perceive as valuable or acceptable in society. Trina explains how the panic of not matching up was melted for her.

So it was just like the moment when I started questioning what was beautiful and then just looking around at the people and saying ‘well, why wouldn’t they be beautiful?’ So, it like took from taking it down to the ‘what’s really beautiful?’ to seeing the beauty in other people...so that now, as I’m continuing this process I can finally kind of see the beauty in myself. So it’s like slowly coming inward, I’m slowly figuring it out... Yeah. I just like, [*snaps fingers*] what really is beautiful? What makes it, that you get to decide what beautiful is. And that goes back to like anthropologic...idea of like who, who has

power. A lot of times people who have power decide what is truth, you know. But...but you can question that! And that's what helped me start the process. I think that's actually where it started, when I started, [*snaps fingers*] that would be my success story right there. I pinpointed it.

Trina attributes her success in managing her body image dissatisfaction to the protective power of questioning the standard of beauty that she perceives determines she is not good enough. In questioning that standard she reclaims her locus of control and can integrate her whole self to evaluate if she is good enough for her. This result is by far the most overarching, data integrated finding.

Exposure to Information

The data is rich with examples of when and how the participants were exposed to information about eating disorders, nutrition, exercise, photo shopping, diet pills, societal norms and the effects of body dissatisfaction, to name a few. Participant shared that they were exposed to such information through novels, movies, academic course work, and contact with individuals who had personal experience with eating disorders or elevated body dissatisfaction. It seems *Exposure to Information* is the only theme that consistently results in protection against disordered eating and other maladaptive behaviors.

Libby shared that her experiences as a former student in the Music, Dance and Theater program facilitated her feeling body critical. She elected to change majors which helped, she also expressly pointed out, "Um, yeah, definitely the change in majors, getting out of that environment where I was think more unhealthily about my body. Um, trying to familiarize myself more with, trying to remind myself of the consequences, you know, I did that report. That's why I research Anorexia..." Furthermore, she voiced,

Um, yeah, I've just seen a lot of partial eating disorders in my major and then, yeah I have like a few of my mom's friends had really bad eating disorders in college when they were my age. Um, so, well I haven't talked extensively with them about those disorders I've seen even still they have issues you know twenty years down the line. They're still being, trying to stay healthy. Um, I read a book about eating disorders. I read a book about a girl who had an eating disorder and went to the hospital and blah, blah, blah, blah um, other than that...yeah I think that's probably my, my experience - enough to know that I'm like 'I don't wanna do that. Why in the world would I wanna do that?' And knowing the consequences are really horrible. But somehow knowing that, like, I'll admit that I still harbor like the 'yeah I know some people say they can't stop eventually and they keep losing weight or whatever, but I could, I could stop.' But not really, I like, uh, I don't really ever want to do that. I don't see myself doing that, yeah, in the foreseeable future.

Jane was exposed to experiential information through another format. She recalled a religious leader who informed her of some of the intricacies of disordered eating experiences and how it affected her long-term.

Um, another thing is one of my Young Women's presidents, growing up she worked in a treatment uh place for people who were recovering from eating disorders and stuff. And, so there were several times she would sort of talk to us and then talk about it. You know, she couldn't give us any specific details about who was there and all that but she told us about the girls that were there and about what it was like and stuff. It kind of opened my eyes, it's kind of like, you know, it's not...there's a reason it's a disorder, you know. It's not glam...or it shouldn't be glamorous. Like, I feel like sometimes it is. Like, one thing

that kind of opened my eyes was she told me, um, one, I guess one of the patients was the daughter of like a really up there magazine editor, I suppose. So the people who were putting out the media and she was like, and the mother was still, um, pressuring her already anorexic daughter to be thinner. And so that really affected me, I mean, the people who are telling us this are people like that. You know, and so that kind of helped me to like think about things differently.

This led Jane to seek more information, it empowered her to enhance her understanding, allowing Jane to reality check her environment and personal thoughts.

Um, I think growing up a little but, I think, um... oh I don't know... ...one of the things is that in my Junior year, I think, I did a paper on the media and body image, you know, and how they retouch all their photos and stuff. That definitely helped me to, um, realize, like, what I'm seeing is fake and, um, real people don't look like that, you know? And so that helped. Yeah, it was good for me. It was good.

No matter the source or the topic it appears that women are cataloging information both academically and experientially derived to question and double check their perceptions. The data in this study suggests that whether the information is dry and academic, fear infused, or just generally dissuading, the majority of participants shied away from disordered eating behaviors. They also more frequently questioned their perceptions of self and more specifically body image as well as societal norms and pressures about body image and food.

Avoidance

Delving into the experiences of women who report feeling body shape dissatisfaction naturally led to a conversation about how they manage emotionally. While there were many tactics reported for managing emotions during situations where they were more acutely aware of

their bodies one was frequently described: Avoidance. The avoidance endorsements seemed to run the spectrum from effortless to active avoidance. It was described in two forms, the first, forgetting and the second, distraction.

On the effortless end of the spectrum was forgetting. It has been considered effortless in part because participants seemed unaware of how exactly they “forget.” Heidi considered the experience of worrying about her body image. “I’ve had like days where I’m like, that’s what I think about. But... ah, I don’t, I don’t know how they, I’d...I guess I’m not really sure how I don’t let it consume me, like specifically. Like I know that I tell myself to, like, just forget about it and I do.” Jane’s coping tactic was simply stated, “Oh... mostly I just try to ignore it, focus on other things.” Heidi later shared that she uses the same tactic when comparing herself to other women. She stated,

I think what worries me the most is like, ...what, like, if other people will see me the way I see myself in that moment. And I don’t want them to. So...I try to forget about it because if I’m thinking about it I feel like they are going to be thinking about it. Yeah and so then it makes just the whole thing...if I dwell on it. But if I distract myself with, you know, conversation, other things, then I’m...it goes away.

Betty used this method even in the small moments such as looking in the mirror. She shared,

Um, I don’t know. When I look in the mirror I try not to focus on like the parts I don’t like...I kinda glance over that and I’m like ‘oh! That’s still there.’ [*laughing*] Then I just like stay busy. ‘Oh time to get ready’ kind of a thing and focus on that, and kind of do homework or ‘time to go to class.’ Like that.

These avoidance strategies were confirmed by Betty again when she was asked how she handles social pressures on her body image, “Just like not focusing on it. Distractions I guess [*laughing*]...just like reading a book, or like texting people.” She also expressed the importance of avoidance in her emotional experiences.

I feel like it’s more like avoidance on my part at least. I feel like, um, like if I were, like, can’t really dwell on it kind of thing. I’d rather like not dwell on it, just go on with my day. [*crying*]. Just like, it’s so negative that I probably would just be sad all day [*crying*]. And I don’t wanna do that...Just like I wouldn’t really know how else to handle it kind of thing. If I wasn’t like avoiding it I’d probably not be very good at functioning with it. Because like when I do talk about it I start crying [*crying... laughing*].

Distractions seemed to be a place to re-channel their energies. Some spoke of actively seeking out distractions while others just tried to attach to whatever was near and available.

Susan outlines her options for managing her emotions when she feels dissatisfied with her body,

And like it's definitely, like, it's obviously something that I, like, think about a lot. You're making me realize I probably think about it more than I thought I did and I used to be way more sad about it than I am now and I think specially when I was depressed and just after my mission I was feeling worse about it and now it's almost, I don't know, I just feel like I'm not someone that gives up very easily or is just like whatever or gives up the point. I either overcome it or, like, I'll just push this to the side and worry about something else and so there's definitely times where I'm really sad and I feel a lot of pressure.

Susan poses an alternative. She views overcoming the dissatisfaction, guilt and distress as something different than mere avoidance. If reframed, avoidance can be viewed as less an action of running away and more an effort to redirect one's energies and focus to ideas and tasks more congruent with one's priorities and self-concept. There is the potential that on occasion the distractions and the avoidance act as conduits to becoming in a sense disembodied, even for just a moment to find relief, such as watching T.V. or doing homework, both of which do not require mind body engagement. However, it is also likely the distractions offer more productive and affirming paths to self-acceptance and congruency with self-concept.

Food Relationship

Interviews for this research contained quite a bit of discussion about food. A number of participants stated they loved food. Interestingly, those who expressed loving food on the whole, even though distressed, either did not voice a belief that they were poorly handling their experience of food and body image or stated that they were doing well enough. Some of the participants seemed more emotionally sensitive to the topics of eating and body shape, and were not as convinced they were managing their experiences with body shape dissatisfaction very well. These participants, at some point indicated that they were not sure they were handling their situation well despite having been selected for the study. Generally these participants did not express a love of food. One even expressed disgust.

Starting with women who felt they were managing enough there were ample examples of affinity for food. Mary suspected that her love of food kept her from following through with urges to eat in disordered ways. Being the sibling of an individual who struggled with an eating disorder for a number of years, Mary has an interesting experience against which to double-checking her experience.

...There were times when, when I was in high school and I'd, like, get mad at my parents and I'd think like, 'Oh, I'm going to go anorexia and stop eating.' And it didn't stick to it cause I like to eat too much [*laughing*]... I would just think about stopping eating, it would last about an hour... My brother still doesn't eat very much so I don't understand how he could do it...I'm like this food is delicious!... I think I would have tried a little harder but I think, I honestly think that my love of food would have won out [*laughing*]... I just, it's just so much fun to eat, well, and the taste and the different textures." Later she said, "I love food. [*laughing*] Yeah, I love food. I love trying new foods. It's just some of the happiest moments right?! [*laughing*]."

The final example comes from Susan. Susan was very open about her relationship with food. She shared,

Well, like, actually, like, when I saw my best friend like right after the class that I had after this... I was telling him about it and, and how cool it is and whatever, and, um. But anyways, I was like 'I have to talk about my relationship with food so what should I talk about?' Cause he knows me, like, super well and he's like 'oh, I know what you need to talk about.' He's like, 'all you ever do is look at food on the Internet all day.' And I'm like that's true because, like, ...if I'm at home, well, I guess, I kind of do, but if I'm in class or whatever and then don't want to pay attention I'll totally just, like, look up menus of different restaurants that I may or may not ever actually go to. But like, I don't know, I just do that a lot...because I like to see what they have and then I'll be like, 'oh look at this' and then send it to him because it sounds really good. Well, okay, and like, here's something else too that's kind of weird about me...Ever since I was a little kid I've been obsessed with macaroni and cheese like favorite food! Love it. And like, I've, like,

literally traveled through the nation to some of the top mac and cheese places and now I'm mad because I want to do a blog about it but, like, I already went everywhere. Anyways, so I don't know. So, I look at that a lot because it's like a hobby almost [*laughing*]. You know what I mean? So it's less of like I just want to eat all the time and more of like I'm just, like, I'm just, like, genuinely interested in it. Does that make sense? ...I don't know if I'm a critic at all but I guess... I don't know that I know anything really about food at all, I just like to eat food.

She also shared, "It's hard for me to be mad at food. I really love food [*laughing*] like I can feel guilty...and I guess in the moment be, like, 'okay like I'm never going to do this again' or whatever but I know that I'm going to."

Not everyone shared this love of food. In fact, two participants very directly expressed their dislike. However, while they both pointed to a sense of dependency on food they focused on two different aspects. The first was expressed by Alyssa, a participant who seemed to match the description of the group that generally endorsed liking food. She shared an element of her relationship with food. She explained,

... Sometimes I realize that I'm not hungry when it's time to eat and I came to this...I got really mad about food a little while ago, I guess I should say. I was thinking one day and I was just like, 'you know what, what is life all about?' And then as I was thinking about this, I was like, 'you know, we work really hard to make money and what do we do with that money? We buy food with that money. That's like the first necessity of life is food.' I was like, 'we take that money and we buy the food, we get the food, and it takes an hour to make a nice meal. Two hours, maybe, if you're going to make a big meal for a family. And then you eat it for like fifteen, twenty minutes and then you have to have an hour of

clean up. This is not worth it! Food is a trashy piece of crap! Like, I can't believe we orbit around this idea of eating so much. Like, we eat three times a day and then we have a snack but all that preparation for all that food!' Like, it made me sick. I was like 'our lives are just about food and it's awful!' Like, 'it's gotta be more.' So I'm like, 'I'm going to school to get a job to pay for food!' [*laughing*]...I was like 'I don't want it to be like this. I don't want it to control my life.' But it does in some...it still controls, like, that's how we function. And I was mad about it for a little bit. I was like shaking my finger at the man upstairs like, 'you silly person.' I'm like, 'I can't believe you had this trick in you!' Like, 'I've discovered your secrets.'

Penny echoes part of Alyssa's conclusion about dependency but the content of her complaints, although similar in theme, are distinct. During the course of Penny's interview she disclosed that she had at times engaged in attempts to stop eating as a way to make her emotional pain more visible, something she had done before but through methods of cutting. Her attempts to restrict her eating occurred the two semesters prior the semester in which the interview was held. In the interview she expressed not liking food. She was then asked for further clarification. She explained,

I just don't like the idea of it. I don't know. Just like food and eating, the entire process. I just don't like it. Uh...like, the 'I have to eat you to live and I eat you and then you get digested and go out throughout my body.' And for some reason that's just, does, I don't like it. It's just weird, even though I know it's natural and stuff and that we have to do it. I just wish that I didn't have to, cause it, it, while some things do taste good it's just like...it doesn't do anything other than momentary taste. Like, I just wish I could taste food more than actually eat it. I don't know, it's just really weird how it just doesn't work

for me. *[laughing]*... Yeah. Uh, I don't like it, just the whole process of eating. Like, if I could go without eating, who wouldn't? Which I think is really weird, most people really like food but I don't for some reason... Yeah I think it's mostly the dependence thing because I don't know, I don't like having to rely on something like that to survive, I guess. And food is something you need and you have to have it or you're gonna die. But, I think liquids are not as weird as food. So...I like how it tastes. I wish I could just taste food but not ingest it. *[laughing]* Just cause, um, I like the flavor and feel like that's the best part of eating is the taste but I don't know.

Penny paints a picture of food as a tasty foreign object upon which she is dependent.

While the relationship women have with food is complicated it seems that it can play a large role in how they ultimately regulate its presence in their life. It at least appears to affect the flavor of their attitude towards food, which may make all the difference in how women engage with food.

Chapter 5: Discussion

The purpose of this research was to approach an old question from a new perspective by attempting to ascertain the motivations and experiences of individuals who do not engage in eating disordered behaviors and attitudes despite experiencing body shape dissatisfaction. The goal was to explore the experiences of these individuals to gain insight into any factors that protect/prevent them from developing disordered eating attitudes and behaviors. There is very little research regarding protective factors among women who fit the sample description for this study. Some research has been conducted on protective factors. Protective factors discussed in the literature to this point include demographics such as age and ethnicity. Arguments have arisen to suggest that age as protective factor is more indicative of developmental progression and skills and ethnicity as a protective factor is better explained in terms of the absence of culturally associated risk factors such as Westernized body ideals and their internalization. Other protective factors that have been discussed include positive affect and coping skills, resiliency, family support, socially prescribed perfectionism as opposed to self prescribed perfectionism, a secure attachment style to God and a lower BMI or body image flexibility. Results from this study align with some of the finding in the literature to this point which will be discussed in this section. Some of the results of this support previous research regarding risk factors for ED. The similarities and differences will be discussed in this section. Results regarding *Priorities* have not be addressed in research thus far.

Control

The framework created for understanding aspects of control is important finding. The data illustrates that while women were screening similarly in regards to body shape dissatisfaction and eating attitudes they were displaying differences in their behaviors and

narratives. At times, participants described feeling restricted and stuck in their situation, by societal pressures, their feelings, etc. At other times, the participants described feeling liberated and empowered, which allowed them to manage or change their situation, respond to societal pressures and cope with their feelings. For example, participants described feeling empowered to set societal expectations aside and eat and exercise however they wanted, or to instead eat and exercise for the goal of feeling healthy as opposed to meeting some visual requirement. They voiced having choices. At other times they expressed feeling stuck which led them to give in to their distress about their body and the expectations around them or to feel restricted to being distressed until they ate and exercised their way out of the conditions they considered unacceptable. They voiced feeling without choice. Some exerted effort, others did not but the motivation of feeling liberated as opposed to fearful made a difference in how the participants managed their experiences.

Previous studies have been conducted on perfectionism and how self-oriented perfectionism is correlated with disordered eating more so than societally prescribed perfectionism (McVey et al., 2002). While the results of this study do not address perfectionism, control is an element of perfectionism. Parallels may exist between research previously conducted on perfectionism types and *Control* as discussed in these results. While all of the participants expressed being aware of the strong societal pressures they did not all appear to be as equally impacted, which may contribute to the flavor of any perfectionism they may be experiencing.

It is important to consider the framework of *Control*. The current figure shows one directional arrows; however, causal relationships cannot be determined. It is possible that the behaviors of the participants informed their choices or made them aware of their power to

choose. Other elements also could contribute to how participants manage or react to body dissatisfaction. Luo et al. (2013) reported, “Research that has sought to explain these complexities indicates that negative affect, caused by failure to achieve one's maladaptive perfectionistic standards, may increase one's body dissatisfaction, which by interacting with low self-esteem, leads to counterproductive behavior” (p. 294). Negative affect styles may have preceded the counterproductive behaviors manifest in the framework wherein lack of choice was perceived. The findings of this study are that negative affect was observable within the data supporting *I'm at the mercy of my environment*, *I give up/in* and *I have to cause change in my life*.

Whether negative affect is a precedent or antecedent was not determined. Hill et al. (2013) conducted a study in which they found that body image flexibility, defined as the general ability to experience body dissatisfaction in such a way that yields value-congruent behavior, has a significant negative association with disordered eating; however, this was true for only women with low BMI. In Hill et al.'s (2013) results, those with average and high BMIs, body image flexibility was not associated at all with disordered eating. In the current study none of the participants were considered to be eating disordered as determined by the EAT-26; however, it is interesting to consider how body image flexibility may interface with how women manage their body dissatisfaction in such a way that yields empowerment-congruent behavior. This study did not take into account participant BMI. Future studies may benefit from doing so.

Overall, the emotional experience of women with body dissatisfaction may be improved by increasing a sense of empowerment in general but specifically in accepting/rejecting/setting body standards and health priorities.

Social

Social elements were interwoven throughout all of the data. Results indicate that internalization of media messages about the female body is occurring and even women who resent those messages at time reinforce them. Keel and Forney (2013) conducted research about thin ideal internalization and how it mostly manifests as concerns about weight gain.

Interestingly, the societal pressures discussed by participants in this study were more varied than simply being focused on thinness. They pointed to pressures to be thin as well as clothing style rules, physical performance or athleticism, and even hair and make-up. Weight gain concerns were expressed but more concerns were expressed about already being in a weight condition that they perceived as disqualifying them from the dating pool. When it came to understanding their loneliness, being unmarried, not dating, they considered their physical appearance as an option, either because others were judging and therefore were not including or because it led to low confidence and self-esteem and therefore they did not include themselves.

For the population under consideration a demographic element that has not been considered in the ED research literature, especially in prevention and protection research is relationship status. In this study there was one married participant and one engaged participant. While neither of the two claimed to have no issues with body dissatisfaction they did voice the buffering and moderating impact of having a significant romantic partner offer them acceptance, especially physical acceptance. It could be argued that for participants that are religious and adhere to conservative, traditional values wherein marriage and family are highly valued and promoted, that being partnered could present a protective force from fear and doubt spurred by

body dissatisfaction. It is possible that acceptance from such a source would buffer the pressures expressed by society and other critical sources.

Another finding of this study that supports these potential protective factors is the soothing effect of positive social affirmation. Participants described the ways in which society does not affirm them such as not stocking clothing in their size in stores, not being considered for dates, etc. They also described the impact positive affirmations have. They described feeling grateful and boosted affectively in ways that helped them feel capable of not remaining focused on their dissatisfaction. It was even suggested that if the media would fight against the pressures it portrays that would feel affirming. Being affirmed could be a great protective factor, and affirmation from a societal source may be essential. Cordero and Israel (2009) discovered that awareness of cultural expectations regarding body shape and weight and an internalization of these ideals overpowered the possible protective effect of reduced body shape and weight messaging from parents. The participant accounts of the protective power of social affirmation and desire to have those messages change may be essential to maximizing the effects of other potential protective factors.

Comparison was also a predominant experience described by the participants. This is supportive of research done on upward and downward comparison among college students. Halliwell (2012) reported that after viewing same sex models both men and women report increased body dissatisfaction. Reductions in comparison were found by Berg et al. (2009) to reduce disordered eating attitudes in behaviors with women who were reporting high levels of such attitudes and behaviors prior. While the populations differ it does become essential to question the progressive effect comparison might have on developing disordered eating attitudes

and behaviors. One buffer that was observed in the narratives of the participants when they had engaged in a comparison in which they were worse off, were intervening priorities.

Last, one of the results that emerged from this theme was the normalization and almost expectation for women to speak negatively and critically about their bodies with others. Such social traditions, even if the goal is to be empathic and strengthen bonds, promote public self-shaming and demote the value of self-compassion. Ferreira et al. (2013) found lower self-compassion levels were associated with higher shame and psychopathological symptoms such as anxiety, depression, and strive for thinness. While more research is required to substantiate these ideas it is difficult to imagine how self-compassion could an unhealthy behavior.

Spirituality

Spirituality and religion are embedded in the culture and environment of the population from which participants for this study were sampled. Fischer et al. (2013) suggested religious hypotheses in response to the results of their study. The study was conducted to assess risk rate and prevalence rate at BYU wherein the EAT-26 scores were lower than expected based on BSQ-34 scores. In an attempt to discuss the unexpected results, the religious social structures, that offers almost immediate social support for incoming freshman, and the teachings of the religious doctrines espoused by the LDS affiliated university, were offered as potential explanations for the discrepancy. Fischer et al. (2013) first hypothesized a supportive social structures specific to the LDS religion being utilized at the university; however, the results of this study did not support this idea. Social structures discussed were not specifically religious. The second asserts that religious doctrines affiliated with BYU act in a protective manner. Results of this study suggest that some of the spiritual doctrines within the LDS faith, and therefore associated with BYU, espoused by the participants in this study were used by the participants in

protective ways. On the other hand, although less frequently, some doctrines were used in more fear based and unhelpful ways.

Prior research in this field has focused on attachment to God as a moderating factor. Homan and Boyatzis (2010) found having a secure relationship with God moderates the internalization of the thin ideal. The authors asserted overall their results indicate “women who feel loved and accepted by God are protected over time from the harmful effects of sociocultural pressures on body image and eating” (Homan & Boyatzis, 2010, p. 252). While the participants of this study did not converse in terms of a relationship with God they often referred to doctrine that did. They often spoke about their own identity with divinity, being a daughter of God, and being loved by God. They also brought up doctrines about physical bodies being sacred gifts, being like temples of the spirit and having potential for perfection at the time of resurrection. Other doctrines that were discussed included having an eternal timeline to consider, having access to the atonement of Christ for mending mistakes and considering which priorities are of spiritual value. These ideas seemed to offer support and comfort to the participants. Less supportive and comforting ideas included specifically The Word of Wisdom. In the LDS faith, The Word of Wisdom is a doctrine concerning diet. It instructs what best practices should be followed as far as diet content and quantity while strictly prohibiting the use of specific substances such as tobacco, coffee/tea, alcohol and any other illicit drug. This doctrine was a source for producing guilt, as did doctrines that were associated with accountability for caring for one’s body. It introduced the idea of sin and reckoning.

For some, like Susan, it was noted that body size may be a sign of disobedience to the standard. While such examples were less frequently mentioned than protective and comforting examples of *Spirituality* it is worth noting that the participants did not perceive spirituality as a

completely or always protective or a positive force in navigating body dissatisfaction. Of equal importance is the acknowledgement that the interpretation of the doctrines as opposed to the doctrines themselves were what determined whether *Spirituality* functioned in a protective/positive manner or a distressing/negative manner.

Priorities

While a number of priorities were reported, in summation, they all oriented around quality of life. These women above all else seemed to want relief from distress and focus on maximizing the quality of their daily and long-term life experiences. It is unfathomable that such priorities could arise in a vacuum and perhaps for that reason priorities should have been analyzed in the context of spirituality, social values, etc. Priorities were noted as successful interventions in the emotional and cognitive aftermath of a comparison made in which the participant felt worse of then their counterpart. In a way it appeared priorities could void negative outcomes obtained from comparison. While research on comparison has mostly focused on upward and downward comparison, intervening factors such as values and priorities may be considered for future research. Finding from this study indicated that priorities that focus on self-improvement, social connection, self-worth, and value/goal congruency seem to have intervening power.

Self-Concept

Self-concept as a theme accounts for the integrated views the participants had of themselves. For those who were distressed or more often spoke of feeling disempowered, socially unaccepted, guilty or defeated it appears that what contributed most to that presentation was a mismatch of who they view themselves to be, or their value to be, and the negative perception of society's opinion of them to be. Society in this case refers to the media community, the family, the church community, the university community, and the apartment community. The impact of not matching up is felt. The more the idea of not measuring up, not fitting or being wrong about one's self-concept, the greater the negative impact. Those who spoke more often of belonging, feeling connected or accompanied seemed to more positively and effectively managing their body image dissatisfaction. They seem to more often redirect their energies when feeling distressed into positive activities or thoughts. Those with the ability to self-accept despite what they believed the societal standards to be fared better. Again this did not happen all of the time for any of the participants but it did occur at times, in moments and for a few more generally.

Some research results are supportive of this interpretation. Cordero and Israel (2009) reported that negative messages about body shape and weight originating from parents were very effective in the development of problematic eating. They did not, however, consider if positive messaging about body shape and weight were protective. Although Herbozo et al. (2013) did find that positive and negative commentary about body image had similar detrimental effects for women. The results of the current study would suggest that what might be most protective goes a step beyond just changing the messages to a positive bend but rather eliminating them all together so that each individual can focus on self-concept definition and acceptance that does not

require comparison from which destructive dissonance and social disconnect arise. Furthermore, pulling from results previously reported in the discussion on contributing social elements, Corder and Israel (2009) found that an awareness of cultural expectations regarding body shape and weight and the internalization these ideals overpowers the possible protective effect of reduced body shape and weight messaging from parents. This suggests that the standards of a subsuming community and the internalization of those ideals can override the positive protective effects of parental acceptance or the absence of messaging in other community groups. Nevertheless, participants who learned to question the standard, or find a place of belonging both in and of themselves and in their communities, were protected from the risk of engaging in disordered eating behaviors.

Exposure to Information

The data overwhelmingly supports the conclusion the exposure to information about nutrition, physiology, exercise and eating disorders is helpful in combating urges to engage in disordered eating behaviors. Exposure to individuals or stories of individuals engaged in disordered eating behaviors also was effective in dissuading the participants from considering disordered eating behaviors. These two types of exposure seemed to offer cognitive tools to counteract the urges during decision reasoning. In some instances, participants considered the emotional consequences of engaging in such behavior, which was a deterrent.

Only one participant disclosed feeling an urge to attempt disordered eating behaviors after an exposure. More research could be conducted to determine what differences were inherent in her experience as opposed to the others. No matter the results, emphasizing outreach efforts and prevention education are likely a good investment in combating the development or risk of disordered eating attitudes and behaviors. Prevention education might also consider the

breadth of information covered providing a more comprehensive set of information for individuals to consume.

One finding within the theme of Control was the glorification of willpower in women with ED as perceived by non-ED women. Exposure, specifically experiential based exposures could potentially combat the glorification. Participants described how awful and ineffective they imagined that experience to be based on their education of the issues and their exposure to the lived experiences of those who were in such situations.

Avoidance

This theme catalogued the avoidance techniques of the participants used to cope with body dissatisfaction and other related negative affect. Many of the participants indicated that forgetting or distracting oneself was a useful short-term technique to redirect their attentions, even repetitiously used it was effective. This finding seems to be at odds with some of the research reviewed. Snapp et al. (2012) indicated that positive coping skills surpass positive body image as an overall contributor to wellness. Snapp et al. (2012) defined coping skills as an active confrontation of one's problems. However, in the present study a coping skill often described was an active avoidance of one's problems or thoughts. What is unknown is if participants favored avoidance for its effectiveness or if they were unaware of other coping strategies. There is narrative data to support both; however, it was not extensively discussed enough to reach a conclusion. Avoidance as a short-term coping strategy has support based on the data from this study; however, further investigation is warranted.

Food Relationship

Results regarding the participants' relationship with food bring up more questions than answers. This theme was covered in an effort to point out a potentially unexpected phenomenon

that warrants further investigation. It could be argued that an individual with body shape dissatisfaction, especially weight related dissatisfaction might also have a strained or complicated relationship with food. Much of the ED and body dissatisfaction research draws some kind of a negative relationship between these two factors. For this reason data showing a positive relationship between women with elevated body dissatisfaction and food is important to consider. It cannot be said whether a positive relationship with food is what protects against engaging in disordered eating behaviors, what is sure is that not engaging in disordered eating behaviors does not guarantee a positive relationship with food.

Limitations

The present study does have limitations that should be taken into consideration when interpreting or utilizing the results. First, this study was conducted using students from one specific religiously-affiliated university. While this sampling was purposeful it is still worth mentioning that the results may or may not be applicable to populations outside the religious community from which participants were sampled. It is also possible a sample with more geographic, religious, and relationship status diversity could have yielded additional or corresponding themes.

Second, participants from this study were purposefully sampled using two measures, EAT and BSQ-26. The EAT is based on DSM-IV criteria which is no longer the most current diagnostic criteria. New criteria have been expanded to more accurately detect disordered eating that is more characterized by over consumption without compensation. Some of the participants in this study indicated that they believed they overeat to the degree they did not believe they were free of disordered eating attitudes of behaviors. The EAT, however, weights attitudes and behaviors associated with restriction and compensation with mild questioning about bingeing

incidents. The current study intended to interview women who, based on their EAT and BSQ scores, screened into the specific category. A logical leap was made at that point that women in the identified category were void of disordered eating attitudes and behaviors. However, if the EAT is screening more for restrictive, compensatory or binge eating attitudes and behaviors it is not, perhaps, as comprehensive as necessary to then conclude the resulting sample is void of disordered eating attitudes and behaviors. If future research intends to further investigate the increased rate of women in the identified category specifically at BYU, then alternative measures may not be needed. If future research intends to further explore what protects women who are dissatisfied with their bodies from developing disordered eating attitudes and behaviors alternative, it is advised that more comprehensive screening measures be used.

Third, this study as well as the preceding study did not include measures to assess social desirability effects. It is possible that within a traditional conservative religious environment that disclosing feelings about oneself is less socially risky than disclosing one's behaviors. While none of the participants in this study misrepresented their situation when responding to the screening measures there were at least two who endorsed past, not present, engagement in disordered eating behavior such as prolonged food restriction, bingeing and vomiting. They responded to the screeners based on the current behaviors. Other screening questions inquired if they had ever been diagnosed or treated for an eating disorder, which neither of them had. Never having been diagnosed or treated does not mean that they did not at some point meet criteria for an eating disorder. Data from these two participants were included in the results. It should be considered that they may not fit the intended sample of women who have never exhibited disordered eating to a level that can be diagnosed.

Fourth, IPA was utilized for this study. IPA is useful for collecting and analyzing data from a small sample size in a more detailed focused and nuanced approach. It is possible that an introductory study such as this may have been better suited for Grounded Theory method, which often yields a theoretical model. Frameworks proposed in this study were observable in the data and were created for a more concise and organized ways to understand the data; however, not every element of the framework was as equally developed. It is apparent that the nuances and details were preferred in both the results and discussion.

Finally, consideration of the participants' body type or BMI was not considered or even noted in the analysis. While this was done to avoid using subjective or socially constructed body typing, it also may reduce insight into aspect of the participants' experiences. A woman who is overweight could potentially have different experience, point of reference or interpretation of herself than a woman that is of average weight. There is potential that the strength of coping strategies might need to be greater for a woman who is overweight. These are all unsupported ideas; however, given that the current study did not address body type or weight factors.

Implications for Future Research

The current study was an introductory exploration into the experiences of women with elevated body dissatisfaction. What was of specific interest were their experiences regarding perceptions of body shape and eating. Ultimately, this research arose in response to prior research that identified this group in higher quantities at BYU when compared to other universities. The motivation to proceed with the present research project was to identify possible protective elements that have kept women who are dissatisfied with their bodies from then progressing on to develop disordered eating attitudes and habits. As a result this research is a starting point for further qualitative and quantitative research into each of the themes identified

to further define and develop what, if any, protective roles they play. Therefore, any of the themes discussed would warrant further investigations. Furthermore, research on how these themes interact would be useful as well. The participants have complex experiences and beyond identifying the players on the board determining how they interact is the next step in transitioning the results from the literature and clinical material.

There are more specific findings that warrant follow-up study. First, results of this study indicate the power of feeling empowered. Additional research is needed to clarify how to foster a sense of empowerment that effectively allows women to manage or combat body dissatisfaction.

Second, a demographic that has not been considered in ED research focused on prevention is marital or relationship status. For some participants being married or engaged had a buffering and supportive effect. The absence of a dating relationship for other participants was described as distressing and was at times interpreted as a consequence of the characteristics of their body they considered unacceptable. Considering how dating or romantic relationships, especially within in the socially contextualized aspects of religion and age, act as a protective factor would be useful. Other sociological research for consideration includes illuminating the role of positive social affirmation, how effective media based affirmations are at combating societal pressures, and the culture and affects of self-critique in a group setting.

Third, the importance of priorities was witnessed in the data; however, more exploration of this theme is necessary to understand how a priority is formed, how and when it can moderate negative comparisons and if they in anyway contribute to avoidance strategies.

Fourth, the current study was conducted in a religious environment and one of the themes that emerged was Spirituality. Future research could investigate what elements of religious

doctrines and practices or what other variables produce interpretations or applications of religious doctrines that are protective and comforting. Also along the religious vein and in line with the limitations that were discussed, it would be interesting to take a closer look at the results of the specified population with the added layer of social desirability effects. While such an endeavor may not be complicated it could offer an added layer to the current research question.

Fifth, there were discrepancies between the results of this study in regards to avoidance as a coping mechanism and previously completed studies. Further investigation could consider how avoidance functions as a short-term coping strategy as opposed to a long-term solution. It would also be interesting to delve into the question of whether avoidance is employed because it is effective or because it is one of a limited set of known coping strategies.

Sixth, there is vast space for women's relationships with food to be explored in conjunction with experiencing body dissatisfaction. How a positive relationship with food is born is a fascinating question to consider, especially if it has a protective element to it. Many of the women claimed to "like" or "love" food but further research is required to determine if this means there is a positive relationship.

Seventh, a number of the themes that emerged in this study are themes that also appear in research with participants who have been diagnosed with an eating disorder. Research to compare how similar themes differ in presentation between the two samples could offer a dialect perspective. Convergent and divergent results could illuminate the progression women experience from health to disorder, as well as spot true risk factors and effective prevention elements. This study also included two participants who endorsed recovering from engaging in disordered eating habits at some point prior to the interviews although they were never diagnosed or treated. This may be a group worth considering for future research.

Last, creating and validating new measures for identifying disordered eating attitudes and behaviors that at least more equally include non-binging overconsumption without compensatory habits would be of great value. Not only would such a measure reduce the sampling confounds in a study like this but it would also open an opportunity to develop new research geared at understanding the experiences of those women. The goal being to prevent, assess and intervene.

Implications for Practitioners

The results of this research offer a number of potential considerations for outreach and prevention planning. Most results are still in the theoretical stage and therefore should be cautiously considered before being incorporated into practice.

Study participants explained the impact information on nutrition, physiology, exercise, eating disorders and media enhancement techniques had on moderating their decisions regarding food and exercise as well as moderating their emotional responses to media and self-critiques. Disseminating information on these topics would be beneficial. The information shared by the participants also suggest making the information available as soon as possible and from sources that seems to adhere to the information being distributed will maximize it's affect. Another element to be considered in outreach and prevention efforts is including an experiential component. Knowing the facts and the data are helpful, also, many of the participants were affected by the stories of individuals who had experienced eating disorders or from knowing or seeing someone in those circumstances. Including more humanistic data (narratives, etc.) as well as didactic information would optimize prevention efforts.

Results indicated that avoidance was an effective short-term solution to coping with body dissatisfaction and weight concerns. It also emerged from the data that priorities seemed to moderate the effects of negative comparisons. Psychoeducational therapeutic approaches could

consider working with clients in a way that focus on merging client's priorities into effective avoidance skills. While the majority of psychotherapies generally dislike the concept of avoidance they do acknowledge that there are times and places where such techniques are protective and allow for introspective boundaries.

Exploration of the emergent themes in this study with a dialectical approach will benefit individuals engaged in psychotherapy. It is likely these topics are already being discussed in therapy. However, one aspect that may warrant extra attention is fostering a sense of empowerment regarding choice, body image, eating, and social engagement. One particular way of approaching this idea is to explore both societally derived and enforced standards for body image as well as individually derived and enforced standards. Clients may need assistance identifying how to enforce socially derived standards they do not agree with. They may also need assistance learning self-compassion in general but more specifically in terms of their body.

For those in a religious setting or who incorporate religion and spirituality into their therapeutic work, specific consideration of how client's religious doctrines are individually being used to promote/demote a sense of empowerment and/or a sense of unconditional worth could be of great therapeutic value without entering into an ecclesiastical role. However, allowing a client explore the comforts as well as the stressors of their religious beliefs and traditions that contribute to body dis/satisfaction could help clients process and confront specifics that are counterproductive.

Conclusion

This research sought to understand the experiences of women who are dissatisfied with their body shape. These same women were required to not have disordered eating attitudes and behaviors. Naturally, their body shape dissatisfaction puts them at risk of developing eating

disordered attitudes and behaviors. In exploring their experiences with body shape and eating it a number of themes were identified that illuminate factors that are both protective and risk producing for these women.

First, a sense of choice or empowerment to change one's situation in regards to body image or definitions of beauty provided women with a space to make choices based on their feelings about their body. Some elected to intentionally create change while other elected to be more spontaneous about their choices. For some it resulted in feelings of liberation while others it created a sense of defeat and fed the fear that motivated them in the first place.

Second, two specific aspects of social factors emerged. Social comparison contributed to women feeling poorly about their bodies on a consistent basis. There were relatively few deviations from this outcome. One effective and supportive social element that was emphasized was social affirmations from friends, family, and even from media, which for many of the participants seemed to be more a source for unrealistic comparison than support.

Third, religious doctrine that promoted a sense of empowerment, divinity, and unconditional worth seemed to intervene in the participants' negative experiences of their bodies. Specific doctrines or interpretations of doctrine appeared to create feelings of reckoning and fear surrounding their bodies as well as food and exercise related behaviors.

Fourth, individual priorities seemed to provide a framework that allowed participants to bypass or reorganize the negative impact of body shape dissatisfaction or other negative experiences and feelings regarding their body. Priorities seem to act as a successful moderator on comparisons in which the participant perceived being worse off than the counterpart. Priorities may be synonymous with values for these women; however, further research would need to determine the nature of the connection between priorities and values.

Fifth, the participants noted the dissuading effect exposure to information on nutrition, physiology, exercise, eating disorders and media enhancement technologies have on their interest in disordered eating attitudes and behaviors.

Sixth, avoidance was often referenced as an effective short-term coping strategy. In some ways the most effective was avoidance by distraction. Distraction was most useful when priorities and social supports were implemented during the distraction.

Seventh, many of the women reported loving food. It is not conclusive if having a strong positive relationship with food is protective but it was important to the narrative of many of the participants. The idea of restricting, avoiding, or hating food was outside the purview of their capabilities based on the relationship with food they had established. Whether the relationship is protective or if the presence of other protective factors allows them to have such a relationship with food is unclear.

Last, belonging, feeling connected or accompanied seemed to empower these women to more positively and effectively manage their body image dissatisfaction. Those with the ability to self-accept despite what they believed the societal standards to be fared better overall. What ultimately seems most protective against allowing body dissatisfaction to lead to disordered eating attitudes and behaviors is having a sense of self that is accepted by both oneself and by others. Overall, this initial exploration into protective factors for women at risk has yielded a number of research worthy leads that hopefully will provide findings that can eventually be used in the preventions efforts against eating disorders.

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APPENDIX A: Instruments

Demographics

Gender: M / F

Age: _____

3. Ethnicity: _____

4. Religion: _____

5. # of semesters completed in college: _____

6. Have you ever worried that you have an Eating Disorder? YES / NO

7. Have you ever been diagnosed with an Eating Disorder? YES / NO

8. Have you ever been treated for an Eating Disorder? YES / NO

9. Are you currently diagnosed with or in treatment for an Eating Disorder? YES / NO

10. Would you be willing to participate in a follow-up interview? (Participants will be compensated with a \$20 BYU Bookstore gift certificate. Participation is estimated to last 3 hours) YES / NO

11. If you said YES to #10 please provide contact information for us to arrange a meeting time should you be selected for further participation.

Name: _____

Email: _____

Phone#: _____

APPENDIX B: Consent Forms

Consent to be a Research Subject

Introduction

This research study is being conducted by Natalie Kirtley, Ph.D. candidate and Lane Fischer, Ph.D. at Brigham Young University to investigate the experiences of women regarding body image and eating attitudes. You were invited to participate because you are a female college student.

Procedures

If you agree to participate in this research study, the following will occur:

- you will participate in two, one-hour interviews held within 2 weeks of each other
- you will be asked to answer questions regarding body image and eating
- total time commitment is estimated to be 2 hours

Risks/Discomforts

Reporting your experience with body image and eating attitudes may be unsettling. However, completing these surveys seems to present minimal risk.

Benefits

There will be no direct benefits to you. It is hoped, however, that through your participation researchers may learn about the experiences of women that may be useful in the prevention of eating disorders.

Confidentiality

The research data will be kept in an encrypted and pass-coded format. Your name will only be associated with your results if you agree and are invited to participate in follow-up interviews. Only the researchers will have access to the data.

Compensation

Participants may receive extra credit or clinical hours in their classes that offer such compensation. An alternative method of compensation may be provided at the discretion of your instructor. Participants that agree and are invited to participate in follow-up interviews will receive a \$20 gift certificate to the BYU Bookstore.

Participation

Participation in this research study is voluntary. You have the right to withdraw at any time or refuse to participate entirely without jeopardy to your class status, grade, or standing with the university.

Questions about the Research

If you have questions regarding this study, you may contact Natalie Kirtley at (801) 362-0155/nakirtley@gmail.com or Lane Fischer (801)422-8293/lane_fischer@byu.edu for further information.

Questions about Your Rights as Research Participants

If you have questions regarding your rights as a research participant contact IRB Administrator at (801) 422-1461; A-285 ASB, Brigham Young University, Provo, UT 84602; irb@byu.edu.

Statement of Consent

I agree to participate in this research.

[Enter Survey]

	Institutional Review Board	
	29 Apr 14 Approved	12 Mar 15 Expires

Consent to be a Research Subject

Introduction

This research study is being conducted by Natalie Kirtley, Ph.D. candidate and Lane Fischer, Ph.D. at Brigham Young University to investigate the experiences of women regarding body image and eating attitudes. You were invited to participate because you are a female college student.

Procedures

If you agree to participate in this research study, the following will occur:

- you will be asked for non-identifying demographic information
- you will be asked to complete two measures about body image and eating attitudes
- you may be solicited for further participation in interviews at a later date (within 2 weeks)
- total time commitment is estimated to be 20 minutes

Risks/Discomforts

Reporting on your experience with body image and eating attitudes may be unsettling. However, completing these surveys seems to present minimal risk.

Benefits

There will be no direct benefits to you. It is hoped, however, that through your participation researchers may learn about the experiences of women that may be useful in the prevention of eating disorders.

Confidentiality

The research data will be kept in an encrypted and pass-coded format. Your name will only be associated with your results if you agree and are invited to participate in follow-up interviews. Only the researchers will have access to the data.

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Statement of Consent

I agree to participate in this research.

[Enter Survey]



Video Release Form

As part of this project, I will be making video recordings of you during your participation in the research. Please indicate what uses of this video you are willing to permit, by initialing next to the uses you agree to and signing at the end. This choice is completely up to you. I will only use the video in the ways that you agree to. In any use of the video, you (or your child) will not be identified by name.

Video can be studied by the research team for use in the research project.

Video can be used for scientific publications.

I have read the above descriptions and give my express written consent for the use of the video as indicated by my initials above.

Name (Printed): _____ Signature _____ Date: _____

	Institutional Review Board	
	29 Apr 14 Approved	12 Mar 15 Expires

APPENDIX C: Additional Data

This appendix holds additional data for reference. It is organized in the same fashion as the results section with minimal guiding interpretations.

Control

While Libby and Susan attempted to lighten up the idea of lacking willpower, Vivian did not. Vivian echoed Libby's reports. She responded,

Um, I, I always think that other women manage better than I do, I guess...they just have more self-control over what they eat and they exercise more, at least. Or if they don't do any of those things, at least they are a little more comfortable in their bodies... I don't exercise like I should and I, I like sweets a lot and I, I don't really diet or go for health trends or anything. So, I, I, if I did try those things and maintained some discipline I probably could lose weight but I don't...Um, I just don't have as much self-control around food and I just eat things. And, uh, I can't seem to just say, 'oh I don't need it right now,' and put it off to the side and eat it later. If there is a plate of cookies by at least two days I will probably have finished it. It's just how I am with food."

The idea was so pervasive that she lacked control that when asked about her sense of self-worth she explained, "I have enough self-worth not to harm myself. I don't know that I have confidence but I have enough self-worth to not do things to cause long term damage." When it was pointed out that her self-worth might be protective she agreed and offered a secondary explanation. The conversation went as follows:

Vivian: Yes I think so. And also I'm just very lazy.

Interviewer: Lazy?!

Vivian: Yes, I think that's pretty important.

Interviewer: So you think one of the reasons why you don't have an eating disorder is because you're lazy?

Vivian: Yes.

Interviewer: Help me understand that.

Vivian: [*laughing*] Well I don't want to put in the work to, like those extreme methods require a lot of self-control and a lot, I know a lot of people start dieting and go for a while and then they just can't go, at some point they bounce back and their weight balloons right back; and I'm that kind of person. I don't think it's worth the trouble.

Interviewer: Hmm to just bounce back and forth.

Vivian: Yeah.

Interviewer: So when you think of women with eating disorders you think of them as not being lazy?

Vivian: Well it takes an awful lot of self-control to be able to do that to yourself when all your instincts are fighting to preserve yourself. [*laughing*]

Interviewer: Oh, so they have self-control and you're lazy?

Vivian: Well, I also mean I don't have self-control in that I don't go out and consistently exercise or eat healthy, so...that too.

Julietta corroborated this idealization of control in women that have eating disorders.

When asked what she thought the difference was between her and women who have an eating disorder she stated, "Cause I'm lazy. That's the difference, I'm lazy." An attempt was made to challenge this idea of laziness by suggesting that perhaps the difference is more like confidence. She indicated that it was perhaps confidence but reasserted that it was also laziness.

I'll do whatever I want. Mary also contributed to the development of this category by sharing that despite disliking her body shape she does not always exercise or adhere to a diet.

Well, like after eating a bunch I would decide like, 'okay I'm going to go on this diet,' or, 'I'm going to do this,' 'I'm going to do that.' Honestly, most of the time I don't follow through. I'll workout a little bit or I, like, figure out the things I need to do to eat the way, to be healthier but then I realized that, that it was all just a moment and then I realize I ate pretty well for the most part and I just have those rare occasions when I eat, eat crap and so... Um, when I have really negative experiences about my body I tell myself that I can change it whenever I wanted. If I wanted to I could start eating healthier, exercising more and develop more of that body that I want... It helps me realize that the way my body is, it because I'm choosing it to be that way and it's not something that I'm stuck with.

In fact, the idea of feeling trapped and being unable to change her circumstances are the characteristics of an eating disorder Mary is least interested in, enough to combat thoughts of being interested in disordered eating. She says,

... Um... I think when I think about developing an eating disorder at the moment it sounds like it would be an easier option but then I always, I always look at the long term effects of how having an eating disorder would actually end up making me feel trapped and worse about myself. And one thing I really don't want is that feeling of being trapped and like I'm unable to change my circumstances.

I can direct change in my life. One participant provided an interesting example of feeling empowered enough to make a change that relieves the distress. However, it is a choice that for some may seem concerning. Julietta shared that after high school she complied with her mother's request for her to have plastic surgery twice, rhinoplasty and a chin/cheek alteration.

Julietta thought her mother was joking but was in surgery two days later while her uncle, the anesthesiologist, watched over the surgery. Julietta reflected on the experience, “Why did I do it? I had no reason to do it.” But then she confesses, “I look at pictures before and I'm like, ‘yeah I was really ugly’ and now I'm like, ‘huh I look better.’” She concludes,

Yeah I'm going to do it again probably in the future. [laughing]. After I'm pregnant I'm going to raise my boobs, after my last baby, to feel better and to look better. I might want to change my stomach because I know it's going to be hanging but, but that's all.

This example is hard to reconcile. More often than not Julietta seems accepting of her body and dismisses her diets and exercise routine when not under the scrutiny of her mother and her community in Mexico. In this specific instance she does not seem motivated by fear or forced into the decision. Instead, she seems to be making plans for future surgeries as something to reward herself or at least something to look forward to.

I am at the mercy of my environment, I give up/in. Libby shares a career and/or academic experience that left her feeling forced to change her body.

... I just switched into Psychology from Musical Theater and so of course that's all about your body ...and so therefore you can be cast as these things and if it's no this then you can't be this. And being compared to, being compared that way I think drove my stress levels up like through the roof. And I thought I could handle that and then I was in a class the last semester I was in it and I was like, I came home everyday, I was crying, everyday. I was just, like, not, not doing well and, and not being able to judge myself healthily. And so I don't know if it's...probably comes from a near life time of doing theater and knowing that I'm being cast because of what I am and because of how I'm presenting myself.

Libby spoke of students she worked with while in the Musical Theater major who would break down in tears in the dressing rooms because of how their bodies looked. She also shared the extreme diets many of them tried and spoke to the pressure she felt to conform and the efforts she made to keep her body in the condition necessary to increase her chances of being cast. Ultimately, she elected to transfer majors taking her away from the pressures that were driving her life; however, out of sight is not always out of mind.

Social

Susan has similar concerns about dating. While she feels at the mercy of what she believes are the rules about who dates, she also is infuriated when there are deviations, which puts her in the role of enforcer. She also speaks to how she is reminded of those societal standards.

...Well okay, I go on this rant all the time to people... I always get super mad because I've gone up two sizes and so for me that means I'm a 14 which means I can't like shop everywhere because a lot of places only go up to a 32 or a 12. And I get really mad because I'm like, well all these other people are a 2 and they go up two sizes and it's like, big deal you just buy it in a bigger size, which sounds dumb but I like get super mad about it [*crying*] and I just feel like...I don't know. Well, and like most of my friends, they're, like, really tiny and, like, really attractive or whatever. And so, that's always been just like, hard. And well, I have all these other issues that I feel like are related but like, I don't know, I haven't really dated and so [*crying*] I definitely like hugely attribute my weight to that. And everyone tells me like 'oh don't think that, that's not true!' But like I still think that just because, just, like at BYU everybody is married and, this is going to sound so bad but...No, but this is going to sound really bad what I'm about to

say, but I'm just being honest with you; but, I just get frustrated because I feel like even the guys who aren't good looking or fat or whatever they're still dating the tiny blondes and so then I'm like what am I supposed to do, you know? But then at the same time it's not enough to make me change. *[crying]* Also because I know that I'm never going to be super tiny like that's just not possible for me.

Susan points out that there are expectations or standards in areas as large as national chain clothing stores down to the campus of a single college. Perceived societal expectations occur at different levels, from the broad to the specific. Jane illustrates this when she discloses that she had some ideas about societal standards regarding style at BYU before attending that had her worried. She was convinced she would not fit.

Mmm... this doesn't have so much to do with body shape but more with how I dress and stuff but I feel like BYU is kind of like... I don't know, at least before I came, it's not so bad now that I got here and saw that's it's different, but, I definitely had an image of, you know, this is probably how all the girls dress, you know, and I don't fit that. I definitely dress however I want and do and wear what I want and stuff. And I had this very specific, 'you're not going to fit in' kind of thing from, from just the idea of BYU. I think I was mostly wrong, like I found, you know, a very wide range of people that, that I wasn't expecting. I was expecting it all to be like, like, in my school, I had this one friend and she was just like the perfect Mormon girl, everyone loved her and she dressed perfectly and it's just perfectly modest in every way. So, you know, that's kind of what I imagined. I'm like 'yeah, they're all gonna be like that and then I'm going to show up and...'
[laughing] And not fit in. But, um, yeah, no. There's definitely this, those kind of people here but I found more people than I expected that didn't fit that mold...

Zoey considers her own dating situation and the pressures she feels. She also points to pornography as a specifically concerning type of material that puts pressure on her as a woman.

I think like the hardest thing is just like having a boyfriend because like when he touches me it makes me...weird, because I don't want him to think I'm gross, you know? So I think that's like part of it too because like before I was like 'well no one is, like, really looking at me or touching me' but like when he like grabs my side, like, it makes me self-conscious I guess. Cause, you know, there's, like, porn and stuff and, like, I know that he's looked at it and I don't look like them so that makes me, kind of makes me feel, I don't know, I don't like that. Cause I feel like well if he's been looking at that then like I'm, like, probably gross, and he tells me obviously that I'm not. But, sometimes...I don't know, I feel like... I guess I just think, like, being skinnier is prettier but it's not like, the people who are bigger than me I think are ugly; so it's kind of weird. It's just like for me I guess. Yeah. And I think it's like sometimes I get caught up in the worldly, like being skinny is everywhere, and everyone is so thin so that just, like, gets me really easily I think.

Zoey continues to share and perfectly demonstrates what the struggle between enforcement of the "worldly" and desiring a release from the "worldly" looks like. In this back and forth dialog she discusses the pressures she believes are put on women and how she has internalized them and how she reinforces them. She also speaks to a desire to eradicate them and how nice it is when women are portrayed in media more realistic within their circumstances. She also declares that what she believes is capable of combating the messages about women in media is more celebrity and media outcry. She suggests fighting media with media,

I think that's kind of hard because, like, I was saying earlier, probably the hardest thing is seeing models and stuff like that. I don't know how it is for everyone cause I don't really ask people about that but I don't, I think it's a hard thing because I feel like it's kind of been engraven in us since we've been, like, at least my age, we've been so surrounded by media most our lives and so even though I know that it's not true, like, I still, like, can't get it out of my mind and like if I see a poster or something with a girl or something that's not pretty or what I don't think is pretty, I'm like 'why is she on that poster if she's not pretty?' Like, it's supposed, she's supposed to be pretty, you know, which is really sad. I shouldn't think that way, but sometimes it's just the way I am I guess. I just think that and so I don't, I don't know. I think...like this stuff, like, I, like, the media stuff, the Dove thing, like those little reminders are helpful because then you're like 'oh yeah this is fake' and just like reminding girls that they are like pretty the way they are. And I think that things have actually been, they've been kind of getting better, like, even, like have you seen *The Fault in Our Stars*?... in my opinion she, well she does have cancer, but she didn't even, like, look good in that movie at all. I was like 'you don't even look pretty.' But then I was like, 'why does she have to?' You know? And so I thought that was, like, a weird confirmation to me. And I was like 'you know you don't have to be pretty all the time, you know, like she's on t.v., and everyone likes her acting and she's not, like, she can be pretty but her face was oily half the time and I was like 'this is weird,' you know, but maybe they're just trying to capture what it's really like to have cancer and stuff. But, I just thought that was touching that they would not make her beautiful the whole time, you know. Cause it's weird in movies when they're supposed to have cancer and they're like all pretty, you're like 'what? They wouldn't look like that if they had cancer.' Yeah,

like maybe girls, like, popular and famous women, if they took more of a stand on it. I think that would be helpful.

Alyssa, a journalist student, reflects on the changes in societal preferences regarding body shape, and she is not convinced any of the expectations throughout time have been moderate or healthy.

It made me think about the phases through the media because I'm a journalist and I look at media all the time and just seeing the phases of you want to be thin and you, like, in the 20's and 40's it was let's-gain-weight pills kind of a thing, see how you can gain weight fast and now it's get thin and perfect. But you also have movements like the movie *Hairspray* that has come out and you can be any size and be perfect and I think seeing all of that you kind of get two extremes. You can eat recklessly or you can be unhealthy recklessly and people should still love you. Um, and you don't have to eat anything and you can look like you're a shadow and you'll be perceived as beautiful but I think it's taking those extremes, I think it's in anything that there's an extreme and just finding that medium. And I think, I feel like we're smart enough human beings to find that medium but we just feel tendencies towards one or the other to justify how we look or how we feel.

Times change but in Alyssa's eyes the message about body image is the same, and its general message is be extreme.

Susan illustrates how that is true for her in the following excerpt.

... The media, like, maybe I'm wrong, but I don't feel like the media impacts how I feel. Because I know that's unrealistic and that's separate from my life so like, I don't really care but when I, like, get upset is walking around campus cause this is real, this is real,

this is my life and this is what I'm actually up against and I'm comparing myself to the girls here because they're my actual competition. If that makes sense? Whereas on TV I'm like, 'well, obviously I don't care if a guy thinks that... like, whoever. I'm like, 'well, whatever they're not going to date her anyways.' And it's the same way where it's not, like, because I think Gale from The Hunger Games is super hot I'm going to date him and I don't expect anybody that I date here to actually look like that. And I think, I don't think that guys feel like that either. And granted, maybe I'm making this too much about dating. I think I've made it a lot about dating, but that's just kind of where my mind goes because I don't think people don't want to be my friend or something because of my weight, I just worry about being attractive enough for people to date me and like me feeling good in what I wear and being able to shop at all the stores and stuff like that.

In a way, the simple wishes Susan has to be dating and to find the sizes she needs stocked in stores are just two ways society offers affirmation to individuals. Social affirmation was mentioned by a few of the participants as being extremely supportive and mood boosting.

Zoey points out that for her having supportive friends is essential,

I just, I think too that having good friends who aren't like, like, I don't have any friends, except for that one boyfriend, which he does not count cause he's just a...*[laughing]*

Like, I don't have any friends that would be like 'oh my gosh you look fat in that outfit.'

And they've always, like all my friends have always been so supportive of me and every time, like, if they think I look cute they'll be like 'oh you look so cute.' You know? I've never had like a bad friend which is nice and, you know, it's just surrounding yourself with good people who are sincerely caring and who actually care about you as a person and they don't care about the way you look. So, I try to do that too.

Zoey illustrates how she compares herself to a past self and to other person. The panic is almost palpable.

Well like I already knew that's why I was coming but obviously I'm not like, I know that I'm not like fat I guess. But I'm just, I'm weird I guess, like I'll look back on pictures and be like 'oh I was way skinnier there than I am here,' and then like every time we go shopping I get discouraged because I see girls that are so skinny, you know? And I'm like 'oh I need to have a flat stomach,' and then my roommate, you know, she has like a super flat, like her skin is super tight and I'm like 'I wish I could have that.' Then I don't have enough self-control to eat better or exercise more, you know? And so sometimes I just like get mad at myself cause I'm like 'ah, why can't I be thinner?!' And then like I get weird about wearing swimsuits in front of guys, like, I don't really go swimming. It's weird.

Mary joins the tradition of comparing herself to others and losing, "I guess, so like, on a mission, I had a lot of tiny companions and I know that I'm still pretty small but like compared to them I felt like a giant but then they like... Like around my sisters, I feel little heavier than them." She provides some background into comparing herself to her sister,

So her name is Kathy and she is the one that I compare myself to, um, when it comes to body image. She's the, she was always the perfect daughter and she, she was the most beautiful and, and, still growing up, like, having those comments I hated them and, like, I know now she barely remembers them. So, that could be that she was just joking but, but I still feel myself every time I'm around her just comparing my body to hers.

Sometimes comparison has help and it is not entirely self-inflicted. Libby's situation studying Musical Theater acts a reminder that others are involved in promoting comparison and

Mary's story acts as a reminder that the promotion of comparison does not only happen on large institutionalized platform.

Mary goes on to state that she even compares how confident women are about their bodies compared to her and she loses that comparison, built on mind reading, as well, "...I think a lot of people are more, I guess when I see people, like, first thing I notice about them is their body but I feel that they are more comfortable with their body like they have a greater acceptance of it."

Susan offers the most comical example of comparison. A method of comparison that is done with friends and in many ways is like playing Russian Roulette with one's emotions and one's relationships.

Me and my best friend, he's influenced me a lot, sometimes for the worse, but it's okay. But, we've always had this thing where we're constantly trying to find someone that has the same body as us so that we can know what we look like to other people. And so like, we've been doing that for years and we've never been able to find somebody because every time we're like 'do I look like that person?' and then the other is like 'No that person is way fatter than you.' But like that's what we're like 'oh no that's what I think I might look like.' And again it's horrible because those poor people were totally judging them and doing exactly what we don't want people to do to us. But yesterday all these people at work kept telling me they thought I was this other girl at work from behind and I was like 'oh my gosh she can't my body double,' and I got so excited and I was like, 'she doesn't even look bad,' and I was like, 'good because I can totally handle looking like that,' and I got so excited about it. And I like called my friend and I was like, 'I'm going to have to send you a picture. It's crazy, it's so great, you will have to confirm!'

If Susan's best friend confirms that the individual at work could be her "body double" then Susan might actually feel bolstered by the comparison, even though the "body double" loses. There were instances when participants described feeling better off than their counterpart in a comparison. Examples of such comparison were less frequent. A classic comparison is comparing oneself to a friend who you believe to be better off than you. Jane flips this traditional comparison on its head,

...Like I have really really tiny friends some of 'em; they're like this big [uses hands to illustrate a small size]. You know, for a while I was like 'Whoa I wanna look like Anna' But, you know, now I'm like 'I wouldn't look good like Anna' [*laughing*] I'm just the way I am. It wouldn't work.

Julietta describes how she, not only does not shy away from not comparing but even seeks to compete with men on food intake,

Comparison does at times happen more contextually. Adrianna states,

...When I don't feel good about my body and I see other girls love their bodies I'm just like 'ugh they're so dumb,' but like when I like my body and have confidence I'm just fine with it and I want to show my body too cause I worked hard to get it, I don't know.

When Adrianna is feeling confident she is less likely to compare herself or at least less likely to feel she is worse off. Libby walks through her body dissatisfaction and how comparison helped combat those feelings and it seems like Libby puts a lot of thought and effort in deciding she is better off than others.

Um, well first, I think recognizing what the things were that I really was unhappy about, about my body. Cause it's not my whole body that I feel that way. Um, so recognizing that there's just a few things that I don't like and then realizing that, first that I had it

better than a lot of people and that it's ridiculous to see myself that way when there are people who are much heavier than me, much...you know, whatever, who are not feeling that way. I guess that was mainly what it was. Just like, my problems are small and just trying to minimize...yeah, just trying to recognize that what I had was not as significant as I'm making it to be.

Spiritual

Libby offers an illustration of how a singular experience can contain both positive and negative aspects of one theme, in this case spiritual. This example demonstrates both the positive protective effect of spirituality and the pressures that can be built out of spirituality. She shared the following,

...You know we have The Word of Wisdom and we're aware of, you know, that we're supposed to eat healthy and as, you know, required by our religion but also, you know, we have large, larger support groups here, larger families, larger reasons to stay connected.”

On a more personal level, she gives attention to the first modality,

...I think, um, also in the church, you know, we teach a lot about our divine nature and um, our importance in this life and that this is not all that there is. And I, I think that, that perspective helps me too; knowing that this is an imperfect world and I'm in an imperfect body that, that there are eternal goals and things that are more important and this will not matter.

Betty was very emotional during her interview so much so that she struggled to generate content. She was eventually asked to reflect on what may have protected her or buffered her from engaging in disordered eating behaviors. She indicated, “Um, like, mostly, like, the

atmosphere I grew up in and the church kind of thing. Like, being LDS you always hear you need to treat your body like a temple and, like, not feeding it or throwing up isn't doing that, kind of thing." It's hard to know from which of the modalities Betty's spirituality functions, what is clear is her spiritual beliefs do actively participate in experience in her body, especially emotional ones.

In reflecting on moments when she feels poorly about her body, Jane noted that she tries to focus on spiritually oriented pick-me-up ideas. She says,

Well, like I said it's better now than it used to be. Um, it used to be that I'd just get like bummed out really bad. It was just like 'uuuuuuugh.' Um, now I can usually kind of shut it off a little, you know, not immediately but before too long I can be like 'no, okay, I'm me. Stop.' But..." She clarifies this idea of "I'm me. Stop." She shares, "Um, I'm trying to remember that I'm a daughter of God and that, you know, He loves me and I have people who love me no matter what. I'm trying to remember that.

After being debriefed on more details of the study, Jane said,

Uh, um, so basically... I would think, number one, is I, you know, I forget it sometimes but I do know that I am a daughter of God and that I'm His and so... and that this body isn't mine. So, like, the logical side of me knows that eating disorders aren't healthy, you know, it's bad. Um, even though part of me is like 'well, you could just do it for a short time and you'd be fine. You'd be perfect.' Um, so I think part of it is knowing who I am and knowing that I'm His. ...I think it's more of an over arching than like every moment, every day. Like I said, with my depression I sometimes forget it and that's when I get, you know, that's when body issues become worse, is when I'm depressed. It's when I forget that and I forget that I'm loved no matter what, you know?

Penny was asked to thinking on a less personal level about what potentially could be helpful. She offered the following, which leans more towards the second modality,

I feel like definitely having the gospel element, having a more eternal perspective on things can help us stay away from things that are damaging to our bodies. Because our bodies are a temple and we should be treating it like one and that's partially why a lot of us are dissatisfied with our bodies because we know that it could be better but it's not so it's like we're not treating it right like the way that it should be.

She was asked if she feels these ideas personally affect her experience,

Yeah it definitely has. I think when it's getting pretty bad and I'm about to start doing something, it like kicks in, like it reminds me and I'm like 'oh, I should probably not be doing this.' It's there but I don't feel like it's...it is a big part of the decisions that I've made but at the same time it's kind of like, it's like the last thing that comes to mind instead of like the first which is what I think it should be but it's not. And then it's usually the one that stops it so.

Alyssa considered how she copes with her body image concerns. She shared,

That's a good question. I think I let it go through my system, like, 'okay I'll cry about it right now' and when I'm done feeling sad for myself it just, I think having the LDS faith helps influence that, of where you're like 'I'm still a daughter of God. He still loves me for who I am and I know he's given me a body I should protect and keep it as healthy as possible.'

Alyssa offered a unique spiritual idea as shared her thoughts on food dependency. She explains that suddenly she realized how dependent her daily tasks are on the goal or requirement of needing to feed herself.

And then as I was thinking about this I was like ‘you know, we work really hard to make money and what do we do with that money? We buy food with that money; that’s like the first necessity of life is food.’ I was like ‘We take that money and we buy the food, we get the food and it takes an hour to make a nice meal, two hours maybe if you’re going to make a big meal for a family. And then you eat it for like fifteen, twenty minutes and then you have to have an hour of clean up. This is not worth it! Food is a trashy piece of crap! Like, I can’t believe we orbit around this idea of eating so much.’ Like we eat three times a day and then we have a snack but all that preparation for all that food, like, it made me sick, I was like ‘our lives are just about food and its awful!’ like, ‘it’s gotta be more.’ So I’m like ‘I’m going to school to get a job to pay for food!’ [*laughing*]. I was like ‘I don’t want it to be like this. I don’t want it to control my life.’ But it does in some... it still controls, like, that’s how we function. And I was mad about it for a little bit. I was like shaking my finger at the man upstairs like ‘you silly person.’ I’m like ‘I can’t believe you had this trick in you!’ like, ‘I’ve discovered your secrets.’ I, I think I had to have more of an eternal perspective, like, coming back to the religion. It’s just like ‘you know what, it’s okay. Like, maybe God needed us to have a little more...of a reliability like food, um, to realize that we need a balance in things.’

Alyssa, in her anger and comic approach ultimately arrives at a spiritual lesson to be learned. Vivian, however, does not find anything comical about the topic and she definitely leans more towards the second modality motivations.

Um, well, I guess The Word of Wisdom and the idea that, uh, that we’re not supposed to be idle and to use all things wisely have made me feel a little guilty because I’m

obviously not handling some things very well when it comes to health. Like, I've never broken The Word of Wisdom but...

Vivian later went on to discuss The Word of Wisdom and how she feels that by eating in excess she is not aligned with the teaching of her faith. However, she continued to point to spirituality as a protective factor,

Probably religion. I mean I can't deny that. The Word of Wisdom isn't about really looking good, it's about overall health so... And that's just kind of in the, like, the doctrine is like always in the back of your mind. Just this idea of cleaning the inward vessel and before the outward vessel. I think that's the best way to put it.

Vivian seems to use her spiritual beliefs to focus her on more important aspects than the physical. Zoey describes how her body image concerns and her spirituality intersect.

So, I just have always, like, felt special in God's eyes I guess because like they always tell us like 'oh you're daughters of God.' And they always say how precious we are and things like that. So I just try to remember that, like, bodies are imperfect and that, like, if I could do everything I can to keep, you know, like exercising and eating as well as I can in certain situations it doesn't mean I can't ever eat ice cream or desserts but like just try to remember that, like, God still loves me and stuff and that... sometimes I feel like when I focus more on, like, God and, like, reading the scriptures and just remembering that, like, how, like, important I am to him then it helps me feel better about myself and then I feel like I look better. I don't know if I really do or if it's just like psychological but I just feel like I look better. And then it makes me have more confidence and think people are more attracted to that. I feel like more people talk to me when I feel confident.

The utilization of spirituality leads Zoey to a more confident place, which illustrates a supportive function. Zoey later shares another facet of the theme after being debriefed on more details of the study.

I think, like, the biggest reason BYU is maybe like that is that, I think the church has a lot to do with it. Because, like, the church, they want you to be healthy, and I think, they don't like push that but secretly they kind of do, like, in an indiscreet way. And, I just think that, like, there's just something about being Mormon that, like, people they love to help each other and they... I just feel like a lot of LDS people are active...like physically active and they, like, like to give service and that usually has to do with being active somehow. And, which is, I don't know. I think it's probably because we know God gave us our brain and He like gave us this whole earth and it's, like, good for our mind to get out and do things and, like, exercise and, like, we know that, like, it'd be, like, I mean, we'd be taking advantage of something if we didn't use it, that He gave us. And so I think maybe that's why. I don't know if other people feel that way about it but...Like, I think that I should, like, go out and see the world cause, like, He made it and I kind of want to see. Yeah. It's kind of weird because I think it's weird mix cause I think it's like unconsciously the church, like I don't think about it. And then when I think about it I think that is like the core of it. But then, like, because it makes me not want to and for some reason if I had an eating disorder, like, I feel like I couldn't even go into the temple. Like, that would be weird, cause that's like, I don't know I feel like that's almost, like, sinning in a weird way. So maybe that's why we don't, cause it's almost like a sin. Cause it's unhealthy, you know, it's like smoking, smoking is unhealthy for you and so is that. So, I think that is a possibility.

Zoey floundered a bit in explaining herself, some the ideas she expressed may be fairly new to her in a concrete way but her ability to express that perhaps there is fear of sin acting as a deterrent is consistent with the responses of other participants.

Adrianna offers a perspective that aligns with the positive/protective modality, “Um, well I think like we might do our bodies differently because it's a gift from God and we need to take care of our bodies so maybe that's one reason we're not willing to do things that damage our bodies.” For Mary it's a whole other reason she is unwilling to mistreat her body.

Yeah, just, I was mainly thinking about why I never allowed myself have an eating disorder and I think that has really stood out to me the most is, like, like, I think too much in advance. I think too much about the consequences of what I would do and... uhuh, and, like, I've definitely wanted to... there have been times when I definitely wanted to try anorexia or bulimia; they seem like the best option but then I would think about everything it would do to my body but the thing that's always stop me the most is that I've just always want to have kids and I just know how much that would affect them more than it would affect me. So, that's always what's been my bottom line factor. ...I just always, like, I've just always, like, being a mom has been one of my greatest goals, something I've always wanted to do. I just have always known how important it was and I just, I don't know, I just, I could never imagine going through the pain of knowing that that this being that I created was disabled because of something that I had done something to do out of a selfish desire.

She stated that her desire for motherhood is “definitely” inspired by her spiritual beliefs.

Susan starts off with an admission of fear about how her actions or in actions might not result in the calming and hopeful outcomes her faith teaches,

And so, like, sometimes I'm like 'oh what if we get resurrected and God is like sorry you can't have a perfect body because you didn't take care of it.' Like, which is so bad! But I'm worried about that. And I'm, like, 'am I crazy to think about that?' But then I'm like, 'no, the Bible says we're all going to get perfect bodies so it's going to be fine but I like legitimately am worried about that.

She continues in an exploration of her self-dialogue when she is feeling poorly about her eating choices. She narrates,

Well, cause I think at first I'm like, 'oh my gosh, I'm so stupid I knew this was going to happen but I still did it anyways.' And then, I guess I'm feeling like guilty. And then guilt more than regret I think it's just about like I know I'm supposed to do and I'm not doing it. I'm just straight up not doing it. Not being healthy. Not taking care of myself and so and giving in to what I want instead of what I know I should do. I think that applies in a lot of areas of my life but especially eating because it's easier to break. If it was a commandment, I mean I guess it technically is, [*laughing*], but like, if straight up it was like eat this many calories a day, I would do it no problem, but since it's like up to your discretion it's harder. So, I don't know.

In response, she was directly questioned if spirituality impacts her experience.

It does. And there was a point on my mission where we, we had this guy who he, he was trying to quit smoking quit drinking and so we taught the Word of Wisdom a lot because he didn't really get it and I started feeling really bad because that's when I was in the country and was going to McDonald's all the time [*laughing*] and I was like, 'man,' well and my companion was super healthy too and so she would get on my case about it because I was always like 'oh man I'm gaining so much weight on my mission.' And she

was like, 'stop eating and you'll be fine! Stop complaining about it if you're not going to do anything!' And I was like, 'okay, whatever.' Anyways, so we were studying it a lot and then I'd feel bad because I was like, 'man I'm totally not following this.' Like taking care of our bodies is a huge part of The Word of or Wisdom and I'm totally not following it and for a little bit I did better but on the mission it's hard... So I mean it didn't really make that big of a difference and it was really only one time where I really felt that, which I should probably think about that more, but I don't know it's something that I've liked prayed about a lot too and that will my mom gave me this book, it's not an LDS book, she's not LDS, but it's just like its called... what's it called... it's some book about eating and God and having God help you. And so I read it in like a day cause I was bored and I had nothing to do. It was pretty good and I totally, and it's one of those things where I totally believe that Christ can help me or God can help me overcome because obviously I believe that we can do anything. I just know that I'm not putting in my full effort and so I totally believe in the fact that the gospel can help with it. I just... I don't know, I... I don't know.

Priorities

Heidi speaks to the elements of her life she would rather be concerned with, Umm... just maybe less of, you know, myself and what I'm doing but what, like, what am I accomplishing, what can I do for other people, what, you know, is my role, you know, like, what am I learning in school, what's going on with my family, my spiritual growth, there's just any, anything. Like I could say, like, all of those things are basically everything outside yourself. It's like easier to get consumed with that because you're doing stuff. But then if you're focused on yourself and how you look and what you're

eating, I don't know, to me it would be boring [*laughing*]. But I don't know, I can still see how it happens, like, because, I don't know, you wanna fulfill, you wanna, like, be the best you can be and so if you believe that you're not then you're trying to fix it. I don't know.

Betty shares her cognitive process during times when she feels enticed by disordered eating. In this excerpt she uses a common phrase “not worth it.” Even though she is unsure why it is “not worth it,” it plays a role in diverting her from acting on enticing compensatory eating behaviors.

Like, sometimes I think about it but I'm like, 'that's not the right thing to do.' Just like, 'that'd be easier' kind of thing. I wouldn't have to worry about eating the right kinds of food, kind of thing or...Um, I just, I think 'it's not worth it to make myself unhealthy that way just to lose it.' Like, getting skinnier. It's not worth being unhealthy to get that.

Penny reminds us about her flirtation with disordered eating and why she believes she did not remain interested in that idea. Her conclusion echoes Betty's “not worth it.”

Um I think I mentioned last time that I tried to give myself one once and it didn't work. So I mean I guess at low points in my life I was kind of envious of that. And at other times, I remember when I was younger I was like 'I can never have an eating disorder because I just couldn't just do that to myself and put myself in that sort of pain.'

While not overtly stated, Penny expresses that ultimately there was a higher priority to protect herself from pain than to achieve whatever an eating disorder would have offered her.

As discussed on the section on Control, Trina has long battled with body shape dissatisfaction and how to achieve her physical based goals. Having confronted the difficulties of

emotionally managing her experience in multiple contexts including therapy, at this point in her journey Trina expresses how she began to shift her priorities to deescalate the experience,

Um, I feel like for most of my life it was just like tunnel vision. It was, like, this is what you have to be and if you're not this then you're not good enough. And just these last couple years, I feel like I'm tired of thinking like that. I'm tired of trying to conform, I feel like I'm just never going to be happy with it if I don't just be happy now, you know? So, I've started to try and figure out and change the way I think about things. Cause I don't wanna think about things... I don't wanna be this person that's never happy with the way they are but is never, like, like an eating disorder, like, this category that I am right now. Like, I don't wanna be this person forever because for one, I don't want my kids to be like that. I want my kids to have a confidence that I never had. And so a lot of it has been influenced from the fact that, like, turning away from myself has really helped me decide that I don't wanna think like this anymore.

So for Trina a battle begins for happiness and family to take top priorities, an effort she hopes will change the course of not only her self-perception but quality of life. Alyssa is also sure there are better things out there and she's not interested in being overly focused on something less important and so demanding,

So I, and I just have to remember you can work on getting that kind of a body, but I mean, I don't want to have a ridiculous mindset where I think I have to have that kind of body and work and to spend all my time and my thoughts and energies on trying to get something that I might be able to accomplish but there are better things in life to get than that.

While that is a fairly broad idea she is also aware of specific instances where priorities won out. Alyssa states,

... I had a protein bar the other day because I went and bought them. I wanted to try some and see if they worked. And it was so disgusting, like I almost vomited for the first bite, I was just like ‘gag how do people eat this?!’... I had like a Fruit Grain one power bar and I open the package and I take my first bite and I was like ‘ahhh’ yeah. And look down at the bar and it’s like bending in half like taffy and I’m like ‘that cannot be good for you!’ [laughing] ‘that is not breakfast!’ [laughing] Yeah, I just threw it away. I was like ‘I wanna try and be better,’ like ‘see if this works’ and I got like seventy percent of the way and then I was just like ‘ugh it’s not worth it.’ So I went and got a fruit snack to wash the nasty flavor out of my mouth. I was like ‘this is gross.’ I was like ‘you know what, that’s not worth the sacrifice. I’d rather eat real food and not eat that.’

Susan joins Alyssa in her priority of eating “real food,” maybe even indulging, Yeah, because, I guess, because, like the sacrifice it would take for me to look how I want to look, this is, and I’m really like this, [laughing], I hate wasting time or energy or anything, but I feel like the sacrifices I would have to make to look like, quote on quote, ‘perfect’ are totally not worth it to me. Like I would rather be able to eat what I want and do what I want and be able to not go to the gym if I don’t want to go because, like, that’s more important to me than having a perfect body.

There is more to Susan though than just a powerful free spirit. She also has some foundational priorities that keep her desires for body shape changes in check.

...Before I was a member of the church even too... I just saw it as like, ‘oh I need to travel the world and have a great job and these are the ways that I can be successful.’ And

then since my mission I definitely don't see it that way anymore and have learned to understand that the worth of a person literally has nothing to do with anything that we even choose, we just have it, we can't make it go away even if we wanted to and so... I could lose the weight or whatever but I don't feel like it's going to be worth it. I don't feel like it honestly would make me feel so much better about myself because, like, I like who I am as a person and I don't think our appearances matter that much... I just I don't know, I think a lot of it has to do with just what you think is the most important thing for you to achieve and the balance that you want to have in your own life and I guess... I don't know, I just feel like I've never as much as I've hated how I look or hated how I weigh it was never important enough. Like, I didn't care enough to lose that weight or to get an eating disorder or whatever because I knew that would take away so many other things that were way more important to me.

In the end though what it boils down to for Susan is this,

...I'm a huge believer in... helping people understand where their worth comes from... I think that's something I've always been really good at is understanding I'm a child of God. And understanding that my decisions in general, including about food, don't determine who I am, or how successful I am, or if God loves me, or if other people love me. And, I don't know, and I think it's easy to feel hopeless if you don't have people telling you that, if you don't have people that love you and you're going to look for any way to make people like you. Um, and so just, I really do just think it has so much to do with what priorities you have in valuing yourself. And if being thin is your number one value then you're probably going to have an eating disorder so just helping people understand where their value really comes from, what their level of priorities really

should be and that's the thing, that's hard as you can't just give people social support or make their mom love with them. *[laughing]*

Mary describes the process of becoming aware of her body in a negative emotional way. She describes making diet and exercise plans in the heat of the emotion and the fear that drives the behavior. Eventually, the situation deescalates and she concludes, “Yeah I like...I, I think it's probably more of an overreaction it's, it's like the beer goggles, you are blinded for a while by what you think that you see but then you have a new priority.” Ultimately she decides that engaging in any type of disordered eating “because I know that it won't give me the happiness I want it will just give me it's temporary fix.”

What emerged from the data was the effect priorities had on moderating the effects of comparisons wherein the participants concluded they were worse off than their counterpart. Here is an example from Zoey,

...I know I sound like I think about it all the time, but I do think about it, but not like, I think about it often, like, when I see girls and I'm like ‘oh she's really skinny.’ But I don't like, it doesn't ever, like, get to the point where I'm like, ‘oh my gosh I can't go on with my day cause I feel so fat.’ You know? It never like, I never get to that point. I'm pretty good at like being like ‘that's dumb and unrealistic and unhealthy to think that way altogether. And there are other things in the world that matter more than that so don't think about it type thing.

Libby considered all the elements that contributed to her leaving the Musical Theater program, many of which came down to a shift or dissonance in her priorities. It's just that I'm looking at it from a slightly different perspective. And I think also because I never had the exact same goals going into that program. I never wanted to go to New

York and be on the chopping block there. So, probably also from that, knowing there was something, even subconsciously, before I even made my decision, knowing that there was something different about me than them. And knowing that I was just a little bit more outside the world than they were. Um, which is probably what helped me keep my sanity before it got to the point where I was breaking down everyday.

Libby attempts to explain how she combats the urge to eat disordered when she feels poorly about her body. “But, yeah definitely, I think it’s, I think it’s prioritizing and just realizing that the thing that really matters, that this isn’t worth all the stress that I’m giving myself about it. Yeah, and just starting to feel more and more grateful for what I have and thinking less about how I should be better.”

Exposure to Information

Trina offers the most interesting example of how information helps her understand her body and its tendency to fluctuate in size and shape, which ultimately deters her from engaging in unhealthy compensatory behaviors. She started by reflecting on how she feels about her body. She states, “It, like, is very, it changes a lot. A lot of the time I’m very dissatisfied with it. Like, I don’t know. I just feel like I try so hard to, to be, like, I guess, like, in shape and be healthy but then just whenever I look in the mirror I’m just like never satisfied with the way it looks. I don’t know.” When asked to clarify what she means by it changes, she shares,

So, I guess it could be part of like, you know, girls have periods every month so it might be like that. Sometimes our mood swings determine our, how we feel about ourselves.

But the majority of it is, it’s also like the time of year, like, winter, normally you usually gain a little bit of weight because, you know, it’s the winter time. And in the summer,

like you're active and you're outside a lot more. So, it like really fluctuates but most of the time I'm very dissatisfied with the way I look.

Perhaps this is a simple bit of information to have, but the information offers her a way of interpreting the body changes she experience over the course of a year. At another point in her interview she discusses her desire to be a mother and how eating disordered may affect her ability to have a child. Having a child is sure to create changes in her body shape and having a foundational understanding of body shape impermanence may continue to console her body shape concerns.

Trina goes on to mention her time in nutrition courses,

Uuum, I like to be active. I like sports. I love to dance. I like to run. Things like that and then I try to eat healthy [*laughing*]. It...it's hard sometimes. I'm actually pretty good about it. I took lots of nutrition, like, nutrition classes in high school and things like that and so I have an idea of what's good for me and what's not." While it was argued that exposure to information mainly protected women from disordered eating, it is worth considering if some information positions them to be more self-critical, accentuating their body shape dissatisfaction.

Earlier in the data Trina's experience serving an LDS mission was shared. She described not having control over what she could eat or how and when she exercised which led to weight gain. She describes being sad and angry about her situation. Interestingly she also described being careful about losing the weight. If you'll remember Trina shared a desire to lose weight after returning home from her mission. She also spoke to feeling hopelessness and regret for having put on weight during her time of service. Despite her sorrow and anger she expresses

concern about following a steady and healthy weight loss process. Later in discussing this same idea she mentions,

Like, I've done a lot of studies on Anorexic and eating disorders and body image because I did, it was like my senior paper or whatever, was about eating disorders and body image and how, like, the world conforms us to their image and what's really beauty, like... a plump person is beautiful here and a skinny person is here. And so I just try to change the way I think. Sometimes it's harder than others.

Her research not only has her informed about eating disorders but also body image concerns and societal definitions of beauty, all of which she attempts to cognitively navigate in times of distress. Trina describes part of that process. This excerpt is a great example of how information is utilized to combat self-critical thinking.

Cause if, like, you're saying, being negative about yourself how is that going to influence someone else that's in the same room as you. So. In the beginning it was always just like thinking 'I'll never be good enough. I need to do this [*snap fingers*]. I need to do that' [*snap fingers*]. And then I would get there, or I wouldn't get there and it was just like always up and down and then, these last couple years just really trying to open my vision of what really is the truth about body image. You know, a lot of it takes into, like, you have to be healthy too, like it's okay to have fat, cause you're gonna have to have children and you need to have that. And just, like, understanding not only what's healthy but also, like, what your body type is. Like, I've done a lot of research about different body types, what's healthy for this kind of person, what's healthy for this kind of person, just trying...like when I do start comparing myself think 'oh well she's taller so it's okay.' Or 'this person is shorter and this is why.' So, just trying to see the facts and put

them into positive thinking so that I can just start changing the way I think, just finding a bit of truth is the biggest, is my big quest right now, finding truth and just deciding to be happy with who I am. Because, I'm, I'm okay. I'm not...for my body type I'm actually doing really good.

Not only was Trina exposed to information, it turns out she was dispensing information. During her time participating in beauty pageants she was required to select a platform, " So like platform, you pick a program that you want to promote. So, if you win, so say I win Miss Connecticut or whatever and my platform was the Dove campaign for Beauty or whatever. When I would go and, um, talk to school or talk to people, this is what I would be talking about." She goes on to explain, "And so that was another, another thing that was almost like contradicting because it was like you're trying to conform your body into one way and then telling people you can just be happy with the way you are kind of stuff." When asked about whether pageants made it more difficult to feel positively about her body she responded,

Um, yes and no. It was good because I realized a lot of things. Like, I think when I was put in that place I realized that I didn't have to conform, that I didn't have to be like that. Like, it clicked me to think you don't have to be like all of the...part of it was always like 'ah, I'm not going to be able to do this because I'm not that kind of person.' So it, there was negative influence but there actually came a lot of positive influence just like I realized that I didn't have to be that person. That I could walk away and be, be okay.

Later in the interview Trina was asked what she would hope for more of in addressing the issue of eating disorder prevention.

Um, I think a lot of it would have to do with...social aspects. Um, like, the getting out of yourself, helping other people, um, or even just getting more information out there. I feel

like people don't have the information. I feel like what has saved me is the information I know. Like, I know what happens to people who are anorexic, I know what happens if you don't eat healthy. And because of, because I have that knowledge...I can... kind of cope. I also think people don't understand the process of change. Like, dieting is a big thing. Like, they wanna lose pounds fast in a short amount of time. And...maybe people should just learn that slower is better, it stays off, you know what I mean? It's like the little decisions everyday, instead of the extreme. I think that's a big thing in our society is the extremes. There's not really over the, little changes. I noticed that a lot, like, I guess that's one thing that the mission taught me is that it's just the little changes, it doesn't happen overnight. Like, that was the big temptation, to come home and just lose it like in two weeks. But I had to tell myself, like, 'no, you have to, you have to do it slow, you have to be careful, you have to be safe about it.' And so, and it was hard because you want it off now, you want it, you to be what you want now.

Trina does not suspect that information will make the difficulty of the experience disappear but she does think it would help. Perhaps in a more expected vein, Heidi shared how her schooling has helped her combat unrealistic ideas about body image and unrealistic methods of eating or weight loss.

I am also a nursing major, I don't know if that has influenced me, but the classes I have taken here has given me a lot better perspective on the body than I used to have. And, but then at the same time, like, there's always, like, I feel like I am always battling that like, okay, I should be grateful and happy; or like there are days where I'm like frustrated like, with that, you know, dissatisfaction, like I wish I was different.

Later she adds,

Um...so usually its, I mean, I know it cause I kinda have this battle, I know, with myself, cause the immediate thought is I should like exercise because I think from a young age that I was always what I was kinda taught and lead to believe is that calories in, calories out and if you exercise that part of your body that's gonna, if I do biceps I'm gonna have nice arms if do squats I'm gonna have toned legs. But then they're classes here I've learned a lot more about what our body does with what we eat and, versus exercise and the combinations of it all. And so I kind of, like in my immediate response or thoughts when I like specifically if I'm like 'oh my butt is too big I need to run.' Then I'm thinking, then I tell myself 'wait, no, that won't just like get rid of it cause it, you know, takes a lot to kinda build your body. It takes a long time, and so, then I think 'oh then I need to change the how I eat,' but then I'm like 'well, I'm already eating good.' So then I just decide 'whatever' and then... I think consciously I probably do still exercise more and, cause it's just like that habit, I guess.

Heidi echoes Trina's idea when asked about what was protective for against considering or eating in disordered ways.

Um, like the first things that come to mind are, like, education and, um, just because learning about the disorders, kind of like learning about addictive drugs, you learn, like, 'yes, this is a possibility,' but you learn all about, all the consequences so it's kind of like you can consciously know 'I shouldn't do that.'

She reflects on when this information became important to her,

Yeah. So I've, like until, like I've never really thought that much about what I was eating or why I was eating it, what was good or bad for me just whatever I wanted to eat I ate until college and then I started getting an education and that stuff. That's also when I learned about eating disorders as well."

Perhaps, this information of what is "good or bad" for someone to eat could create some distress but knowing about, being warned about eating disorders seems to be the potential flip side.

Education on nutrition also seemed to be personally valid in Alyssa's experience. She was diagnosed with Diabetes as a child and has over time had to learn about the condition and how it affects blood sugar. She describes the learning she has gained in connecting that with her personal daily experience with food and her body image. She shared,

I feel like for the most part it's pretty good. Like, I like to have my ice cream but I also know that ice cream every day is not the best decision. It's like I'll eat really well and reward myself with some ice cream. And also, with my diabetes, um, that changed my family's diet completely like cutting out lots of sugar and lots of carbs and trying to eat much more healthy, um, like have a much more healthy lifestyle. And, just, and in doing that I think I've become a lot more aware of what I'm eating as well, because I needed this kind of sugar for me to feel right and there's a balance in measuring your blood glucose levels and I know that if I eat this kind of thing I'll be miserable for the rest of the day because I'll be too high to care about anything. And I feel like sometimes when my blood sugar is high I am self-conscious about my body because it makes me feel gross and when my blood sugar is high I'm not in the right mindset and I feel kind of pukey and I don't feel good about myself and I can focus more on my body when I not feeling as good. And when my blood sugar is really low it's kind of the opposite, it's like

‘give me anything! I’ll eat anything right now!’ Like, ‘give me as much food as you want. I’ll eat as many Oreos...’ cause kind of the thing when you’re staying balanced is you’re not eating lots of sugar and you’re not eating tons of carbs, um, to stay balanced it’s just more of a, I feel like it’s more of a food pyramid picture perfect plate of food kind of a thing kind of a thing. But when my blood sugar is low I can eat the kind of things I choose not to eat cause I don’t wanna be hanging out in the high blood sugars. I think that’s really influenced kind of how I feel about myself and how I feel about food...kind of a thing.

This intricate understanding of how her physiology affects her body and body image as well as her eating habits is impressive and could potentially benefit many individuals whether or not they struggle with Diabetes. Alyssa calls attention to not just the information but also the quality of the source. This next excerpt points out the importance of the nonverbal information being distributed by those who verbally are distributing health information. Consideration of this excerpt may suggest that more than just word distribution every exposure is experiential. Alyssa says,

Oh, that’s a tough one. Let me take a minute and think about it... .. I feel like most girls don’t want to have to care about how they look. I feel like the common thread is that everyone wants to be healthy and everybody wants to feel healthy. And that we look to adults as examples. Um, you know when I go in to see my doctor if they don’t look so good I tend to not trust what they are saying or be like ...I guess like in a sense seeing too thin of a doctor just cause how you see people is how you connect with their health and like I had a diabetic doctor who looked awful all of the time and he was never very helpful for me. Um, he would sit there and talk about what I should do as a little kid

and I just knew he wasn't doing those things and I didn't trust him and so I kind of fell off the deep end for that. But then having a doctor who lives by what he teaches kind of a thing you can feel that, you can sense about what they believe. I feel like if they great you like 'oh you kind of look not so healthy today...' like we read body image and body language so closely and looks are so important in how we judge someone. I think as long as they are living what they teach and that they're letting them know a lot of it can be just perceived differently.

Not all sources cited were as academic or medical. Libby introduces some new sources of information. Libby, like Trina, participated in beauty pageants.

Actually, I just remembered, I feel like I saw a link on Facebook about, um, a woman; she had taken before and after pictures. But the before pictures were pictures of when she was pageanting and swimsuit modeling and the after pictures were after had she kids and all that. And they were kinda controversial photos because they were like 'those aren't...' whatever. But, then she, she had written like a blog post or an article about how she had come to love her body in every shape that it's in. And I don't remember specifics about it or anything but I feel like that is more when I was like 'okay, the way that I'm thinking is not healthy and I will be happier if I don't feel this way. So, I need to start changing it.' I don't know if that changed again because I got stressed or if I just couldn't overcome the obstacles that I feel like I'm facing. Uh, yeah! At least for a ... at least for a couple weeks. It allowed me to realize, well, I already knew it was unhealthy, but, allowed me to recognize this thinking is unhealthy and I need to change it. And I felt like I was making some headway doing so.

In many respects the data shows that exposure to information, in it's many forms, is

protective because it offers alternatives, tools to combat self-criticism, pressures to conform or perform and urges to engage in harmful behaviors.

Zoey shares a fear inducing exposure to information about EDs that occurred in high school. Even though the exposure was more fear based it still had the desired effect of deterring her from disordered eating behaviors.

Yeah and ever since I had to watch that health video in ninth grade, oh my gosh. It was like this bulimic girl and she like threw up in jars. Have you seen it? I feel like it's a Utah thing. Yeah and she like put it, she like hid it in her closet and her mom found them and she had to, like, go to therapy and then she lied to her therapist. And then she went to college and she found this other girl that was like her and they would, like, every Friday they would eat a ton, you know, and then like throw it up in this lake and then her friend died. Like, she found her friend dead and stuff and it was just gross. And now, ahhh, eww, it's disgusting. I just don't know why you'd do that? It's just so unhealthy. I try to stay healthy that's why. Yeah and plus the acid it's like bad for your something, up here (points to throat). I don't know. Yeah, it's just...I don't wanna die, you know!

[*laughing*].

Adrianna had a similar exposure; however, she is the only participant that describes feeling inclined to engage in disordered eating after the exposure.

Um yeah, I have been tempted to try them...like throwing up. Actually, it was after I read a book about a girl's horrible experience with it and I wanted to try it. It was when I was in high school. Well, it was written so that girls... It was like a Jack Waylan book and I remember thinking that maybe I would... I wouldn't get to the point where it was out of

control...that I would feel in control and I would know what to do then. But I never actually went through with it, I just thought about it sometimes.

Despite her intrigue to try “it” she still did not actually do so.

Another exposure that focuses on consequences of unhealthy weight loss means comes from Mary. Mary has a brother who struggled with disordered eating. It turns out he is not the only one in the family with some first hand experience. Mary shares,

My mom, in high school, when my mom was in high school her mom bought her diet pills and she would have an apple and a diet pill everyday for lunch. So my mom always made sure to tell us what the diet pills did to mess up your body. I don't think she still deals with it but like the fact that her mom bought her diet pills really made her feel insecure. And then she saw... she never really told us exactly the effects but enough to tell us to never use them.

The support demonstrated in this example is important and weighty yet there is still value in the information and testimonial accompanying it.

Considering what might be done to help other women who are concerned about their body shape or considering disordered eating behaviors, she hypothesized, “I don't know, the thing that really sticks out is awareness of the effects of eating disorders and stuff...before they started, at least I guess that's what always stop me because of my brother and my mom.”

What if they have already attempted such behavior? Gina offers some insight into her experience. Gina disclosed that she engaged in disordered eating habits in high school including bingeing and vomiting. At that same time she considered the experience of a friend who had previously engaged in similar behaviors.

Um, well with her situation, she was very, like, she was like ‘I need to always be skinny,’ and this kind of deal. And so, she would, you know, she would go days without eating. And, you know, when she did she would either throw up or like she would go for like a five mile run just to... I know, like, with her it’s just like, if she wasn’t, and she would like track her weight, like, all the time and so. And she thought that, that was, like, healthy living. And so, like, she actually wanted, you know, to be like a fitness coach and then she’s like, ‘after I realized what I was doing to myself I knew that I wouldn’t be able to teach anyone because I was destroying my own body... um she, she’s like ‘I feel like I need to tell you this because you’re a good friend’ and so she just had this feeling of like telling me and I was just like, ‘wow that’s,’ you know, ‘powerful,’ type deal, ‘I’m sorry that you had to deal with this’ but then, like, it didn’t kind of, like, dawn on me that, like, there’s probably a reason why she, you know...that, that, why she had the feeling to tell me and so that’s when I, like, started taking into consideration, like, ‘this isn’t what I...I don’t wanna end up like that.’

Avoidance

Interestingly enough other participants discussed this method with mirrors as well, such as Alyssa. She said,

So I think it’s an overarching theme and usually when I, I used to always say when I looked in the mirror ‘well, this is as good as it’s gonna get’ and then I’d leave. Like, I hate mirrors, I avoid them like nobody’s business. My sister has like seven in her room because I will not have one, like, I do not like them, but, I still, like, I think as I’ve grown up a little bit more it’s more of a... I can look at myself and go ‘okay, you look, you look good today, you look good. That’s good.’ And then go on with my daily routine and I

don't, I, I usually don't dwell on it, I just whisk it away. I just kind of drop it out of my mind.

This avoidance did not end with mirrors for Alyssa, it also included shopping for clothes, especially trying on clothes. She shares,

Avoid the shopping. Mhmm! *[laughing]*. I don't like it. *[laughing]*. Um, like, I usually go to the D.I. and I'll find something that I think is cute and I never look at sizes that's like one of the things, I, I know it's too small. I know the smalls I can avoid but other than that I don't look at the number or the tag I'm just 'this looks cute I'm going to go try it on and then I just have a whole ton at the same time so that I know at least one in that bunch is going to work. And then I try them all on at the same time. And I try not to look at the mirror too much. I'll just try to be like 'these feel good.' But I don't like looking in the mirror. I'll look at the mirror and glance 'does this look good to someone else?' But usually I'm must like, 'does this feel good to me? Great.' I don't like to look at the mirror. *[laughing]*.

To combat self-criticism and comparison Gina describes her approach,

I think I just, like, I just kinda try to get through them type deal; where it's just like, it's like I know that, you know, it is that way, and so it's just like, like Imma just try to like get through them or try to, you know in a way change, you know, like my mindset to focus on something else that you know I don't have to, you know like do that... you know like even if its like playing music just something, you know, to get my mindset off of it. And so...sometimes it works and sometimes it doesn't...Intermittently just, you know, try to distract myself or like even try to like push them aside sometimes. Like, you know, sometimes I'll have the, you know, the thought and then I'm like 'just push it

aside!” So I’ll try to be like overly happy about, you know, stuff. Like I’ll go be with family and I’ll just be like trying to be as happy as I can be, just to like put it aside.

Jane described her avoidance, which comes in the form of distraction and diverting her attentions. She even points out a way off addressing her tendency to munch when she is bored, suggesting that if she could just keep busy not only would her thought cease to be distressing but her behavior would change as well. She says,

A lot of the time I just focus on something else like ‘Oh! I have to go do homework now!’ [*laughing*] You know, and, you know, just don’t think about it...I just try to ignore it, focus on other things... I just kind of try to get distracted with other things. Um, do something else instead. I need to work on not eating when I’m bored cause that’s something I do a lot. I’m like “I don’t know what to do, I guess I’m hungry.’ [*laughing*] you know. Yeah but, um, just like I said, distract myself, find something else to do.

Penny opened up about how at one point in her life she was focused on shifting her coping strategies from more harmful methods to the safer option of plain distraction. She explained,

Well, I used to cut a lot, so that really did not help with the body image...Because then I have lovely scars all over the place and having people ask questions about that it just like a reminder of that. So, that is, was what I used to do with that negative energy. But I’ve been trying to channel that more into using it elsewhere. I burn it off with other stuff like playing my instrument or homework [*laughing*].

While the shift is preferable, it may not be a functioning long-term solution. Penny divulges how the avoidance might actually be functioning for her,

...Just ignoring it and just like pushing it aside and like 'I'll worry about this another time.' Sort of like a procrastination, sort of thing, I guess that's what it feels like... So it's more like if I like worry about you later then I don't have to worry about you right now because I think it's stressful to have a... so I just kind of push that under the rug until later. And then later comes and then I'm like I don't wanna deal with you either so...

Vivian expressed how she feels she is in a similar situation.

... Not really sure I think I just deal with it by criticizing myself all the time. I, I guess it's not the most healthy way. If I was healthier I would probably have lost some weight and been better but it seems like I deal with it by maybe a passive resistance. To ignore it... although there is still always a voice in my head telling me that."

She indicated that when she dislikes the way she has eaten she copes with the guilt by attempting to distract or make promises about the future.

Mmm... I usually distract myself or I say 'I need to exercise but I should probably do homework first' or something. I always promise myself that I'll, that next time I'll get myself under control... If I distract myself quickly it goes away sooner but, um, if I don't it will nag me for a while.

Food Relationship

Consider Libby who at one point in her interview acted confused about women avoiding bread because she loves it so much. She expressed,

[*laughing*] But I love food! [*laughing*] I love food. I love it. I love going out to eat. I love, my husband makes really great food. He's a really great cook. So, I, I love it. We've, we're, we've been staying at my in-laws house for the last few days so we've been eating really good there and just... [*laughing*] I don't know, we love it. And I've always been the

kind of girl who was like, we go to get all-you-can-eat french toast and my friends can't even finish their plate and I'm on my second. So, I have no problem eating. I love it. Um, it tastes good man!

When Jane was asked to describe her relationship with food she energetically exclaimed, "I LOVE food!" And like, Libby identified activities associated with food that she also likes.

Yeah. Um, baking is, like, one of the, those things that when I'm really stressed out, I just go and I make something. It's calming for me, I don't know...I've been cooking for a long time, like, I was probably ten or eleven when I started. Yeah, so cooking for me is, it's a good thing. I probably enjoy it a little too much... I really like to eat. Um, you know, we, like we talked about, I know I don't like how I look but at the same time I'm like 'I like food a lot so...' Sometimes it's a struggle with which one wins.

Zoey first brought up her love of food while talking about her mother who eats healthy and exercises but never loses weight. She said, " Maybe she just likes food too much like me. [*laughing*]. No seriously food is so good." She went on to further illustrate the nuances of her love of food,

I just think that food is, like, so cool because it, like, it shows different cultures too, I think. I just love Asian food and Indian food and American food. I love burgers and fries, you know. And, I don't know, I just, if I could eat more I would... not more but, like, if I could eat whatever I wanted I would go to like, I don't know, Mc Donald's more because I, like, love their fries but they're really bad for you. But like when I go places, like, even, like, Chick-fil-a, I make sure I, like, get, like, a small fry instead of a bigger one. Um, yeah, I like food. I think it's fun to make it and everyone likes food!

Julietta took her affinity for food to a new level, drawing a connection to her happiness.

She describes a pattern she began to notice that is unique. This idea may sound familiar since it was partially covered in the section about Control.

Because I think that I have an option of being happy or being sad and I like food... I think about food and then I'm better...Cause when, cause when I was sad it's when I was skinny but when I was happy I was fat so that's why I like to be fat because then I think that I'm happy. Yeah [*laughing*] it's weird. Cause one time, sad and I don't want to do anything. I don't want to laugh or eat.

She indicated that because of this she lost weight. In contrast, she described her experience when happy, “I will choose some fries and some of that, and some of that [*pointing to imaginary items*]...” She went on to describe a context in which this pattern has been most observable. “When I break up with my boyfriends I'm skinny....or when I have a boyfriend or started dating I'm fat. [*laughing*]. It's weird because I want to be skinny but I don't want to be sad.” Julietta disclosed that she had previously been engaged. When the engagement ended she felt depressed. In this excerpt she shares how the depression following her disengagement might be affecting her current experience,

Mmm... when, when he broke up with me I got depressed. When I'm depressed I lose weight, but I didn't want it to be sick, so I need to eat a lot. And I think that right now I'm eating a lot because of that kind of idea, ‘I need to keep eating, I need to keep eating so that I don't get sick, because if I get sick then I will not success and if I will not success then I was [*sic*] be depressed...’ Yeah because I didn't wanted to be sad, I wanted to happy so I needed to do the things that make me happy. And I realize that when I am chubby I'm happy or when I'm happy I'm chubby. So if I wanted to be happy maybe I need to eat a lot, so, I needed to be happy.