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GENDER AND THE BODY: EXPLORING THE RELATIONSHIP BETWEEN
EATING DISORDERS AND SEXUAL ACTIVITY

By

Emma Foong

A Thesis
Submitted to the Faculty of Graduate Studies
through the Faculty of Education
in Partial Fulfillment of the Requirements for
the Degree of Master of Education
at the University of Windsor

Windsor, Ontario, Canada

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Gender and the Body: Exploring the Relationship Between Eating Disorders and Sexual Activity

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June 11, 2019

DECLARATION OF ORIGINALITY

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ABSTRACT

Drawing from the insights provided by feminist theory, this study explored the relationship between eating disorders, body image, and sexual activity. The desire behind most individuals with eating disorders is to achieve a “perfect body” (Barth & Starkman, 2016). Key to this inquiry was to find out whether or not a positive body image led to an increase of sexual activity, and if a negative body image led to a decrease of sexual activity. Using a qualitative methodology, this study employed semi-structured interviews, participants expressed that on days they feel confident about their bodies, they were more likely to engage in sexual activity, and days they feel “fat” or bloated, they were less likely to engage in sexual activity. Results also found that gender norms, like having the “perfect body” were the cause of some eating disorders or unhealthy eating behaviours, while other causes such as sexual violence were revealed. Future researchers, clinicians, and teachers in the sexual health field can continue to educate individuals with eating disorders or body image issues, teaching them to think more carefully and thoughtfully around how gender and gender relations shapes attitudes toward sexual health.

DEDICATION

I dedicate this thesis to my dad.

ACKNOWLEDGEMENTS

I would first like to thank my advisor Dr. Christopher Greig for believing in me. I also want to thank my committee members, Dr. Christine Vanderkooy and Dr. Sarah Woodruff who were supportive and helpful throughout my whole thesis. Thank you for letting me “de-stress” with you.

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CHAPTER 1: INTRODUCTION

Problem Statement

Individuals under the age of 24 represent 25% of the sexually active population in North America (Widman, Choukas-Bradley, & Helms, 2014). Eating disorders (EDs) typically develop between adolescence and young adulthood (Le Grange, 2014). For individuals under the age of 20, the prevalence rates for EDs are 13% (Stice, Rhode, Durant, Shaw, & Wade, 2013) and EDs are a significant health problem for youth and adolescence. EDs wreak havoc on individuals' overall well-being, including their physical health, their ability to "function, study and work" (Thompson, 2017, p. 9). It goes without saying that the issue also impacts families and friends. There are few studies in the past that explore the relationship between EDs and sexual activity. Additionally, those past studies have been limited in that they have mainly focused on how EDs affect relationships between the individual with an ED and their partner (Newton, Boblin, Brown, & Ciliska, 2006; Pinheiro et al., 2010; Warin, 2005). Though these studies have touched on intimacy and sexual activity, no recent study has explored the relationship between EDs and sexual activity. This study attempted to address this gap in the research literature.

Purpose of the Study

The purpose of this study was to explore how gender and gender relations produce EDs. I also wanted to explore individuals with EDs and how these disorders might shape their sexual activity. This study was done to fill the gap in research literature about the relationship between EDs in sexual activity, along with a view to educate and further the field of EDs.

Definition of Terms

In order to help the reader better understand the nature of the study, I now provide definition of terms. Adolescence and emerging adulthood (the phrase “young adulthood” is used interchangeably with “emerging adulthood” for the purpose of this study) are broken down in three main categories: early adolescence (ages 10-14), late adolescence (ages 15-18), and emerging adulthood (ages 19-25) (Arnett, 2013). The beginning of adolescence typically is marked with the start of puberty (Arnett, 2013). The end of emerging adulthood (ages 25 plus) is complex to define due to cultural variations like getting married, or providing for a family financially, but for the purposes of this study it seems reasonable to accept the age as 25 plus (Arnett, 2013). Many cultures believe that marriage is the marker of adulthood because of adult privileges and responsibilities (Arnett, 2013).

EDs are best understood as being “characterized with a persistent disturbance of eating or eating-related behaviour that results in the altered consumption or absorption of food” (American Psychiatric Association, p. 329). EDs also impair physical and psychosocial functioning (American Psychiatric Association, 2013; Thompson, 2017). EDs are a diagnosable mental disorder and the full diagnostic criteria can be found in the DSM-5 (Diagnostic Statistics Manual 5th edition) (American Psychiatric Association, 2013). For the context of this study, EDs and all their classifications are grouped together as a whole.

For the purpose of this study the phrases “unhealthy eating behaviours” and disordered “eating behaviours” will be used interchangeably. Unhealthy eating behaviours are characterized by restrictive food intake, dieting, purging, elimination of

food, and often accompanied with excessive exercise, which can lead to an ED (Soo, Shariff, & Taib, 2008). These behaviours may lead to unbalanced nutrition intake, which can slow development and metabolism (Soo et al., 2008).

Both body image and self-esteem are interconnected (Soo et al., 2008). Self-esteem is an indicator of mental health, well-being, and quality of life, focusing on specific aspects of self (Pila, Sabisto, Brunet, Castonguay, & O'Loughlin, 2015). It is found that body image has a great influence in adolescents on their self-esteem (Polce-Lynch, Myers, Kilmartin, Forssmann-Falck, & Kliewer, 1998). When body shame and guilt about weight status occurs, these emotions affect self-esteem often having psychological outcomes (Pila et al., 2015). Pila, Sabisto, Brunet, Castonguay, and O'Loughlin (2015) theorized that weight status directly influences self-esteem, but can also first influence body shame and guilt, then having affects on self-esteem.

Sexual activity can be both coital and non-coital. Non-coital sexual activities include masturbation, mutual masturbation, oral sex, and anal sex (Lindberg, Jones, & Santelli, 2008). Coital sexual activities include vaginal intercourse (Lindberg et al., 2008).

Sexual anxiety is the feelings and experiences of discomfort, nervousness, fearfulness, and tension towards sexual acts, either non-coital or coital (Brassard, Dupuy, Bergeron, & Shaver, 2015). High sexual anxiety can lead to lower levels of sexual functioning and satisfaction (Brassard et al., 2015).

These definitions will all be elaborated on in the literature review.

Locating Myself in the Research

I am a middle-class woman of Chinese descent, who has, in the past, experienced an ED. I had an ED for 9 years of my life. This experience has motivated and inspired me to explore this topic in a scholarly way through a research study. I also minored in sexuality in my undergraduate degree, which helped spark my curiosity and interest in the topic. Furthermore, I hope this study has broader and more useful implications insofar as I am also very motivated to help people recovery from their EDs.

Research Question

The central research question that was addressed in this study was: How does an ED shape the sexual activity of individuals? The guiding questions that shaped the proposed study were:

- a). How does sexual intimacy shape individual's identities with an ED?
- b). How does an individuals' (with an ED) sexual activity change, if/when they believe they are near their "target" or "perfect" weight?

Theoretical Framework

This study adopted a feminist theory framework. Feminist theory positions gender relations as the categorical center of inquiry and uses gender as a lens through which to focus on social issues (e.g., EDs). When research is grounded in a set of theoretical traditions that privilege women's issues, voices, and lived experiences, it is considered feminist. A theoretical lens informed by feminist theories also views gender as a social, historical, and cultural construct (Butler, 1990; Connell, 1995). For example, from a liberal feminism perspective, this oppression exists because of the way in which men and women are socialized, which supports patriarchy and keeps men as a group in

positions of power (Friedan, 1963). Understood against the backdrop of intersectionality, socialization encourages various acts of gender and perpetuates systems of oppression as well as systems of privilege. More specifically, femininities are socially constructed “configurations of gender practice” created through historical and social processes situated in patriarchal relations of power, rather than an essentialist product of biology (Connell, 1995). By focusing on knowledge acquisition through the inclusion of women and these social constructs, the specificity of women’s lived experiences has become a central component of feminist theoretical research and this literature review (Hesse-Biber, 2013). A feminist perspective provides space for the exploration of broader questions of social justice while simultaneously addressing multiple forms of structural inequity (i.e., gender, race, able-ism, ethnicity, class, and sexuality). Research informed by feminist theories fosters empowerment, liberation, and emancipation for women and other marginalized groups, and is consistent with the broader aims of gender justice (Brooks & Hesse-Biber, 2007). Feminist theories offer insights into the social construction of gender and the possible complex relationship between EDs and sexual activity, in particular.

A feminist lens pertaining to gender also acknowledges the differences of race, ethnicity, social class, sexual preference, religion, and any other intersection with gender, which create and perpetuate “essentialist mindsets” (Martino, 2008). In this sense, queer theory can also be applied to this notion, as it also challenges the idea that gender is part of the essential self (see for example, Butler, 1990; Fryer, 2010; Halberstam, 2005). Contemporary feminist research strives to give voice to women’s lived experiences that have been traditionally ignored and silenced. This study will use semi-structured

interviews to explore women's experiences, along with all of their thoughts and feelings. In a feminist interview, a safe space is created, giving individuals the freedom to narrate their story, letting them focus on themes throughout their story they believe to be important and relevant. A feminist framework gives women in a patriarchal society a chance to speak their truths, while researchers can analyze their reality (Hekman, 1997).

Feminist theory is providing truth through narrative and how researchers and a patriarchal society justify those truths. It is done to show different life experiences and differences, giving power to the individual to tell their own story. This framework provides a platform for women to explore their experiences and claims, especially to a societal group that has been oppressed for so many years. Using a feminist framework is very empowering because it allows the opportunity for everyday stories to be heard. It enables many to connect with these stories and allows researchers to analyze everyday lifestyles through a social institution (Hekman, 1997). Since women fall under an oppressed group, a woman's standpoint is achieved and not given, as with men (Rice, 2003). So a woman's story may not often be believed or taken to be true material. Feminist theory's foundation is through personal experience, but those who reflect on those experiences are the ones who construct it. My proposed research, then, strives to utilize this philosophy and epistemology by placing women at the center of the research process and allowing their concrete experiences to provide the starting point from which to build knowledge. By doing so, this research may assist in achieving a much more authentic understanding of the complex relationship between EDs and sexual activity.

The feminist framework must also consider the different methods it uses: inclusive, relevant, reflexive, transparent, and accountable (Rice, 2003). This framework

also gives the researcher power in the research study. The study must be inclusive to the differences found amongst different women. In this particular study, all participants must be either diagnosed with an ED or have had unhealthy eating behaviours, making this study inclusive to those who have not been formally diagnosed but still believe they have a problem. This study will remain relevant by asking pre-determined questions to ask to make sure the researcher or participant does not stray off topic. It will also be relevant because previous studies have not touched on this area of EDs focusing on participants' stories. Using a feminist framework will show transparency through the use of narrative story telling. Through this framework the participant becomes transparent by sharing their true story, their emotions and thought process during their experiences. Through thematic analysis the researcher will show reflexivity in finding themes and picking out which of these were most important to each participant. This study will reflect on the participants' transparency in the discussion section of this paper. The Research Ethics Board at the University of Windsor will keep this study accountable by making sure the participants are treated with the upmost integrity, ensuring their safety and protection throughout the whole study's process. Accountability will also be maintained between the researcher and participant through written contracts completed before the interview process begins.

Some feminist and social researchers turn confusing, everyday situations into categories that show political arrangements (Harding & Norberg, 2005). The social sciences have the ability to exercise power, which includes power differences between men and women (Harding & Norberg, 2005). More specifically, feminist researchers strive to have practical implications to improve women's lives. Feminist research brings

oppressed and marginalized groups together to produce knowledge that the researchers desire (Harding & Norberg, 2005).

Feminist researchers strive to minimize or eliminate the power differences between the researchers and the participants. Power differences can lead to issues for the researchers and the study. According to Harding and Norberg (2005), there are three ways that these issues can arise in feminist research. First, the researcher and the participants bring different types of social power into the research. Types of social power include: race, class, gender, and ethnicity. Second, the researchers define the social power differences within the research. The researcher defines what the problem, or problematic situations are, the hypotheses, and who is the focus of the research. The researchers also have to determine what questions are asked during the research process and how data is collected is analyzed. Third, the researchers present their research, creating and exercising the power differences between the researchers and the participants. Though researchers try to minimize the power differences, it is nearly impossible to do (Harding & Norberg, 2005).

Researchers need to consider feminist theory and a feminist standpoint. Researchers now need to make the shift of listening to women's stories whose opinions were once oppressed (Heckman, 1997). Also, employing a feminist theory for the framework and analysis of this study will deepen the respect for the participants' experiences and differences, along with educating the participants that they can narrate and choose their own story (Heckman, 1997). A feminist framework allows the researchers to dig deeper and find out more about concealed social relations. The framework also allows females and the participants to express their experiences and

emotions during a certain time and place within a set of social relations (Heckman, 1997). Researchers using this framework need to understand the differences between women experiences, and men experiences, remembering not to discount women's experiences or differences just because their voices and accuracy of the conception of reality have been often oppressed in the past (Heckman, 1997). Men are often believed for their truth claims and their reality, while women trying to receive that same standpoint need to achieve it as it is not merely given to them (Heckman, 1997). Dorothy Smith was a front-runner in this movement. Smith argued for the experiences of women to be made visible, as their lives are often absent, invisible, or missing from the main narrative of sociology. Because of masculinity, a women's experience is "always situated, relational, and engaged" (Heckman, 1997). Smith wanted to reorganize sociology so future research would be based on all lived, human experiences (Heckman, 1997).

Gender and gender relations have powerfully shaped experiences of women and girls. Since the early 1900s, women as young as 17 years old were getting married and their goal was to be the perfect housewife (Friedan, 1963). "Their only dream was to be perfect wives and mothers; their highest ambition to have five children and a beautiful house, their only fight to get and keep their husbands" (Friedan, 1963, p. 5). In light of the restrictive nature of patriarchal relations, housewives could only have two problems: their marriage, or themselves. Friedan (1963) used the feminist theory to interview housewives in the 1950s and 60s on their feelings about not having fulfillment in their home and family. She interviewed women across America and found that many women share this problem. Here is Betty Friedan describing the issue: "And yet the women I have talked to, who are finally listening to that inner voice, seem in some incredible way

to be groping through to a truth that has defied the experts” (Friedan, 1963). Friedan gave frustrated and disgruntled housewives a platform to speak their truth and have someone who cares to listen to them recognizing their problem and wanting to help. Though Friedan’s work is getting dated, feminists have shown over time that there are gendered men and women, not just generic men (Harding, 1986). Feminist researchers fear and risk replicating oppressing the women whose voice and lived experiences have not been heard yet, just how patriarchal society has been doing to women for countless years (Harding, 1986).

Through the use of feminist theory in this study, each participant in each individual interview was given the opportunity to voice their lived experiences so their story could be heard. Mental illness and being sexually inadequate are topics that are not often talked about, and are more likely to be shamed in Western culture and society. This is why it was so important to ensure that each participants’ story was heard to know the physical and emotional struggle both men and women go through with EDs, disordered eating, and a negative body image. Using a feminist framework is useful for this study because it is respectful to all who participate, creates a safe place to share and be heard, and each participant has the opportunity to recount their experiences regarding the study’s topic. Since this study is relying each participant’s story it is important that they feel safe and protected to get their full story, including their thoughts and emotions, to make each story truthful. It is important to the researcher that the participant feels they are heard and appreciated for their story and their time, and the feminist framework allows for this to happen.

Scope/Limitations of the Study

In order to conduct this study as a graduate student, reasonable measures were taken. First, due to a limited amount of resources and time, participants from only one Ontario city were recruited. My scope, then, was limited to the experiences of a small group of individuals, located in a mid-size city in Ontario, grounded in the historical context of 2018. In light of the scope of the study, future researchers are encouraged to gather data from multiple and diverse regions across Canada. This would be helpful in order or to glean a deeper understanding and a more well-rounded picture of the relationship between ED and sexual activity, that perhaps takes into consideration regions and geographical contexts.

This study was also looking for a specific type of individual, limiting the number of possible participants. Individuals had to have an ED, engaged in unhealthy eating behaviours, or have an opinion on their body image. Speaking about EDs, sexual activity, and body image are sensitive topics, contributing to a possible limiting factor on who was to open up about this topic. Not only that, but the topic of sexuality is also a sensitive subject. So, it is likely that opening up about this topic would also be a limiting factor to this study. Since the study requires the openness to speak about two sensitive topics, this may also have been a limiting factor for participant recruitment.

With my past history with an ED and still being in remission, knowingly or not it might have shaped how I understood and interpreted the data. Knowingly or not I might have had biases towards eating disorders, sexual activity, and body image because of my past experiences. I believe I stayed neutral with the participants, not mentioning my history to them to influence or lessen their own experiences and story.

CHAPTER 2: REVIEW OF THE LITERATURE

Introduction

The central topics of this research are: EDs, body image and self-esteem, sexual activity, and sexual anxiety. A review of the literature related to these topics is essential to understand and locate the proposed research. The review of the literature will begin with a background of EDs, prevalence, what EDs are, and research regarding EDs. The next section will discuss body image and self-esteem both in the context of EDs and in healthy adolescents and adults. The next section will discuss what sexual activity looks like in adolescents and young adults. Sexual activity includes the types of sexual acts that a particular age group engages in, the prevalence, and how it might affect them. Finally, the last section will look at the definition of sexual anxiety, how sexual anxiety occurs, and how it could affect sexual activity.

Eating Disorders

The Diagnostic Statistics Manual 5th edition (2013) (DSM-5) states, “Feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behaviour that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning.” Over the past few decades the epidemiology of EDs have changed. Previously, EDs have been seen as a disease for young white adolescent females (“People of Color and Eating Disorders,” 2018). But a growing body of research has found increased rates in ethnic and racial minorities, and in men and boys (Golden et al., 2015; Thompson, 2017). There are multiple categories of EDs (i.e., Otherwise Specified Feeding and Eating Disorders and

Pica), but the more commonly known disorders are anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED), with their onsets found in adolescence and young adulthood (age 16-24 years). EDs are typically developed during adolescence (Golden et al., 2015), however, some studies have found that earlier onsets are becoming more common. Pinhas et al., (2017), for example, reported the onset occurred between the ages of 10-20 years among a Canadian study. Pinhas et al., (2017) even reported children developing EDs as early as the age of 5 years old. There is a higher prevalence of BED in adults compared to AN and BN (Hudson, 2007). There are different diagnostic criteria for each disorder under the category of EDs under the DSM-5. Some criterion includes excessive exercise, bingeing, restricting, fasting, and fluctuation of weight (Golden et al., 2015). According to the National Eating Disorder Association (2018), EDs have the highest mortality rate for any mental illness (“Statistics & Research on Eating Disorders,” 2018).

AN is an eating disorder that impacts primarily youth (Golden et al., 2015). AN is an ED which requires excessive weight loss by an individual, or lack of appropriate weight gain in young children. AN is most commonly developed in adolescence, but can also be diagnosed in adulthood. AN does not mean the individual is always underweight. Larger-bodied individuals can also be diagnosed with AN, but it is harder to diagnose because of cultural prejudice (Golden et al., 2015). There are 3 criterion that must be met to be diagnosed with AN under the DSM-5:

1. Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory and physical health.
2. Intense fear of gaining weight or becoming fat, even though underweight.

3. 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 denial of the seriousness of the current low body weight (American Psychological Association, 2013).

Though EDs are often seen as a female dominated disorder, 25% of those who suffer from AN are men and boys. But since men and boys are often diagnosed later and eating disorders have historically been gendered female, many in the public assume that men and boys do not have EDs (National Eating Disorders Association, 2016; Thompson, 2017; Raevuori et al., 2009).

BN is distinguished by cycles of bingeing on food, followed by self-induced vomiting or other techniques used to eliminate food (i.e., laxatives) to reverse the effects of the binge eating (National Eating Disorders Association, 2016). A binge would consist of consuming large amounts of food sometimes 2-3 times more than an average size meal. Binges are followed by a purge session, where the individual would try to eliminate the food from their body through self-induced vomiting. According to the National Eating Disorder Association (2016), individuals with BN feel out of control during a binge cycle, and have self-esteem and body image issues. In the DSM-5 there are five criteria that must be met to be diagnosed with BN:

1. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following: Eating, in a discrete period of time (i.e., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances. A sense of lack of control over eating during the episode (e.g., feeling that one cannot stop eating or control what or how much one is eating).

2. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise.
3. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for three months.
4. Self-evaluation is unduly influenced by body shape and weight.
5. The disturbance does not occur exclusively during episodes of AN (American Psychological Association, 2013). In the general population only 1% of women and 0.1% of men meet the criteria of BN (National Eating Disorders Association, 2016). Research has shown that the prevalence of BN has not changed over time (1980-present day) (National Eating Disorders Association, 2016).

BED is the newest ED added to the DSM-5, it was first listed under a subtype of ED first named EDNOS (Eating Disorders Not Otherwise Specified), which is now referred to OSFED (Otherwise Specified Feeding or Eating Disorders). BED and BN are similar with their binge eating, but BED does not include purging or the reversal of the effects from the binge period. The DSM-5 has five diagnostic criteria for BED:

1. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following: eating, in a discrete period of time (e.g., within any 2-hour period, an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

2. The binge eating episodes are associated with three (or more) of the following: eating much more rapidly than normal, eating until feeling uncomfortably full, eating large amounts of food when not feeling physically hungry, eating alone because of feeling embarrassed by how much one is eating, and feeling disgusted with oneself, depressed or very guilty afterward.
3. Marked distress regarding binge eating is present.
4. The binge eating occurs, on average, at least once a week for three months.
5. The binge eating is not associated with the recurrent use of inappropriate compensatory behaviours (e.g., purging) as in BN and does not occur exclusively during the course of BN or AN (American Psychological Association, 2013).

BED is more commonly developed in late adolescence and early adulthood, and 40% of individuals diagnosed with BED are male (American Psychological Association, 2013).

In attempt to lose weight, adolescents may develop an ED (Golden, Schneider, & Wood, 2016). Their study found that health professionals should focus on a healthy lifestyle, and not just examining weight. This study also found that adolescents might not understand what healthy eating actually is and might mistake it as fad diets or unhealthy eating behaviours. Obesity is prevalent in adolescents and is another factor that might lead to an ED (Golden et al., 2016). Adolescents who are obese might try fad diets, skipping meals, increased physical activity, and laxatives to try to lose weight. It was found that family and friends first praise the initial weight loss by the adolescent. But if the adolescent continues this unhealthy lifestyle it can lead to a distorted view of their own body image, and possibly an ED.

Both the Fisher et al. (1995) and Le Grange et al. (2014) studies found that EDs are most likely to develop during adolescence and young adulthood. Walker's (2005) study found that adolescents and young adults have a lot of stress and pressure on them, and sometimes they put it on themselves. Walker's (2005) study reiterates the findings found in Troop, Holbrey, and Treasure's (1998) study that stress could develop into an ED.

Since EDs are multifaceted illness being both a physical and mental, teams of healthcare professionals are vital in the recovery process. There are lots of medical complications that companion an ED. Some medical complications include hypothermia, electrolyte disturbances, amenorrhea, and much more (Golden et al., 2016). So psychologists, social workers, dietitians, doctors, nurses, and pharmacists are all needed for a healthy recovery.

Body Image and Self-Esteem

Body dissatisfaction is a known risk factor for EDs (Golden et al., 2016). Also, with body dissatisfaction, unhealthier eating behaviours and dieting can also be found. Body image and self-esteem are very interconnected (Polce-Lynch et al., 1998). Polce-Lynch et al. (1998) studied body image in their qualitative study on boys and girls between the grades of 5-12. Questions about body image for were asked, and the responses varied between genders. This study found that the most common answers to how body image affects the individual were: having a positive effect on their body image, having a negative effect on their body image, having no effect, or a neutral effect on their body, and having somewhat of an effect on their body image. Grade 8 and 12 students were more likely to have a negative body image, compared to the boy participants who

said that there was no effect (Polce-Lynch et al., 1998). But more participants in Grade 12 were more likely to have a negative body image. Adolescent girls in Grade 8 and 12 were more likely to have a negative body image compared to their adolescent male peers (Polce-Lynch et al., 1998; Dorak, 2011). Though both males and females were affected by cultural norms and judge their own physical features, females are more likely to let this judgment affect their self-esteem (Polce-Lynch et al., 1998). Dorak (2011) also found that adolescent girls with a positive self-esteem also had a positive body image. A more positive self-esteem and body image were more prevalent in athletic girls, than non-athletic girls.

Adolescence is the time when the body begins to change because of puberty (Arnett, 2013). Because of that either a positive or negative body image is formed (though opinions of body image can be formed before adolescence) which influences their weight and self-esteem (Voelker, Reel, & Greenleaf, 2015). A negative body image can lead to disordered eating and exercise, and possibly turning into an ED. As Voelker, Reel, and Greenleaf (2015) defined it, “Body image is a multidimensional construct encompassing how we perceive, think, feel, and act toward our bodies...” (p. 149). Negative body image can also develop into an ED during the time of puberty in adolescence. Adolescents under the age of 19 have a more negative body image because of the images media portrays showing thin women as the most desired. Media also shows dieting, exercise, beauty trends, and much more through television (reality television shows), movies, magazines, and the Internet (Voelker et al., 2015) that promote and often celebrate a culture of ‘thinness’.

Cultural factors and the adolescents' environment also need to be taken into account. Teasing from family members about weight is related to a negative body image (Golden et al., 2016). Also diet talk, fat talk, and family members who have a negative body image can also accelerate a negative body image. Friends and peers also influence cultural factors. Friends and peers may compare appearances, criticize each other and others, judge others, and feed into social conflict and exclusion (Voelker et al., 2015). Another strong cultural factor is a romantic relationship. Adolescent girls believe that being thin is what attracts boys and, therefore, their body image is closely tied to their understanding of what constitutes a 'healthy' romantic relationship (Voelker et al., 2015). Adolescent boys believe that being thin is an attractive quality in girls (Voelker et al., 2015). All of these factors can contribute to a negative body image for girls.

Adolescent girls who are going through puberty may experience weight gain such as in the widening of the hips (Voelker et al., 2015) but with the cultural factors showing girls that thin is better, their drive for thinness may increase. Adolescent girls may have a stronger drive for thinness especially when they compare their changing bodies to media's ideals (Voelker et al., 2015). Adolescent boys are no exception for being susceptible having a negative body image. The media portrays photos of men being tall and muscular. Adolescent boys who mature later may have a more negative body image compared to adolescent boys who matured earlier (Voelker et al., 2015). Weight status of adolescents is strongly connected to body image (Voelker et al., 2015). An adolescent with a higher BMI is more likely to have a negative body image. Also, internalizing unrealistic body ideals leads to a negative body image and strengthens the relationship between the two. Adolescents with higher BMI's are more likely to be bullied, pressured,

have their weight discussed, and be compared, which also can further lower their negative body image.

Ferreira, Pinto-Gouveia, and Duarte (2013) found that the participants with an ED reported higher scores of body dissatisfaction compared to the participants who did not have an ED. Harsh critical attitudes towards self positively correlated with participants with body image dysfunctional behaviours (Ferreira, Pinto-Gouveia, & Duarte, 2013). The study also found that body dissatisfaction is directly correlated with a drive for thinness.

Huang, Norman, Zabinski, Calfas, and Patrick (2007) found in their study that girls were more likely to report a lower self-esteem compared to boys. With early health intervention informing adolescents about healthy behaviours, adolescents who are overweight are more likely to be self-conscious about their weight, a negative body image, and low self-esteem. Huang et al., (2007) found that adolescents put more personal effort into their weight management because they were dissatisfied with their body. Huang et al. (2007) found that there were gender differences regarding weight desirability. Where the intervention had a more positive effect on girls who maintained or lost weight, with boys it had the opposite effect. The study reminds health promoters and educators to focus on healthy behaviours and the health outcomes from living a healthy lifestyle, instead of focusing on weight loss.

When it comes to body image issues among young people, self-esteem is an occurring theme within the literature. Wiederman (2000) found that self-esteem and physical intimacy are related. Having a low self-esteem and body image lead to greater sexual dissatisfaction. Building on Wiederman's (2000) study, Newton, Boblin, Brown,

and Ciliska (2006) explored EDs and how it affects relationships. They explored how their participants identified intimacy when they have an ED. Intimacy included a variety of different subsections like feeling known and appreciated, trust, emotional closeness, and physical closeness (both sexual and non-sexual). The study found that when the diagnosed individuals felt comfortable with their bodies with their partner, physical closeness promoted a positive relationship. The individuals also believed that this physical closeness made them feel valued. Given the results of this study, it would seem that the more sexually active individuals with EDs are, a more positive body image would be the result.

McFarlane, McCabe, Jarry, Olmsted, and Polivy (2001) found that individuals who are more dissatisfied with their body shape might also be dissatisfied with other aspects of themselves, which would produce a lower self-esteem. Some individuals with EDs will value their self-worth based on their weight and shape, how much exercise is completed, or how much food was resisted (McFarlane, McCabe, Jarry, Olmsted, & Polivy, 2001). Also, individuals who are satisfied with their shape may also be satisfied with other aspects of themselves, producing a higher self-esteem. McFarlane, et al. (2001) stated in their study that this topic has not been well researched, but is a major factor in recovery for ED. The study found that initial weight loss is related to positive self-esteem because positive comments are often given to the individual. This positive self-esteem will increase the individuals' confidence, achievement, and social interaction (McFarlane et al., 2001). There were two groups of participants: individuals with EDs and individuals with restrained eating. Individuals with EDs use their weight-related self-

evaluation in other aspects of their lives, like school and work, compared to individuals with restrained eating who use their weight-related self-evaluation in a social context.

Clay, Vignoles, and Dittmar's (2005) used an experimental design to compare images of models to body satisfaction and self-esteem. The age groups tested on were ages 11-12, and 15-16. Participants were shown images of models on magazine covers and had to rate their reactions to them. This study found that viewing ultra-thin and average sized models led to a decrease in body satisfaction and self-esteem in adolescent girls (Clay, Vignoles, & Dittmar, 2005). This study found that there was no different in reactions in adolescents who saw ultra-thin and average sized models compared to adult women who would view average size models and feel relief (Clay et al., 2005).

Sexual Activity

Adolescents and young adults under the age of 24 years make up a quarter of sexually active population (Widman et al., 2014). "The majority of adolescents engage in sexual intercourse by the time they graduate from high school" (Widman et al., 2014). There are a multitude of different sexual activities that adolescents and young adults engage in. Some sexual activities include "sexting" (sexual text messaging), masturbation, oral sex, anal sex, and vaginal sex (Lindberg et al., 2008). Many adolescents and young adults do not consider oral and anal sex to be "sex", and see oral sex as more socially acceptable than vaginal sex in the terms of health consequences, like pregnancy (Lindberg et al., 2008).

Most adolescents own cell phones, and even more own phones closer to young adulthood (Benostch, Snipes, Martin, & Bull, 2012). At the time of that study the United States had more than 320 million individual phone connections (Benostch et al., 2012).

This rapid increase in cell phone use has had detrimental consequences when it comes to sexualized communication, especially in the past few years. Sexting (sexualized text messaging) has a multitude of negative outcomes including embarrassment, mental health problems, spreading the sexually explicit content around (photos), and legal consequences if the individual is under the age of 18 (Benostch et al., 2012). Adolescents might engage in this type of behaviour because of peer pressure, or wanting to attract or keep a potential romantic interest. Benostch, Snipes, Martin, and Bull (2012) found that adolescents who engaged in sexting were more likely to have engaged in substance use and high-risk sexual behaviours like unprotected and sex with multiple partners.

Through the “hypersexualization” of Western society, the pornography industry has grown and has taught young girls and adolescents that boys like certain behaviours from them. These behaviours include sexting, sharing revealing pictures as a “sexy present” for their partner, dressing in revealing clothing and much more (Gillespie, 2013). One downside is being in possession of child pornography (intimate and revealing photos of an individual under the age of 18) and having a criminal record because of that. Also, sharing of an intimate photo on the Internet, even though it may be brief, the photo can be quickly downloaded, copied, mirrored, and distributed forever (Gillespie, 2013). Also, with the use of cellphones, the sharing of photos can occur even faster than before. Another downside is “revenge porn”, which is the sharing of intimate photos by the ex-partner done in revenge, or to get back at their ex-partner (Gillespie, 2013). The photo meant to be part of their intimate relationship is now shared in hate and revenge to harm the other ex-partner. This can cause embarrassment, bullying (both online and off),

harassment, and shame to the individual (Gillespie, 2013). In extreme cases, the individual may commit suicide.

Hogarth and Ingham (2009) studied masturbation and its associations with sexual health. They found that masturbation depended on the young women's belief about themselves. If the young women had a positive view of sexual health and sexual activity they were more likely to masturbate, have pleasure, be more comfortable with their own body, and most importantly feel empowered and in control. "...In many cultures, masturbation is as shameful and problematic activity (often based on religious doctrines), despite the fact that many modern cultures appear to accept this sexual practice as a normal part of human sexuality" (Hogarth & Ingham, 2009, p. 558).

Oral sex is more commonly practiced among adolescents and young adults (aged 15-19) compared to vaginal sex and anal sex (one tenth have engaged in anal sex) (Lindberg et al., 2008). With schools and health care providers pushing the idea of abstinence onto adolescents and young adults, they are trading vaginal intercourse with oral and sometimes anal sex. Since oral and anal sex are not considered to be "sex", adolescents believe they are abstinent. Engaging in anal sex greatly increases after vaginal sex, along with other noncoital activity. It was also found that adolescent females were more likely to give oral sex to an opposite sex partner than adolescent males. Also, adolescents who have had vaginal sex were more likely to also have had noncoital sex (Lindberg et al., 2008). This study found that young girls could express their sexuality without engaging in vaginal sex and risking a pregnancy. There was no correlation with what order adolescents and young adults engage in different noncoital and coital activity,

meaning that some participants experienced vaginal sex before oral or anal sex, and others experienced oral or anal sex before vaginal sex.

Woodside, Lackstrom, and Shekter-Wolfson (2000) found that in a relationship intimacy and sexuality was decreased at the beginning of ED treatment. As participants were discharged and recovering, intimacy and sexuality increased within the relationship. This study found that self-esteem was a major issue with body image and intimacy. During ED recovery and treatment, the individuals' body weight was still fluctuating, which the individual still needed to adjust to. Both members of the couple agreed that through all stages of the ED, including recovery, intimacy and sexuality was an issue.

Sexual Anxiety

Pinheiro et al. (2010) found that two thirds of their participants with an ED lost sexual libido and had sexual anxiety. This study supports prior research in which a low body weight greatly impairs sexual and physiological functioning. It was also found that if relationships continued without sex, there would be increased tension. Also, the female participants viewed their marital relationship less satisfying than their partners' view of it. But when treatment for the ED started, marital satisfaction improved because the treatment targeted the ED symptoms. This study concluded that sexual intimacy is vital to a healthy relationship, and the ED puts stress on this aspect of the relationship.

Brassard et al. (2015) found that higher sexual anxiety is related to lower sexual pleasure. The goal of this Canadian study was to examine sexual self-esteem, sexual anxiety, and sexual assertiveness to explain anxiety and avoidance. Brassard et al. (2015) theorized that attachment anxiety is the fear of being rejected or abandoned and engaging in sexual activity with a sexual partner served as an attachment figure. This sexual

activity satisfied the participants' attachment needs. The study found that the need to feel wanted and valued often pushed participants to engage in sexual acts they were not comfortable with. When the participants were more attachment-anxious, the participants were less sexually confident and were anxious about their sexuality. This anxiousness was associated with the participants being less sexually satisfied. With the feeling and thoughts of anxiety, it could increase negative perceptions of self. This would interfere with sexual desire, arousal, and satisfaction, limiting their ability to enjoy sex and reach orgasm. Some partners who have sexual anxiety might feel obligated to be sexually active with their partner. This obligation combined with their sexual anxiety may compile different emotions like nervousness, inadequacy, and being uncomfortable. The study ultimately found that lower sexual self-esteem was correlated with higher sexual anxiety. Also, if the participant was anxious about their partner leaving them, more anxiety and less confidence was found, which further showed poorer sexual functioning and satisfaction.

In Warin's (2005) study, she observed 44 women and two men in different public and private ED treatment programs. Warin (2005) found that individuals diagnosed with an ED engage in social relationships differently. For example, during social gatherings which revolved around food, the individuals became high anxious, which led the individuals to withdraw from engaging socially. The withdrawal from social networks resulted in negative social relationships and isolation. Warin (2005) found that over 70% of participants were not in a relationship, which was very significant. Participants relayed that having and maintaining intimate relationships was difficult because they were already in a relationship with their ED.

Both the Fisher et al. (1995) and Le Grange et al. (2014) studies found that EDs are most likely to develop during adolescence and young adulthood. Walker's (2005) study found that adolescents and young adults have a lot of stress and pressure on them, and sometimes they put it on themselves. Walker's (2005) study reiterates the findings found in Troop, Holbrey, and Treasure's (1998) study that stress could develop into an ED.

Conclusion

This review of the literature started with an overview of the different types, categories, and diagnostic criteria under the DSM-5 for EDs. Body image and self-esteem was reviewed next showing the close connection between the two topics. This section discussed how adolescents view on their own body image could affect their self-esteem. A positive body image leads to higher sexual satisfaction, and a negative body image leads to a lower sexual satisfaction. It was also discussed that the age of adolescences is crucial for individuals to have a positive body image and self-esteem to avoid unhealthy eating behaviours. The sexual activity section reviewed what age adolescents and young adults are engaging in sexual acts and which sexual acts. With the age of technology, the way adolescents and young adults communicate is much different than previous generations. Also, with readily available resources, more adolescents and young adults are engaging in more non-coital activities and using more protection while engaging in coital activities. Sexual anxiety was the last topic reviewed and it was found that individuals with an ED or lower body weight have a lower sexual libido and have higher sexual anxiety, resulting in less sexual pleasure with their romantic partner. With the

thoughts of sexual anxiety, it could lead to a lower self-esteem and attachment anxiety with the fear that the individuals' partner might leave them.

The majority of the ED studies reviewed did not research the relationship between body image and sexual activity, but knew that sexual anxiety increased. Though some studies did confirm that sexual activity decreased because of an ED, it failed to explain the reasoning behind this decrease. This study hopes to find out the reason behind the decrease of sexual activity with individuals with EDs. All these past studies have uncovered fascinating research. Past studies seem to contradict each other if EDs affect sexual activity; some arguing it increases, and others arguing it decreases. Almost all agreed that EDs do start in adolescence, and that stress and perfectionism can develop into an ED. This proposed study hopes to further research this topic under the updated DSM-5, educate health professionals and clinicians, and entice future research.

CHAPTER 3: METHODOLOGY AND PROCEDURES

Description of the Study

The Research Ethics Board at the University of Windsor approved this study. It was classified as a medium to high-risk study because participants might have perceived emotional and psychological risk. To mitigate these risks, the participants were given a list of local clinics and helplines (see Appendix A) if they needed to talk to a professional after the interview. Participants were allowed to withdraw from the study at any point. There was informed consent through the whole study's process and participants were informed of their rights (see Appendices B and C)

This study employed qualitative research methods. According to Marshall and Rossman (2010), qualitative research commonly occurs in naturalistic settings, uses a variety of methods that respect the participants involved in the study; focuses on substance; is constantly developing and changing; is centrally explanatory. In addition, working with qualitative methods, this study employed theoretical frameworks used as the basis for interpreting and making sense data, therefore, making it explanatory in nature (Gratton & Jones, 2008). This approach was also chosen because it is exploratory rather than confirmatory, and it seeks to identify themes or categories, rather than prove relationships or test hypotheses. In addition, the study focused on the meaningful quality of the data as it will likely be constantly in the process of changing as research questions and probe questions for the interviews constantly edited as the data collection continued.

This study employed face-to-face semi-structured interviews and was conducted in accordance with criteria set for aims as well as feminist theory. In doing so, these methods recognize the notion of "experience" as central to feminist methods (DeVault &

Gross, 2007). This interview approach was conducted by talking with participants, gathering their stories and learning about their experiences and perspectives (DeVault & Gross, 2010). At the start of the semi-structured interviews, it was important to begin with a broad, open-ended question so that the participant themselves can guide the direction their own personal story (Valeras, 2010). I also chose semi-structured interviews as they are less structured but still a rigorous form of interviewing that allows empathetic and interpersonal dialogue, which are key components of rich, qualitative research (Hesse-Biber & Piatelli, 2010). Consistent with qualitative research methods, I began with asking participants to share their stories, either by responding to the semi-structured interview questions, or by engaging in conversation or dialogue (see Appendix E). By allowing the participants to speak freely and openly about their personal experiences as a person with ED, it generated better, more in-depth responses than a very specific, direct "interview-type" question. It also allowed me as the researcher to listen attentively to the participants. All semi-structured interviews were audio-recorded and transcribed verbatim.

This study also used close-ended questions. This was done in order to receive direct information from the participant. An example of a close-ended question would be, "How old were you when you were diagnosed with an ED, or began in unhealthy eating behaviours?" Using this approach reflects the feminist methodologies through deeply listening and trying to understand the participants' experiences, thoughts, and feelings on the event (DeVault, 1990). All participants were interviewed separately to provide a sense of confidentiality.

I conducted interviews in places and locations that were convenient for my participants. My interview locations included: University of Windsor, and coffee shops. I listed these options for each participant so they could choose which location they were most comfortable. A meeting time was set up that was convenient for the participant and the interview was conducted at their desired location.

Participant Selection

Participants in this study were between the ages of 19-28 years. A lot of previous studies have used the adolescence and young adulthood age group. Previous studies have utilized participants in high school up to approximately 20 years (Aragona, Catapano, Lorio, & Alliani, 2011; LeGrange et al, 2014; and Uehara et al., 2001). The diversity of ages encompassed adolescents and young adults. Individuals in this age group are typically experiencing a lot of stressors like transitioning into post-secondary education, work, dating, and a lot of other life changes. EDs typically develop during this age group, and individuals are typically sexually active during this age group as well (Pinheiro et al., 2010).

Participants recruited were either diagnosed with an ED under the DSM-5, or believed that they had an ED. Though this study is touching on the topic of romantic relationships, the participants did not currently need to be in a relationship.

Recruitment Process

Participants were recruited at the University of Windsor. Flyers and pamphlets were hung throughout the university campus and in different faculty buildings, like the Faculty of Nursing, Faculty of Human Kinetics, and Faculty of Education (see Appendix D). Participants were prompted on the flyer to contact the primary researcher by

telephone or email. There were a total of 7 participants in this study, 5 female, and 2 male. There are 12,780 full and part-time undergraduate students and 2,794 graduate students. The student/faculty ratio is 26:1 (University of Windsor, 2018). The male to female ratio is 48% male, and 52% female. The Student Counseling Center (SCC) at the University of Windsor provides free mental health counseling to students by trained professionals (University of Windsor, 2018). The SCC offers counseling and therapy services to an array of problems including stress, physical health, mental health, mental illness (i.e., EDs), moving away from home, and relationships.

Participant Overview

Seven face-face, semi-structured interviews were conducted in this study. The age group ranged from 19-28 years old. There were 5 females and 2 male participants. One male participant identified as belonging to the LGBTQ+ community, and the other 6 participants identified as being heterosexual. All participants have been sexually active with past or present romantic partners. One participant was married for over 6 years, and the other participants ranged from being recently single to being in a relationship for over 5 years. In order to help the reader better understand each participant, I provide a brief description of each, below.

Participant A identified as a 24-year-old female who is now single. She feels her sexual identity is fluid, although to a limited measure she identifies as heterosexual. Participant A explains: “So, for me I’m like heterosexual in the sense that I want a relationship with the man. But I am very sexually attracted to some women too.” She ended her heterosexual relationship a few months prior to the interview and sexual activity relating to her body image was one of the many deciding factors that ended the relationship.

Participant A starting having ED thoughts since age 4, and had AN between the ages of 14 to 24 years and is still recovering. She currently does not have a positive body image and mentions that being in her “body is really hard.”

Participant B identified as a 26-year-old heterosexual female who has been in a committed relationship for over 5 years. She identified having a positive body image despite her knowing that she was on the bigger side. Between the grades of 6-8, Participant B’s father was especially hard on her about her weight. He would make comments that she would not be able to have a normal persons job, and needs to eat less junk food. When her father made those comments, Participant B would have a low body image. As she moved onto high school and university, she accepted her body for the way it is, and then began to have a positive outlook on her life and her body image.

Participant C identified as a 28-year-old heterosexual male in a committed relationship. He identified having a negative body image throughout his life, and it still continues today. Yet, Participant C expressed a low self-esteem during our interviews. In a historical and societal context, men are often portrayed and encouraged to be physically strong to show little emotion or vulnerability, except for anger. Participant C broke this gender norm by coming forward and expressing his weaknesses and his low self-esteem.

Participant D identified as a 26-year-old homosexual gay male who is single but has been intimate in past relationships. Participant D is a sexual assault survivor. Participant D had BN and has an ongoing negative body image which started after being “raped” by an older male. In his own words, he still struggles with “body dysmorphia.”

Participant E identified as a 19 year-old-female who has disordered eating including some cases of over exercise and restriction. Participant E received treatment before her

unhealthy eating behaviours turned into an ED. Participant E has had one previous relationship, and is currently at the beginning stages of a new one. She believes in body positivity but knows that some days she struggles more than others.

Participant F identified as a 28-year-old female Iranian immigrant who has been married over 6 years. She identified with having some tendencies of disordered eating classified with occasional purging.

Participant G identified as a 26-year-old female who is single, but has been sexually active in previous relationships. She is very body positive and wants to let others know that bodies are amazing.

Data Collection

Data collection happened during one on one interviews conducted for this study. Participants were reminded at the start of the interview that they did not need to answer all of the questions if they feel uncomfortable or did not want to answer. Participants were also reminded that everything said in the interview was kept confidential, and their identity was not revealed. Interviews were recorded on a digital recording device. Interviews were transcribed and coded on a word processing document to analyze and find common themes.

Data Analysis and Procedures

Thematic analysis began after the first interview. Analyzing data thematically and engaging with the data occurred simultaneously to develop emerging themes. Building off of themes found in the first interview brought more insight into the next interview and so on. While analyzing each interview, common themes would appear, prompting more direct questions on those varying themes in subsequent interviews. This back and forth

process of analyzing and engaging continued until the last interview. The interview process helped elicit certain responses from the participants. Each interview was transcribed from the audio recording onto a written word processing document. Thematic analysis was used to analyze and code each interview, looking for common themes to appear within the responses. Each interview was read over and analyzed multiple times to prevent overlooking any data, and to locate patterns within the interview (van den Hoonaard, 2015).

Methods

The data collection process was through a one-on-one interview with the participant and the researcher. There were set interview questions including both open-ended and close-ended questions for the participants to answer (see Appendix E) Close-ended questions gave direct answers that were needed for demographics or basic knowledge about the participant. Examples of a close-ended question in this study include age of the participant, or which type of ED the participant has been diagnosed with. The open-ended questions allowed the participant to answer the question giving their thoughts, ideas, and experiences without too much prompting from the researcher. An example of an open-ended question in this study includes, “how did your ED start?” or “how has your ED effected your sexuality?” Each interview was recorded using an audio recording device. Each audio recording was transcribed onto a word processing document. To effectively transcribe each interview, an online resource ([transcribe.wreally.com](https://www.transcribe.wreally.com)) was used. It is an online resource to help speed up the process of transcribing multiple interviews. Using this tool helped to get the audio recordings onto a

word processing document faster and, therefore, started the thematic analysis faster, as well.

Once each interview was fully transcribed onto a word processing document, analysis of the interviews began. Each interview was analyzed to find reoccurring themes within the participants' answers and speech. This study hoped to find multiple recurring themes found in all interviews. These themes would further indicate how an individual with an ED's view on body image might affect their sexuality.

Ethical Issues

This study ensured to engage in ethical practices throughout the research study. The study obtained approval from the Research Ethics Board at the University of Windsor before the study was conducted. Participants understood the purpose of the study before they signed the consent form and understood that the research would treat them ethically. This study contains minimal or greater than minimal risk because the participants might have experienced psychological and emotional risk. The participant might have also experience feelings of embarrassment, anxiety, and tension during the interview process. An informed consent form was understood and signed by all participants who voluntarily participated in this study. All data collected was confidential, along with the identities of the participants. This study also respected the wishes of the individuals who choose not to participate in the study. All researchers involved in this study were respectful to the research site and participants, practiced reciprocity, and maintained confidentiality to the upmost standard (Creswell, 2015).

Participants Definition of Terms

Participants were asked to identify some terms in their own words. It was found that there was a double meaning for the term “positive body image” and “negative body image.” Participant A explained that when she had her ED, she believed that a positive body image was when her body was very sick and at a low weight. This “positive body image” gave her the confidence to go outside and not worry about her body for that day because of her restriction of food, purging, and over exercise. Participant B defined a positive body image: “whether you feel your body is a 10 out of 10 looks amazing, or if you’re not feeling great about your body that you have a positive outlook on your body...you can accept yourself with flaws.” Typically when participants used the phrase “positive body image”, it meant that their body was fitting into the gendered idealized body. Participant A described a negative body image, “I’m very nuanced, it’s an obsession for me. I’m always checking to see, is it bigger, does it ugly, do I look ugly? To me ugly is tied with fat in my head, and that’s just the reality.” So, for most participants the phrase “negative body image” meant not fitting into the gendered ideal for body.

The term “target weight” was another term participants were asked to define. Target weight was defined as a weight the participants wanted to achieve or maintain. For example participants had target weights set up by health professionals to get them at a healthy weight. The goal of the target weight was to gain weight in a healthy and monitored way. For participants who believed they needed to lose weight, target weight was a low number they needed to achieve to be happy, confident, and achieve their positive body image. For the purpose of this study the phrase “low target weight” will refer to the low, unhealthy weight participants with an ED, disordered eating, or

unhealthy eating behaviours had set for themselves to achieve. The phrase “high target weight” will refer to the higher target weight participants had to gain to become healthy again.

CHAPTER 4: RESULTS

The purpose of the current study was to explore the relationship between EDs and sexual activity. As was previously mentioned, the study adopted a feminist theoretical framework to analyze the interview data. In this chapter, in discussing each theme, direct quotations from participants are included to help provide texture and richness in illustrating the emerging and developed themes. As discussed earlier in the methods chapter, each participant was given a “pseudonym” and coded under this name. The first section of this chapter provides an exploration of the three key themes emerging out of the analysis of the data collection. The three emerging themes found in the analysis were: 1. Gender, Food, and Exercise, 2. Gender and Body Image, and finally 3. Gender, Clothing, and Appearance. I begin this section with a focus on the theme, Gender, Food, and Exercise.

Theme 1: Gender, Food, and Exercise

The first theme that became evident throughout the interviews was gender, food, and exercise. Participants A, D, E, and F all used restrictive food intake and excessive exercise as a way to reach their gendered ideal. Participant A is a very serious individual who takes these comments to heart. Often when given a compliment instead of just receiving it, her mind will take it to the extreme.

‘You should go into modeling you’re so beautiful’. And I was like now that’s the standard I need to hold myself to and my body doesn’t fit modeling, so I have to make it fit modeling because I’m told I could model. That was where my brain went, instead of ‘thanks, that’s a nice compliment.’

This particular quote is revealing in a number of ways. First, it once again highlights that, for women and girls, body weight, their physical appearance and beauty are often conflated with their sense of popularity and social identity. Within the context of Western culture, being thin and physically beautiful is often set up as the feminine ideal (Simpson et al., 2016). Additionally, it is also important to point out that Participant A was so affected by these gendered compliments, believing that they must be true or must happen, that she engaged in excessive exercise and food restriction, to make it possible. “I started obsessively exercising. At school, I would stand or walk as much as possible. Before school I would go for a run. When I got home from school I would go for a run.” Participant A also restricted her food intake. “I slowly started cutting out certain things, it started with sweet things then unhealthy things...like any fast food, any chips, desserts, cookies.” These thoughts show Participant A’s relationship with her ED, holding herself to a prescribed gendered standard she felt she needed to achieve (Meyer et al., 2011), which often leads to obsessive exercise or other methods to control one’s body. But what led to Participant A’s eating disorder in the first place?

Like some other participants in the study, Participant A felt she acquired her eating disorder at a particular moment in time. A simple comment, delivered to her at a very young age by an adult triggered Participant A’s lifetime struggle around body image and eating disorders. Participant A explains:

I was really young when my eating disorder started. So, I started having ED thoughts at around 4 years old. It was triggered by an event with a babysitter, who told me I was too big to ride in the stroller. I wasn't a big kid, but I was a tall kid. So, I was always the taller one in the class. And growing up ... this

babysitter at the time when ... her daughter at the time, we were the same age, and she was short and I was tall, so I was big, the big kid.

It is likely that the babysitter would not have thought much about this particular comment and the way it unfortunately shaped Participant A's childhood. Clearly, the comment was powerful when it came to shaping Participant A's understanding of herself. Here is Participant A

So, growing up I was always very aware of my size compared to everyone else. Like hyper aware. And I would compare myself to the skinnier girls in the class and all the time. I remember my best friends always slightly bigger than me, they weren't "big kids" but they were slightly heavier. I remember having the thought when I was in Grade 3 being like 'it's ok I'm ok because I'm smaller than her' was the thought I had. So [a] very disordered body image

Participant A's comments reveal the gendered nature of eating disorders, whereby very young girls begin to establish their identity, with themselves and with other girls, based on body image, an image that tends to be grounded in the rigid binary of 'fat/skinny'.

Participant A has been an athlete almost her entire life. She started around age six, for example, "doing Irish Dancing" competitively. But her experience in this sport was less than positive. Here, Participant A describes her time in Irish dancing:

So, I grew up doing Irish dancing from for 6 years competitively...that was hard because we were put down a lot, in order to make us perform better. The strategy was to put us down, put us down, put us down, they told us we were

idiots, that we sucked a lot of the time. So that didn't form a good basis for myself worth or body image. Then I transitioned to ballet.

Already struggling with a poor body image triggered by a comment from her babysitter, Participant A was further humiliated by her dance instructors who undermined through their negative comments, her self-worth. As she mentions from the above quote, from Irish dancing she moved to ballet. But this transition did not necessarily provide positive experiences either.

Participant A has been a dancer most of her life. She believes that being a dancer is difficult for her body image. "Being in dance obviously, body image is pretty difficult. You're constantly critiquing and trying to perfect the body." Though she loved to dance, ballet was becoming increasingly difficult for Participant A's body image and worsening ED. "Every single day when I was dancing, I hated it because I couldn't get my body to do what I wanted it to do. That's a standout thing in my lifetime." It is likely that Participant A was more focused on her outward appearance and being thin, than her dance abilities. This is a common gender norm often found in female athletes, where the patriarch's idealized body image overshadows exercise and performance for their sport (Lunde & Gattario, 2017). To put it a little bit differently, women and girls are sent the message at a very young age that they need to cultivate and maintain a beautiful and delicate body, and largely remain passive and docile (Murnen, 2018). This powerful and deeply gendered message creates tension and anxiety for some female athletes as they carefully navigate this tricky gendered terrain, while trying to be a successful athlete, which means cultivating and nurturing a body that's powerful, active, agile and strong. The problem then, to some degree, is that women and girls may convert their exercise

and workouts from sport based to thinness based (Lunde & Gattario, 2017; Tiggemann & Zaccardo, 2015).

How Participant A feels on any given day is determined in a strong sense by her attitude toward her body. Here she explains:

Every day I'll wake up and based on how my body is feeling physically, so am I bloated, stomach ache, does this part of me stick out more than it did yesterday, do my thighs look bigger today, does my face look bigger today, does my stomach have more fat on it? Based on all those things, in which I have a way of going through the checklist of them, based on that it kind of dictates my day.

Preoccupied with the shape of her body (too fat?) and how it feels, it is a wonder to some degree how Participant A focuses on other matters. Clearly, patriarchal norms that tell women in powerful ways to pay close attention to their physical looks has shaped this woman's experiences in the everyday sense of the word.

Oddly, and this is worth mentioning, that simply because one is aware of how patriarchal norms shapes body image, does not necessarily mean they are resistant to them. Had some genuine understanding about patriarch and gender norms for women and men. She explains:

The patriarchy on women, dictating essentially what a woman has to look like and then even on top of that now it's even more so maybe, how men should look. I think there's, because we've pushed it so far, and we're all affected, some more than others to have that negative bias against our bodies.

What is interesting about her comment, is that it reveals how powerful patriarchal norms are in that some women (and some men), who quite clearly are able to identify the problem, still struggle to fight their efforts to conform.

Nonetheless, it is no surprise that Participant A restricted her food intake in hopes to control her weight. “I was still eating things, but just very small amounts and very specific things like fruit and vegetables. I remember I used to eat this one type of granola bar, and I used to split it in half, so half in the morning, half in the evening, or afternoon/evening.” It was the voice of her eating disorder that fueled the need to restrict her caloric intake. Here is Participant A, explaining: my ED would tell me, “You need to lose weight now,” which would lead to more restriction of food. Participant A is certainly one of many women who engage to some degree or another with caloric restrictions. Restricting food intake is a characteristic of AN (American Psychiatric Association, 2013) and also a gender norm which tells women that eating small portions is more feminine as it will likely lead to the desired thinness (Lunde & Gattario, 2017).

Early in Participant A’s history with her ED (in high school), she started cutting out “unhealthy food” from her diet. Here is Participant A explaining:

I slowly started cutting out certain things, it started with sweet things, then unhealthy things like any fast food, any chips, desserts, cookies, candies, chocolate, white bread, stuff like that started to go. And then fats started to go quickly after that. So, I would eat anything that was super low fat, only if it was low fat. Certain calories I had limits to.

On the one hand, there is nothing inappropriate about trying to eat in a much healthier way by eliminating well known junk food, cookies, chips or fast food. However,

Participant A's efforts to eat much healthier, but also pay particular attention to her caloric intake, was largely motivated, to not necessarily be healthy, but much more about fitting into an 'ideal' body type. Again, reiterating the norm that eating small portions of healthy food is seen as feminine (Lunde & Gattario, 2017).

Another way Participant A tried to control her weight was through obsessive exercising. "I started obsessively exercising. At school, I would stand or walk as much as possible. Before school I would go for a run. When I got home from school I would go for a run." Compulsive exercise and over exercise is a common symptom that often accompanies AN, and is done as a means not to necessarily become healthier, but to become thin (Meyer et al., 2011). Of course, nutrition and exercise are essential to good health, but extreme behaviors when it comes to nutrition and exercise are cause for concern. Participant A, seemed to be much less concerned about the relationship between exercise and healthy living, and much more preoccupied with the way in which exercise could shape her body to meet the standards of the feminine 'ideal.' Of course, the obvious contradiction is that her efforts will most likely come at the expense of her overall well-being and health (Meyer et al. 2011; Noetel, Dawson, Hay, & Touyz, 2017).

Similarly, Participant D would also try to control his weight through exercise, food restriction, but also purging. Participant D did not want his family to know about his illness so he used different techniques to fool his family members. For example, he would throw out his packed lunch at school to fool his parents that he actual ate it at school. "I started skipping out on my lunch...I would throw it away at school." Another way that Participant D fooled his parents into thinking that he was eating was by putting a dirty dish in the sink. Since Participant D was often home alone his parents could not monitor

his food intake. “If I was home alone, I would pretend I ate. So, I would get a plate, smother food on it, put it nicely in the sink so it looks like its been used and try to wash it.” Participant D went further by putting a meal-sized portion out of the fridge and putting it in the garbage. “I would pack whatever food was in the house, and [wrap] it in tin foil, just layers and layers, then three or four grocery bags then go to the garage, go to the big garbage bin and dig it to the bottom.” Hiding and throwing away food is a common behaviour often seen in EDs (The Meadows Ranch, 2019). Participant D would engage in this behaviour so he did not have the opportunity to eat his meal, even if he wanted to. This troubling behaviour shows the extent of his ED and what he was willing to do not to consume food.

Participant D was more focused on his restriction of food, for fear of gaining weight, rather than consuming food for nutrition (Hetherington, Stoner, Anderson, & Rolls, 1999). He did this for the pursuit of the ‘ideal’ body, instead of the pursuit for a healthy body. This is another way Participant D tried to maintain and lower his body weight to reflect the patriarchy’s ideal body (Legenbauer et al., 2009). But more needs to be said on this point in relation to Participant D in order to contextualize his eating disorder, before I move on.

Participant D is a sexual assault survivor of men’s violence. When he was 16 years old he was sexually assaulted by someone his “Dad knew.” The man who committed the violent crime was doing “renovations” around his home. At some point, Participant D was left alone with the man. According to Participant D, the man then approached him and asked if he would like to watch a “porn video.” Participant D agreed. Although they engaged in mutual sexual intimacy soon after watching the video, at some point the older

man physically turned Participant D on his stomach without his consent and proceeded to rape him. Here is Participant D recalling this horrific violent male sexual assault and its aftermath:

He wanted to do penetrative sex and I was like, no ... he like turned me over [and] he stuck it in and it hurt a lot. And after that ... [is] where I started shifting towards like that negative body image ... and so like I started hating myself. I started hating like I was like, I don't know I started really thinking like I was so ugly that he had to like, you know, like rape me.

The origins of Participant D's eating disorder along with his self-loathing emerged out of horrific and violent sexual assault, perpetrated by an older man. Thus, in order to best understand Participant D's ongoing struggle with body image and self-esteem, we have to have the knowledge that experiencing acts of sexual and violent assaults such as this can have powerful and lasting implications over the course of a lifetime.

Participant D interpreted, in some way, his experience with sexual assault as a signal to himself that he was 'ugly', that no one would find him physically attractive, and that the only sexual intimacy available to him was through violence. He saw himself as 'chubby,' with "man boobs." In light of this new development around body image that came out of the sexual assault, Participant D aspired to be a 'Twink.' A 'Twink' is common gay slang for a young man in his late teens who is considered physically attractive, along with typically having no body or facial hair, a slim build and a very youthful appearance. Here is Participant D explaining:

When I had my eating disorder, positive body was to be like slim ... like I really wanted to be in gay community. There's a term called Twink and a

Twink is like the skinny kind of hairless, you know, younger-looking first boy. . . I was always kind of like a chubby hairy guy. So, like I would you know, like that was the body positive body that I wanted. . . . And so, body image for me was like, you know trying to look like a Twink trying to be more attractive . . . like, you know, it's you that slim attractive look that . . . not only promoting the Twink community.

So, Participant D began to feel like he had to fit into the notion of a 'Twink' which reflected his ideal body type in relation to the gay community.

Nonetheless, after pretending to eat dinner, Participant D would purge and exercise to be slim. "I would go upstairs, take a shower at night, then force myself to throw up. Then go downstairs to the gym, . . . we had a treadmill in the basement, and run there for half an hour." Participant D restricted his food intake, purged, and exercised so he could be physically attractive. "I started trying to be more good-looking and slim." Participant D exercised so he would be attractive and slim, two common characteristics of the patriarchy's idealization of the perfect male body (Legenbauer et al., 2009). Though exercise is known to be a part of a healthy lifestyle (Fleig, Kerschreiter, Schwarzer, Pomp, & Lippke, 2014), Participant D's obsessiveness brought it to an unhealthy lifestyle. Also, in recent years exercising to become slim has become its' main purpose, compared to its' original purpose of becoming fit (Lunde & Gattario, 2017), and Participant D also followed the new purpose.

Participant E also exercised not to become fit, but to be thin, again placing herself in a similar situation as Participant A and D (Lunde & Gattario, 2017). She took exercise to the extreme stating, "Every moment I had an opportunity to reach that target weight."

Even while brushing her teeth she would do an intense workout in the bathroom. “While brushing my teeth, perfect time to put in a workout. I’m going to put my toothbrush down and do a ten-minute really intense workout, in the bathroom!” Participant E’s intense exercising isolated her from her friends, because she would rather exercise than hang out with them. “The movies, I didn’t want to do that because...that was a lazy activity [with] snacks...I definitely didn’t spend time [with them, unless it was] something where they wanted to be active...like tobogganing.” Participant E’s obsessive exercise drove her to become isolated in her social life and focus solely on becoming thin and attractive. Becoming thin was her goal, not being fit or active, which is the intended purpose of exercise (Lunde & Gattario, 2017). Participant E wanted to be attractive according to the patriarchy’s ideals, so she focused on her relationship between herself and being thin and attractive, rather than the healthier relationship between herself and an actively fit body (Simpson et al. 2016). Participant E’s drive for thinness started at a young age. Her story will be explored now.

When Participant E was young, she remembers that her mom and aunt would compare their bodies to each other. “When I was a kid growing up my mom, my aunt would always be comparing themselves to each other.” But the comparisons were based on gender and gender relations as it relates to femininities. “You know, ‘you’ve lost so much weight! Like how did you do it? What did you do?’” Participant E was around 7-8 years old when she heard comments like these. “I started noticing like 8, 7, 8? years old, like at a young age.” Participant E recalls these gendered comments resonating in her mind and internalizing them in a way that she began to develop negative attitudes towards her body.

She remembers, for example, having a ‘bigger’ stomach as a child, most likely since she was still developing, and these little comments put stress on her young mind.

My stomach’s just got so much bigger...and I know that may not seem like a big deal to them. But like as a kid constantly hearing your mom talk about the fact that she’s fat or your aunt come up to you and just tell you ‘Oh like you better watch that because you know, you’re going to end up looking like your mom one day.’ Like just little comments like that.

Participant E greatly disliked hearing comments like that, not surprisingly. But, clearly, to one degree or another seeing her family members engaging in these behaviours revealed to Participant E how ‘fat phobia,’ worked itself out in insidious ways among women and girls.

Her family’s behaviour went further at family events like Thanksgiving dinner. “They like weigh each other at Thanksgiving. Just totally random, [why] are you doing that? I don’t know but, just like comparing each other, comparing themselves to each other [and] that kind of thing.” As Participant E reminisced on these childhood events, she came to the conclusion that her family and the patriarchy puts stress on managing a woman’s weight at a young age. “We put a stress on you, and like a stress to look good at a young age when you don’t have to even worry about that!” But Participant E did conclude that it was not the magazines and ‘photoshopped’ images that affected her as much as her mom and aunt’s gendered comments. Here is Participant E explaining:

I knew about magazines [that they] were all Photoshop. So that didn’t affect me in any way. It was more of the people in my life who would constantly stress about what they [were] eating. Stress about their exercise and stress about their body.

That kind of affected me because like if you're seeing them constantly [doing] this attention on their body, rather than on other things, that kind of puts you in a state where should I be focusing on my body constantly? Should I be focused on losing weight? Should I focus on this or that?

It is not surprising that this defining childhood memory resonated so deeply with Participant E, and later in her life contributed to her disordered eating and patterns of thinking. Families who talk about dieting behaviours, body dissatisfaction, or eating disorder behaviours can influence these behaviours in the individual, in particular young girls (Quiles, Quiles, Pamies, Botella, & Treasure, 2013).

Participant E's mom and aunt both wanted the patriarchy's ideal body, and engaged in behaviours to achieve their means, like fat talk and fat shaming, which is a common topic among family and friends. And this ideal was then taught to Participant E, continuing the cycle of women taking great strides to achieve the ideal body to be considered beautiful in the patriarchy (Lunde & Gattario, 2017). The main technique Participant E used to lose weight was through restriction.

Participant E also tried to lose weight by restricting her food intake. "I would eat reasonably small portions and it was salads, tuna, or some protein...avoiding fat, avoiding all sugar." Like Participant A, Participant E cut out foods from her diet, and ate only in small portions, a gender norm linked to an 'ideal' femininity (Lunde & Gattario, 2017). As stated before, it can be part of a healthy lifestyle to eat less of known junk food, but eliminating so many foods in means to restrict food intake to become thin crosses into the realm of an unhealthy lifestyle (Castillo, Feinstein, Tsang, & Fisher,

2015). She engaged in these behaviours so that she too could achieve the patriarchy's ideal female body (Simpson et al., 2016).

Participant F tried to control her weight through exercise by going to the gym. When asked how she tried to control her weight, she answered, "going to the gym and eating healthy." Participant F believes that she is in a continuous cycle between her weight and the gym. "The more I gain weight, the more I don't want to go to the gym because of [the] skinny clothes, and the more I don't go to the gym, the more I gain weight, and it's a damaged cycle." The "skinny clothes" Participant F is referring to are the commonly worn tight athletic clothing for exercise and sports. The phenomenon of "appearance culture" (Lunde & Gattario, 2017) as touched on with the previous participants (Participant A, Participant D, and Participant D), shows how the patriarchy's gender norms of exercising to look thin and having the idealized body is more important than a body that needs to perform for sports or be functional (Lunde & Gattario, 2017), or even healthy. It also demonstrates how internalized appearance gender ideals come to be established as personal goals and standards against which to judge oneself, often harshly. Though Participant F frequently exercises, her over exercise may be her downfall to an unhealthy body that cannot be functional (Noetel et al., 2017).

Whenever Participant F has a meal with her husband, she insists that his portion is always larger than hers. "I always insist on my husband to eat more than I. It's very important for me that in comparison to him by not [being] fatter. I want to be a good match for him." Even though she realizes that this behaviour is deeply gendered and she should not do it, she still participates in it. She tries to convince her husband to eat more food, so that she can also eat more food. "When I cannot convince him to eat as much as

I want him to...I start not eating as much as my body needs.” Shaped by the broader patterns and gender ideals, small portions of “healthy” food is seen as feminine, compared to larger portions of “unhealthy” food is viewed as masculine explaining Participant F’s need to always eat less than her husband. Expanding on this idea, females often experience of sense of shame when they eat or when they eat “too much” (Lunde & Gattario, 2017). Participant F might feel a deep shame when she wants to eat more than her husband making her “bigger” than her partner. So rather than eating more, she chooses the other option of not eating enough, in turn, not giving her body the sustenance it needs.

The extent of Participant F’s food control goes further because she tries to ensure she is receiving the perfect amount of calories, vitamins, and carbs daily. “I have this scientific definition of [eating healthy]. Eating the perfect amount, trying to receive the perfect amount of calories that your body needs for the day. Trying to receive all the macro elements and micro elements that your body needs, all the vitamins and carbs, everything should be on a schedule.” Though she does not count her calories, she closely watches what is on her plate and what enters her body. “No, not specifically by [calories] numbers, I just watch [my food].” Eating the correct number of vitamins, carbohydrates, and calories for ones’ gender, size, and age can be healthy, but Participant F taking this set of rules and trying to survive on the minimum amount is not a healthy habit (Castillo et al., 2015). Again, Participant F might be trying to avoid the shame of wanting to eat more food, or the correct amount of food for her gender, size, and age, in an attempt to be feminine (Lunde & Gattario, 2017). When Participant F engages in these food rituals she is trying to ensure that she stays thin and attractive, staying beautiful so her husband

wants to be with her, and ensuring that she is beautiful according to the patriarchy's standards (Simpson et al., 2016).

Though food and exercise are part of a healthy lifestyle (Meyer et al., 2011), Participant A, D, E, and F all took it to the extreme for different reasons. They all took measures to control their body weight through restriction of food, purging of food, or excessive exercise. These measures all took tolls on their physical health and their body weight. These factors fed into what they believe is the 'perfect body', showing the extent of how far they are willing to go to achieve their means, meeting various standards, reflected in an ideal of femininity, or the standard of a masculine Twink. The participants' exercise and food rituals also led to their ideas of what a positive body image is compared to a negative body image, begging the question: how else did body image and EDs affect the participants' life?

Theme 2: Gender, Bodies, and Sexual Activity

All participants admitted to having both a positive body image and a negative body image of themselves and their body image did change the amount of sexual activity they engaged in. The phrases being the non-conventional meanings since to the participants "positive body image" meant being and fitting into the gendered ideal, and "negative body image" not being or achieving the gendered ideal. Across all genders a common idea arose: positive body image typically led to more sexual activity while a negative body image led to less sexual activity, but target weight did not have too much of an impact on sexual activity.

Positive Body Image and Sexual Activity

Participant A believed a positive body image day for her is typically when she is very sick with her ED. “Oddly enough, if I want to say that I had a positive body image, the best I felt about my body, this is usually sad, is when I’m really sick.” The word ‘sick’ to Participant A meant she was extremely underweight because of her ED. “I was sick, that meant I was really underweight.” Participant A also felt more confident when she had a lower weight. “When I was at my lowest weight I was insanely more confident.” Not only was Participant A more confident, she felt she could go outside and not worry about her body.

The difference was I felt like I could go out of my house and I didn’t have to worry. And that’s why I liked it. That’s why I felt I had confidence, when I was at a really low weight, because I felt I didn’t have to worry about it.

Unfortunately, the feeling of being slim and skinny is something many women strive for because it boosts their confidence and self-esteem (Grogan et al., 2013). Body image fears around being too ‘fat’ fuel women and girl’s ambition to achieve patriarchal standards of beauty. According to the patriarchy, to be a ‘good’ woman means to be a ‘thin’ woman. Also, in achieving this ‘ideal’ body shape, Participant A must have felt proud of herself because she had achieved the patriarchy’s gendered standards (Simpson et al., 2016) and it was only then that she could be confident about her body.

Though it was rare for Participant A to have a positive body image, she admits that if she was having a positive body image day she would be more likely to be sexually active with her partner. “I know that even just from the last few months being in a relationship if I was feeling skinny one day, like thinner and not bloated or full and not, I

was much more apt to be really intimate.” Adhering to the same principle previously mentioned, relating the ideas that being slim and confident, as Participant A experienced, can result in more sexual activity (Grogan et al., 2013; La Roque & Cioe, 2011).

Participant A felt positive about her body when she had reached her positive target weight. Her ‘positive target weight’ refers to a healthy weight she was striving to achieve during her treatment. When she was at her positive target weight, she felt like she had more to give sexually.

For my healthy weight, like my positive target weight...I did feel more like I had something to give sexually...I did have moments where I felt more sexy and more like ‘oh yes, I have something to offer.’ I kind of embraced it, and embraced that he was having a positive response to it...I think it did improve my sexuality for sure.

It is likely that since Participant A was feeling positive about her body and felt she could be more sexually attractive to her partner, since she had more to give him, that she did engage in more sexual activity because of her positivity. Relating the idea of body positivity and confidence with the idea of more sexual activity is confirmed again with Participant A (La Roque & Cioe, 2011).

Participant B has always had a positive body image and believes it positively affects her sexual activity. “I have actually always really had a decently positive body image and I have just been a really confident person most of my life.” She believes her body positivity and confidence stems from her experiences in high school being involved with different clubs. “I decided I love doing all this stuff and I should be confident.” Women engage in a lot of different behaviours to maintain a higher body image, like

clothing, appearance, grooming products, and makeup (La Rocque & Cioe, 2011), and Participant B is no different. “My sisters and I were all super crazy girly girls who love to be pampered and do our hair.” Participant B’s positive body image can be explained through the time and effort she spends on her makeup, hair, and clothing along with being active within school clubs. In addition, Participant B states that she is the most “horniest” when she is dressed up for an event with her hair and makeup done. “I would say [I’m] horniest on nights where we go to a formal event. I am dressed up and my makeup is like a full face of makeup, and my hair is done.” This continues the idea that her makeup and clothing boost her confidence making her more likely to engage in sexual activity (La Roque & Cioe, 2011).

To continue, Participant B believes that sexual activity with her partner is part of their healthy lifestyle. “When I think about sexual activity I’ve always thought of it as like another quadrant in my life...it’s a part of a healthy lifestyle.” And Participant B strongly believes that how much she enjoys sex is dependent on how she feels about her body image.

How much I enjoy sex is 100% depend on how I feel about myself that day...I agree with that like upon a positive day and I did feel happy [I] was way more likely to have sexual activity, especially on the times where I feel like I’m really dolled up.

Sexual activity is part of a healthy relationship (Pinheiro et al., 2010) and it has been found that women who have a positive body image engage in more sexual activity. Since Participant B typically has a positive attitude and a positive body image, this can explain why she is more likely to have sex when she is “dolled” up.

Participant C typically does not have a positive body image, but does not believe it affects his sexual activity. “I’m a pretty amorous gentleman, [I’m] good to begin with, but I think I would be.” Instead he believes that a positive body image would give him confidence to be more friendly and flirtatious. “I think I’ll be more likely to be friendly and flirtatious because I just feel confident.” His sexual activity and libido may not be affected by his positive body image because sometimes the frequency of sexual activity can affect an individual’s outlook on body image. Having a higher frequency of sexual activity can relate to greater satisfaction in a relationship (Ackard, Kearney-Cooke, & Peterson, 2000). It is possible that since Participant C is quite amorous with his partner that he has a greater satisfaction in his relationship, which could overpower his feelings of a positive or negative body image. Also, Participant C’s amorous behaviours can be linked to a distinctly masculine norm, where men are expected, compared to women, to initiate and enjoy sex, and to be hyper-sexual (Kiefer & Sanchez, 2007).

Participant D had a positive body image before being raped. As mentioned earlier, this was the turning point in his relationship to his own body. Nonetheless, when he was frequently going to the gym to exercise and he noticed that he was getting slimmer, making him more confident. “I finally started going to the gym and I noticed I was getting slimmer and leaner...more muscular. This is something ideal that I wanted for a long time.” Participant D, like many others who exercise, felt more confident when he saw changes in his physique. Participant D was near his ideal body making him feel positive about his body image. It is common for individuals who exercise to have a positive body image. There are many people who exercise for the sole purpose of having

the body that the patriarch idealizes, and Participant D might fall into that category (Lunde & Gattario, 2017).

Participant D believes that if he had a positive body image he would be more likely to have sex, or actively look for someone to be sexually active with. “I definitely think if I had a more body positive image I would definitely be actively looking for sex.” But for participant D, he still operates from a binary framework when it comes to understanding a positive body image that excludes notions of being healthy. For Participant D, to have an ideal body simply means to be slim, not necessarily healthy. In the same way, he still believes explicitly or implicitly that a fat body is a bad body, an unattractive body, which gestures towards how powerful the discourse around fat-phobia is in our current culture.

I feel like I would definitely be more inclined to like look for sex and have sex and stuff. I think what it is to like I go on Grindr and I see like all these guys are they're like, you know built bodies and slim bodies and whatnot. I'm just like I don't fit in any of that category and . . . One of my friends, I'm also kind of attracted to. He's like really good-looking and he's like such a nice slim body . . . with the lean fit . . .very fit body. That's just like hot like, you know, I mean like I love that but the same time and then I keep thinking like if I know he wouldn't like it if you were to hook up . . . [he would] probably look at my body be like a like “ew.”

It is noncontroversial to suggest that we live in a ‘fat’ shaming patriarchal society (Meulman, 2019). People who are described as ‘fat’ are meant to feel shame about their bodies, to feel inadequate, to feel inferior, and to feel unworthy in a patriarchal society

that worships youthful ‘skinny’ and ‘slim’ (Uhlmann et al., 2018). ‘Fat’ people are meant to feel like their bodies are “ew”, to use the words of Participant D.

Nonetheless, Participant D explained that he is actively looking for sex on dating apps. “I would definitely be more inclined to look for sex and stuff. I think what it is I go on Grindr.” Participant D knows that when he becomes more confident with his body image he wants to put himself out there to find his lifetime partner. “I am still looking for that one special person...I think the more positive body image [I have] I would put myself out there and be inclined to even go on a date.” Participant D’s thoughts of dating, or putting himself out there only when he has a positive body image, are the same thoughts of many others. Many others avoid sexual activity and relationship because they do not have a positive body image, but engage in sexual activity and a relationship when they have one. It seems like Participant D is engaging in that same behaviour, waiting until he has a positive body image to be sexually active. Participant D did not want to be actively looking for a partner until his body looked better. He probably believed that for his body to look better he needed to adhere to the patriarch’s idealized body. For men, the idealized body is typically lean but muscular (Murnen, 2018). Since his body was not at the standard that he was holding himself to, he was actively avoiding sexual activity due to his body image (La Roque & Cioe, 2011).

Participant D experienced a positive body image when he was in high school and still had his ED. He admitted that in high school his positive body image encouraged him to be more out there and sexually active. “I felt really comfortable and happy about myself... When I was going through the disorder, I was really out there.” Because he had such a positive body image he felt he could engage in sexual activity anywhere and not

be ashamed of his body. “During the day I didn’t care if any lights were on or off. I was fine with doing whatever. So, I think [a] positive body image would definitely encourage me to be more out there with the lights on.” Having a positive body image often results in not caring if the lights are on or off during sexual intercourse (Ackard, Kearney-Cooke, & Peterson, 2000). Additionally an individual with a positive body image is more likely to keep the lights on during sexual activity. Since Participant D was very comfortable with his body and had such a high body image, it resulted in him not caring where he had sex or if the lights were on.

Participant E had a positive body image when she engaged in disordered eating. She lost weight rapidly one summer, due to her highly physical job, and received many compliments about her lower weight. These compliments made her feel positive about herself and she wanted to keep receiving those compliments. “After I lost all that weight accidentally, that now I was beautiful. So that took me down a path of obsessing over my body image.” It was through positive compliments and Participant E’s realization that she had the ideal body that Participant E started having a positive body image. Many other women feel they also have a positive body image when they receive positive compliments and feel slim (Grogan et al., 2013). Participant E followed suit and tried to continually have a positive body image.

Participant E had a positive body image when she was able to reach her low target weight. “I had a goal for a certain date. If I were to reach [the goal], that would be a positive body image because I was able to reach that goal.” Her target weight affected her sexual intimacy as well. “I remember a time when he was trying to lift up my shirt, but I didn’t want it because I didn’t feel like I was the ideal shape yet...I wasn’t gonna allow

any type of intimacy because I didn't feel beautiful." But when she lost more weight, she allowed herself to be sexually active with her partner. "I lost more weight so, therefore, I felt as though I had reached or was able to maintain the kind of body shape that I wanted. And that's what I allowed, you know clothes come off, that kind of stuff." Participant E withheld herself from engaging in sexual activity with her partner because she believed she did not have the body shape she wanted. This body shape that she desired was most likely the one that is idealized by the patriarch (Simpson et al., 2016; Uhlmann et al., 2018), which led Participant E to believe that she was beautiful only when she had a slimmer figure (Grogan et al., 2013).

Participant F believes that she usually has a positive body image but will turn negative if she gains even one pound over her target weight. "I think that I have a positive body image of myself most of the time. Sometimes, I don't, mostly when I gain weight, even one pound, it bothers me." But when Participant F does have a positive body image, sometimes she is the one to initiate sexual activity with her husband. "When I have a positive body image, I even try to start the sex on [my] husband." Participant F's eagerness to initiate sex when she had a positive body image is similar to the experiences of many other women (Ackard et al., 2000). Body positivity is also related to frequency of sex, orgasms, and giving the partner sexual pleasure (Ackard et al., 2000). When Participant F had a positive body image she was not only likely to initiate sex, but to have a more positive experience because of it.

Participant G is very positive about her body image. "I'm pretty good about having a positive body image." Even when it came to her sexual activity, she had a positive outlook. "[I'm] coming at it from a very healthy mindset. I wasn't looking for

sexual validation.” Participant G did have a few past relationships but never let her body image get in her way. “My body, my business and if you appreciate it then good, and if you don’t like it we need to talk. You don’t need to be [a]part of [my life].” Since Participant G had such a positive body image, it is very likely she had a very high self-confidence leading her to believe that she did not need sexual activity or be in a relationship to keep her happy. Participant G had no reason to be sexually anxious or engage in unhealthy eating behaviours, nor did she need sexual activity to validate her body image because by herself she was already satisfied (Pujols, Meston, & Seal, 2010).

Negative Body Image and Sexual Activity

Participant A cannot recall too many times that she has had a positive body image, because she has always hated her body. “My earliest memories is me hating my body. That’s where my memories start.” Her negative body image continues and affects her daily life to this day. Participant A let her body image control her. “It dictates a lot of my brain thought too. I get very depressed. It dictates my mood. So, if I feel bigger, I’m sad and more sad. If I feel thinner, then I’m happier.” Participant A must relate to many other women who believe that when they feel slim or skinny, they also are happier about their body image (Grogan et al., 2013). This could also be an ideal that many other women, like Participant A, have internalized because of the patriarch and the media (Simpson et al., 2016).

When Participant A was having a negative body image day, which is quite common as mentioned previously, she believed that she would be more inhibited to be sexually active. “If I was feeling bloated and fat definitely was less sexually active, less wanting to put myself out there and be sexually active. Much more inhibited.” Participant

A also felt “disgusting” on a negative body image day. “I would just feel disgusting. I just wouldn’t want to be touched, I wouldn’t want anyone to look at my body.” Since Participant A was still recovering from her ED, she did not want to be touched, for fear that her partner will think she is “fat.” “I don’t like him touching me there because I feel it, I feel the fat there.” The avoidance of sexual activity is common when individuals have a negative body image (La Rocque & Cioe, 2011). So, Participant A, like many other women, avoided sexual activity with her partner because of her negative body image.

Participant A also experienced a lack of sexual libido because of her ED and her negative body image. “He kept giving it to me and I kept attempting to do it with him and I couldn’t go there. I don’t know what it was but my level of libido and attraction, it just felt so not there.” EDs have a high co-morbidity with depression. Depression is known to cause a lack of libido (Michael & O’Keane, 2000). It is probable that Participant A’s deep negative body image and ED led her to a depressive state resulting in a lack of libido, and that this lack of libido led to the lack of sexual intimacy in her relationship.

Participant A’s negative body image put tension on her previous relationship. “It put tension on my last relationship because we couldn’t go places he wanted to go sexually.” She believed that her negative body image affected her self-confidence, and since being sexually intimate was a new experience for her, that added another level of tension. “It makes you feel not attractive and sexy too...It was definitely difficult and I was definitely timid and low self-confidence. And it was all new territory, even being touched.” Participant A knew that she was not giving enough to him sexually, even though he was giving sexually to her, and she felt this unfair. “That made me feel bad,

but if you can't give as much as you get, you know?" Participant A believes that this was one of the reasons her relationship failed. "There were a few reasons, it was in the mix. Because I knew he wanted more [sexually], and I wasn't giving it to him." It is known that sexual activity is important in a healthy relationship, but an ED can cause sexual anxiety, leading to a decrease in sexual activity (Pinheiro et al., 2010). It is likely that Participant A's ED and lack of sexual experience made her feel sexually anxious, leading to the absence of sexual activity in her relationship and to its demise.

To understand Participant B's body image, more understanding must be brought to her childhood. Participant B had a complicated relationship with her father. "My dad is foreign and he didn't always understand how to talk to a girl." Without her dad understanding her emotions, Participant B would often be hurt by some of her dad's comments about her body. "I remember in those pivotal years, Grade 6-8 that he was very hard on me about my weight. And you know, was trying to make positive contributions but didn't really know how to go about it." During this pivotal time, Participant B had just reached puberty and just wanted to fit in at school. "When you're that age you want to hang out with your friends and eat pizza. I want to eat junk [food] or you want to do those things. But he had always had the best intentions." Participant B felt that since her dad was saying negative comments about her weight and body that he did not love her. As Participant B describes it:

I definitely think that that contributed to me feeling very hard on myself about my body image because I was like, my dad doesn't even love me because I'm fat. I remember thinking that, which is so sad when I think about that now because it's not true, but that's how dramatic it felt at the time...He would just talk...I saw a

psychologist, we talked about it and she was like, ‘Would you categorize it as like verbal abuse sometimes?’ Yes, sometimes no. It depends on like when it would like escalate, but he was never like ‘you’re fat.’ He would never say that, but he would say, ‘you know you’re overweight You’re getting so big you can’t be eating junk food, you know. You’re not going to be able-’ These are things that [are] very strange to say to a child... He would say things to me like you’re not going to be able to work a regular job if you gain too much weight.

These comments from her dad hurt her at the time and did affect her body image in the future. These comments made Participant B aware of her body, and being bigger, and knowing that other people thought she was bigger too. Participant B and her father have made amends and she knows he said them out of love.

When we care about people we care very intensely. I don’t know how to love anyone half-ass. I’m a full love kind of person, so I think he’s the same, I think I get that from him. So I remember stuff like that. So yeah, grade 6, grade 8, I feel like me and my dad have a really strained relationship because of that and that’s when I would say [that was] the height of my negativity about my body.

Participant B’s dad’s negative comments encouraged her negative body image. This was damaging to Participant B because she believed her pre-teen years were ‘pivotal’ in her development, and her dad’s deeply gendered comments only added stress, which is a common phenomenon found within families (Quiles et al., 2013). It is likely that Participant B internalized these comments, and started to believe they were true, contributing to her negative body image that was evident in her pre-teen years and sometimes arose in her adult life. But because of Participant B’s innate positive

personality, she managed to overcome this and maintain a generally positive body image and attitude.

Participant B has struggled with her weight most of her life. “I’ve been overweight most of my life. Probably since the sixth grade I’ve struggled with my weight.” Despite this she has maintained a positive attitude and body image. But once every few months she has a negative body image and attitude leading to a downward spiral of her thoughts.

I know of spiral...I don’t feel good about myself, and then I don’t feel good about the way I look, I don’t feel about the way I like personality. I don’t feel good about my friendships and relationships. I don’t feel good about my life.

When Participant B is in a downward spiral, she admits that she and her partner go through dry spells in their sexual activity. “We go through occasional dry spells in the fact of when I feel really bad about myself, when I’m really going through a hard time.” Participant B is thankful for her supportive partner, but knows it affects their sexual activity. “I think it does affect my sexual life [and] my body image because that can be part of the negative feelings.” It is not uncommon for women to feel negative about their body image. Typically women who experience a negative body image will avoid sexual activity (La Rocque & Cioe, 2011). This idea can explain the reasoning behind Participant B’s negative body image leading to an absence of sexual activity with her partner. Also, the negative feelings and her lowered self-esteem might have made Participant B feel undesirable because of her physical appearance, not achieving the gendered ideal, very similar to the participants in La Rocque & Cioe (2001) study who also felt they were undesirable because their bodies did not fit into the gendered ideals.

Participant C describes himself as “a bigger boy” and at 28 years old he has seen noticeable differences in his physical appearance due to his age. “I got old, fat, and sad...I’ve also gained a significant amount of weight.” Because of Participant C’s weight, he prefers sexual positions that are easy for him to do and where he does not feel he is hurting his partner. “Sexually, I don’t like being on top because I find that I get really in my head, that I’m crushing the girl underneath me and I can’t stay hard.” Revealing how shame operates in relation to his body, Participant C also prefers to have the lights off, so neither he nor his partner can see. “I also prefer, generally speaking, if am on top you know, I’d like the lights to be off. I’d like the lights to be off. I don’t really like to be seen.” Along with the lights shut off, Participant C also enjoys sexual positions where he does not need to look at his partner. “I like the spooning position because it feels good, but we don’t have to see each other.” Participant C does not like to be seen when he is sexually active, he prefers positions where he is not facing his partner or turning the lights off. The lack of libido that Participant C said he experiences sometimes (his inability to stay “hard” or erect during sex) can be explained through negative body image. Individuals with a negative body image have been found to have a lack of libido because of their negative thoughts (La Rocque & Cioe, 2011), explaining Participant C’s inability to stay erect during sexual activity. Also having the lights off during sex is a common method to still engage in sexual activities despite having a negative body image, which Participant C does (Ackard et al., 2000).

Participant D’s ED fueled his negative body image. He believes that if he had a negative body image he would not want to be sexually active. “I have such a negative body image, I feel really ashamed and I feel like it’s something that would not be desired

by anybody.” Participant D is afraid of the rejection he might receive if he puts himself out there and being ridiculed for his body. This is a reason why Participant D does not look for sexual activity when he has a negative body image. “When you already have such a negative body and such a low self-esteem and you put yourself out there and you get shut down or you don’t hear back from them, why would [I] even attempt that?” His negative body image interferes with his sexual activity and other experiences, which can be labeled as sexual avoidance. It is categorized under sexual avoidance because Participant D is only avoiding sexual activity and relationships because of his negative body image (La Rocque & Cioe, 2011), which fuels his anxiety and fear of being sexually rejected when he does attempt to put himself out there.

Participant D believes that his negative body image caused tension in a previous relationship and often asked for the lights to be turned off when they were sexually active. “I would be like, ‘can you please turn off the light?’ Because I didn’t want him to see my body.” Participant D did not want his partner to see his body because he believed he was chubby and he felt worthless because of it. “I would just shut him out, be like no I feel worthless. I feel like garbage because the way I look and I don’t really want you to see me.” Participant D’s constant negative body image made his partner pull away from him. “I can’t give you anymore because I’m encouraging you enough...why am I putting so much effort and work into being with you?” Participant D believed the relationship ended because he hated his body so much, and his partner could not do anything about it. A negative body image can often lead to sexual avoidance. Sexual avoidance is often accompanied by fear (La Rocque & Cioe, 2011). Participant D’s fear was his partner seeing his body, and him being ashamed of it. Though Participant D tried to cover his

fear of sight by having the lights turned off, a commonly used fix (Ackard et al., 2000; La Rocque, & Cioe, 2011), it did not stop his avoidance of sex because his negative body image was too powerful.

In Participant E's most recent relationship she had a negative body image. She only felt good about herself if her partner was complimenting her or giving her attention. When her partner was not doing that she tried to perfect herself through disordered eating. "I craved the attention. Didn't take care of myself, saw myself in a negative light unless it was through him." When she engaged in sexual activity with her partner she felt negatively towards her body. She was ashamed that she would let him push so far sexually, and for her to allow it. "In the weeks following [when] we broke things off, I felt horrible. I felt horrible that I had let myself relapse, and see myself in a poor image." Participant E's negative body image might have led to low self-esteem, and lower sexual assertiveness. It is possible that her lack of assertiveness to her partner led her to go further sexually than she had intended to, which led to a greater dissatisfaction with herself and her body image (Pujols et al., 2010).

Participant E would ask for the lights to be off if she engaged in sexual activity with her partner. She went further by closing her eyes because she did not want to see if he was dissatisfied. "[Lights] always off, and even, this might sound stupid, but closing my eyes the whole time because...I wouldn't be able to see if he was dissatisfied either....Just totally blocking it out." Turning the lights off is often used when a partner or both partners do not want to see each other's bodies during sexual activity (Ackard et al., 2000). Participant E used this method to not only keep her partner from seeing her body, but also as a method so she could not see her body or see if her partner was

dissatisfied with her. This method could also be interpreted as a form of sexual avoidance, avoiding certain sexual interactions, like sight, with her partner (La Rocque & Cioe, 2011).

Participant F knows that when she has a negative body image and is above her low target weight, she engages in less sexual activity with her husband. “When I have the negative body image, even if he wants to start the sex, I push him away.” When Participant F is above her low target weight and when she has a negative body image she prefers to have the lights off during sex and decreases the frequency she has sex with her husband. “When I have negative body image, I try to turn off the light during the sexual activity...I turn off the light during, [and] sex from three times a week goes down to once a week may be less.” Participant F loves her husband very much and it makes her sad that she reduces the frequency of sex she engages with her partner. “It makes me sad my sexual activities will reduce...I had times that I had sex with my husband once a month even.” Even though Participant F loves her husband, she still avoided him sexually when she had a negative body image. Appearance concerns are often associated with sexual avoidance and is found more often in women than men. This might be because women’s bodies are more publically judged in a patriarchal society. Participant F was anxious about her appearance, which is why she preferred to have the lights switched off during sex so her husband would not judge her (La Rocque & Cioe, 2011).

When Participant F has a negative body image she feels sad but knows that her husband will love her no matter what she weighs. This negativity brings tension into their relationship. Participant F’s husband has tried to find the problem in their relationship; he

is not worried about the lack of sexual activity, but rather wanting to know if there is something wrong to help fix the problem.

Sex is a very important part of a romantic relationship and he was seeking for the problem and that annoyed me more that he thought that something is wrong and he didn't know what and he just wanted to solve the problem. He didn't care about the sex that much but he just wanted to solve the problem. What's wrong with me? Is there anything wrong with me?... Do you have any problems at work? And he was all the time [asking questions]. I didn't want to share this with him because I thought that he will might he might think less of me and I didn't want this to happen. So I withhold the problem.

Participant F is correct when she states that sexual activity is important for a healthy, positive relationship (Pinheiro et al., 2010). So she must understand that it is unhealthy for her relationship if she does not engage in sexual activity with her husband. This could be why Participant F's husband was invested to solve the problem. Also, it is more often that women obsess over their appearance compared to men (La Rocque & Cioe, 2011). Which may be a reason why Participant F puts such a high value on her appearance and body image compared to her husband. Since men spend less time on their appearance, it is likely that Participant F's husband overlooked this factor when trying to solve Participant F's problem.

Participant G can only recall a few times that she had a negative body image. "There have been times like when you're in a fitting room and something doesn't fit and you think that's you're size...I must have gained weight." The other time she recalled having a negative body image is when her insulin pump left scarring and swelling, but

she used clothing to cover up her scars. “I wear an insulin pump sometimes. So sometimes that leaves scarring or swelling and so you can have a negative body image.” Overall Participant G is neutral about her body. “I’ve always just been very neutral about my body.” Similar to Participant B, Participant G also has a generally positive outlook on life, and rarely has a negative body image. Though Participant G is neutral about her body, she still believes that if she had a negative body image day that she would avoid having sexual activity. “I probably wouldn’t have gone seeking sex or seeking more people to view my body.” Though Participant G had never experienced this idea personally, her mindset does follow a common school of thought that women who have a negative body image are less likely to engage in sexual activity (La Rocque & Cioe, 2011). Although she had never experienced it, Participant G still understood the idea of having a negative body image, and what she would avoid on those days. Her thoughts could stem from media’s portrayal of women’s bodies and how they are supposed to be and act when they have a negative body image, or they are not the ideal shape to the patriarch (Simpson et al., 2016).

Theme 3: Gender, Clothing and Appearance

Participant A does not wear tight clothing because she dislikes the feeling of clothing against her and believes that tight clothing showcases her body, which she does not want. “Generally, I wear very loose clothing. Very, very loose. Sizes that someone might say are two or three times my size and I’ve been told that actually make me look bigger and not to do that. But I can’t stand the feeling of anything being tight on my body.” Wearing loose clothing is a common gender norm that Participant A relates to. Participant A takes focus off of her body by wearing loose clothing. “I don’t want

anything to stand out. I don't want to be noticed for my body, and so I hate when it is." Also, the loose clothing hides the disliked parts of her body. "There's parts of my body that I spend time picking apart and loathing it. Actually, hating it." Participant A may have engaged in this behaviour to take focus away from her body and hide it with clothing, so no one she interacted with could see her body that she disliked so intensely (Grogan et al., 2013). Also, Participant A making the conscious decision to wear very loose clothing can mean that she spends a lot of time thinking about her body and how people might perceive or judge her based on her body, like she does to herself.

Participant B was hyper-aware of her clothing and appearance on her Cancun vacation with friends when she was 19 years old. Participant B knew what types of clothing looks best for her body type and tries to dress accordingly. "I love dresses. I love skirts and I just feel like that flatters my body type. So, I remember being like 'Oh I'll wear dresses, people wear dresses to the beach.'" Perhaps, shaped by prevailing gender norms that so often function to regulate women's bodies (Simpson et al., 2016), Participant B explained that for her body type she wore less revealing bathing suits compared to her friends' more revealing bikinis. "Even my bathing suit was still like I would say not conservative because like my boobs are still kind of out...my butt was still kind of out, but like covered my stomach, covered my tummy. Like I had higher waisted bottoms and I was wearing a tankini, which were popular at the time." Clearly, Participant B, while certainly putting some time thinking about which clothing she preferred to wear, she was still self-conscious about areas of her body including her 'tummy'. Perhaps, like other women, Participant B felt because she did not have a flat

and toned stomach that is often attached to an 'ideal' body for women she felt the need to cover up (Simpson et al., 2016).

In addition to being hyper-aware of her clothing and appearance, Participant B also became aware that boys who were also on vacation were not pursuing her, like they were with her friends. Participant B tried not to care, reminding herself she had a boyfriend back home, but it still left her insecure. "I felt very insecure especially because they were getting a lot of attention from guys... But I was the only girl there who had a boyfriend and I remember being like 'Oh, like I don't even care that guys aren't talking to me because like I have a boyfriend anyways.'" Participant B believed that boys were not pursuing her because she covered up more of her body compared to her friends. "They are here like practically naked, you know ready for the taking and I'm here and I'm wearing a sundress, I'm kind of covered up." Participant B might have felt that she was not involved in the vacation fun with her friends because boys did not talk to her and chose to talk to her friends who wore more revealing outfits than her. Participant B might have believed that boys were not approaching her on vacation because her body was more covered up, going against a common gender norm that women need to showcase their body and attractiveness to potential romantic partners (Voelker et al., 2015).

Participant C was also very particular in what clothing he wore. "I wear black a lot because it's a slimming colour. I'm frequently in black 99% of the time." Participant C is constantly worried about tight fitting clothing and is sad how his body looks. Participant C wants to be perceived as slimmer than he is. Gender norms indicate that women are more sexually attracted to men with muscle mass compared to fat mass (Lei, Holzleitner, & Perrett, 2019). Gender norms and studies have also shown that women are

more attracted to a more masculine man, with masculine features. “I don’t have a distinctly alpha male presence, but I don’t care. I don’t really identify with that type of male.” The patriarch associates men with risk-taking activities, assertiveness, and toughness to showcase hegemonic masculinity (Murnen, 2018). Because of Participant C’s more quiet and non-alpha male demeanor, it could be possible that no romantic partners approached Participant C in the past because of this, solidifying the patriarch’s gender norms that alpha risk-taking males are deemed more attractive.

Each morning Participant D tries on multiple outfits, finding flaws in each of them before leaving the house. With almost every item of clothing he wore, he would find an imperfection.

I hate the way I look a lot of the time. Even this morning I was trying to put on this shirt and my stomach [is] sticking out...I hate myself every morning because I’m dressing myself for the day. It’s like ‘Oh my God, my jeans are so tight, like I’m such a fat-ass.’

There are a number of interesting things related to Participant D’s comment. First, it challenges the idea that men do not care much about how they look to others. Clearly, Participant D considers carefully his outward appearance and how that may be taken up by others, typically an attitude associated with femininity. Participant D’s intense dislike of his body extends further than his clothing. “Right now, I’m chilling here, I’m fine. It’s not a big deal. But as soon as I see myself naked in front of the mirror, that’s when it comes out...I just pick on every little point that I feel isn’t good enough or isn’t ideal.” Similar to Participant A, Participant D also uses clothing to hide his body and his perceived flaws, like not having the patriarchy’s masculine ideal body. Participant D

might have opted to wear looser fitting clothing so others do not perceive him as “fat”, because looser clothing does not cling to the body, compared to tighter fitting clothing which can emphasize the appearance of “fat” (Grogan et al., 2013).

Participant E used loose fitting clothing, like loose t-shirts and shorts, to hide her decreasing body weight from her family. “In the beginning of June I kind of relapsed. Where I stopped eating and I quickly lost a lot of weight. But it’s summertime, so you’re wearing shorts, wearing tank tops...so my mom and no one ever really noticed.” Similar to the previous participants, Participant E wanted to wear loose clothing, which hid and took the focus off her body. She did not wear tight or clingy clothing in an effort to not showcase her body, especially when she was not pleased with her weight. Also since Participant E was still in the process of losing weight she may have wanted to hide her body until she believed she had reached her perception of the patriarch’s standards (Grogan et al., 2013).

Participant E wanted to be really thin so that during the summer she would look really good in a bathing suit. “I just want to be really thin, [look] really good in a bathing suit.” The patriarch’s ideal body for women is to be lean and skinny and Participant E wanted to fit the idea (Uhlmann et al., 2018). Though she wore loose clothing to hide her lowering body weight, she believed that when she ‘achieved’ the patriarchy’s ideal feminine body she could wear a bathing suit so she could show off her body. Clothing that fits well or makes an individual feel slim or skinny creates body positivity (Grogan et al., 2013), a sentiment that only can be understood against the backdrop of our culture’s fat phobia. When Participant E was at her ideal weight and wore her bathing suit, she

may have felt a boost in her body positivity, making her more confident and more determined to stay at that 'ideal' weight.

Participant F also used loose fitting clothing to hide her body shape. "I try to choose dresses that cover my body." She uses this type of clothing to hide her body from others. Because she is from a mainly Islamic country, she sometimes enjoys wearing a hijab because it covers her body. "When we go travelling in the summer, I don't go to the beach. You might know that Hijab is obligatory in our country and those times it's the only time that I like the Hijab." Participant F uses loose fitted clothing to hide her body, so others cannot see her body shape and judge her for it. Interestingly enough, Participant F is from an Islamic country and uses the modest "dress code" as an excuse to wear looser fitting clothing. Participant F might have felt pressure to wear looser clothing because of where she lived, or maybe she was using the dress code as a way to avoid showcasing her body (Grogan et al., 2013).

Participant F had designated clothes for good and bad days. Her good day clothing consisted of colourful dresses and clothing, compared to her bad days where she wore old, less pretty clothing. "When I have a positive body image, I wear my pretty dresses. And when I have the negative body image I wear the old ones that I don't like. Somehow, I think that this is what [my] body deserves, not the pretty ones." It is found that women who have a lower self-esteem are typically less satisfied with the fit of their clothing (Grogan et al., 2013). Participant F might be able to relate to this gender norm because she has designated clothing for certain days. Participant F also stated that she thought she does not deserve pretty clothing on a negative body image day. This could be seen as a punishment tactic to reprimand herself for not having an ideal body. And the

pretty clothing for a positive body image day could be seen as a reward, allowing herself to look pretty on those days.

Participant F's clothing habits extend further because she does not shop or buy new clothing when she has a negative body image, or believes she has gained weight. "I don't go shopping because I just wait for my body to go to the best style and then shop the things that I like more." Participant F was explaining that she does not shop when she feels like she has gained weight, but rather waits for her body to lose weight before she buys new clothing. That way the new styles of clothing will look better on her body and she will like her new clothes more. Participant F's shopping habits mirror her good day clothing and bad day clothing. Where she is more satisfied with the fit of clothing on her body on a good day (when she has lost weight), compared to a bad day (when she has gained weight and does not go clothes shopping). Often, women identify with their clothing size, making their size very important to their self-worth and self-esteem. So, in turn, buying clothing that is bigger than their usual size can make them unsatisfied (Grogan et al., 2013). Participant F most likely connects to this gender norm by making her slimmer body her ideal clothing size. Because of this, Participant F does not want to go clothing shopping on days she feels she has gained weight because her smaller clothing size is attached to her self-worth and self-esteem. Also, buying a larger size than usual would make her doubt her worth and self-esteem.

Participant F has always been very focused on her outward appearance. She believes it stems from her childhood when she fell down and cut her face, leaving a large scar. "I hurt my face with a scar because I was a child and I dropped down...a slide." Participant F had hurt herself before, but she knew by the way her mother reacted that

this injury was different. “I remember that face on my mother that she thought ‘wow, what should I do now?’ And she was so stressed...My knee was always injured and she didn’t make that face, but that specific time, the problem was with my face.” Participant F’s mother insured that she got laser therapy to remove the scar, but noted that the scars on her knee were still there, and did not go away. “Maybe it’s very important for me to have a pretty face...I saw her looking for different kinds of doctor for laser therapy to remove the scar, the scars on my knee she didn’t care, but my face was that important.” This experience shapes Participant F’s outlook on appearance today and takes measures to ensure her beauty (i.e., facials and exercise). “I think that’s part of culture that girls must stay pretty.” Participant F learned from a young age from her mother that physical appearance, especially her face, is important. Participant F’s mother might have learned this from a gender norm believing that beauty is feminine, and that females must alter their natural beauty. She solidified this mentality into Participant F when she treated the scar on her face, but not her knee. Females are told through gender norms that beauty is feminine and they must alter their natural appearance (Grogan et al., 2013). This lesson and gender norm still may be very present in Participant F’s life, shown through the extreme measures she takes, like exercise and nutrition, to keep herself beautiful according to the patriarch.

Participant F wore Spanx or shapewear under her clothing at work so her clothes would look good and that she would have a more desirable figure. “I wear tight dresses and [wear] tight [shapewear] under the dress, so the dress looks good.” Participant F admitted that the shapewear hurt her, but since she could wear what she wanted to her work since she was the boss, she chose clothing that she felt pretty in. “I wear it even at

work and it is bothering, you cannot even breathe perfectly. I had my own business, I could wear anything I want.” Because of gender norms around the ideal body, Participant F might have felt pressured to wear Spanx or shapewear under her work clothes everyday so she could be beautiful according to the patriarch (Grogan et al., 2013; Scott, 1997). Even though it was painful and it made it hard for Participant F to breathe, she still wore it every day, striving to have the perfect feminine body that the patriarch and now Participant F idealizes so highly.

Participant G has Type 1 Diabetes and would change her clothing to hide her insulin pump. Though she typically has a positive body image, the scarring and swelling from the insulin pump does affect her body image. “I wear an insulin pump sometimes. Sometimes that leaves scarring or swelling, so you can have a negative body image.” Participant G worked in a clinic and would hide her insulin pump with certain clothing. “I worked in a clinic and [was] careful about covering up scars...you don’t want them to think you’re weak and vulnerable.” Women often use clothing to accentuate their attractive features, but also to cover up features they are not satisfied with. Utilizing clothing in this way can boost confidence, especially when hiding flaws (Grogan et al., 2013). When Participant G used this technique to cover her scars it is likely that her confidence raised because she felt less vulnerable to patients.

Through the participants responses it is clear that clothing and appearance was ever present in their everyday thoughts, adding confidence to the impact of gender relations. Clothing was another technique used to cover up imperfections, and to generally hide their body from the world. By ways of covering up, wearing loose clothing or even a Hijab, the participants were hiding their body from being judged from others,

and to have the appearance of a better body shape than what they believed they portrayed. This shows the tight grip the patriarchy still has on young minds, telling them to cover up their body if it is undesirable, and show it off when it is.

CHAPTER 5: DISCUSSION AND CONCLUSION

Discussion

This study wanted to explore individuals with EDs and how that might shape their sexual activity using a feminist framework. Individuals who had unhealthy eating behaviours or just an opinion on their body image were also interviewed to create a more diverse picture surrounding this topic. Two participants were diagnosed with an ED, two participants engaged in unhealthy eating behaviours, and the last three participants all had a positive or negative body image. There were two male participants, which is quite rare for a study regarding EDs and body image because of the patriarch's stigma about males not having EDs, or not admitting to their weakness. The five of the participants are from Canadian or European descent, one participant was an immigrant from Iran, and one participant was from Indian descent. The diverse range of disorders, opinions, ethnicity, and age all contributed to a fuller picture of this topic.

Feminism explains how patriarchal understandings of gender are taught to people, beginning at a young age, in a way that powerfully shapes their self-identity when it comes to bodies and body image. Regarding the first theme, the majority of the female participants in this study wanted to be thin, small, and docile compared to their male counterparts who wanted to be viewed as an alpha male, being strong and fit, or in the case of the one participant, acquiring the look of the 'twink' (Murnen, 2018). The participants had these ideas ingrained in their mind because of how patriarchal views of gender insidiously work their way through culture, in a way that seems unavoidable. But as mentioned before, it is through a feminist lens that the participants' behaviours and actions can best be explained. For example, reflecting how the patriarchal relations

shapes attitudes toward eating, Participant F ensured she always ate less than her partner, to make it seem she was a good match for him. By eating less than her male partner, she was engaging in a behaviour that would make her seem smaller and more docile than her husband, which is a gender idea likely internalized at a young age. The feminist lens showcases the inequality that Participant F, and the majority of the participants, face each day, the inequality of not eating enough food to support bodily functions, followed by excessive exercise, all with the aim of achieving the feminine 'ideal' when comes to body image.

Also, this inequality that Participant F encountered supports the patriarch and keeps men in a higher position of power than women, being that women need to be small and submissive (Friedan, 1963), both physically and otherwise. Compared to Participant C where he knew he could not be an alpha male, even though he believed that it was men who worked to display a hegemonic masculinity that were more attractive to women. This showed the inequality that men feel within their peers. These examples highlight the strict gender roles that the patriarchy portrays in daily life, women being submissive, and men being strong and fearless (Murnen, 2018). It is through these gender roles that help keep men in power, continuously reinforcing the fact that women should strive for a skinny and lean body to be beautiful, which could lead to eating disorders, and men should strive for a strong and lean body with the ultimate six-pack, which could also lead to eating disorders, to further the social constructs (Hesse-Biber, 2013).

This study found that most participants believed if they felt slim or skinny, that led to their confidence, which often resulted in engaging in more sexual activity. Compared to when the participants did not feel this way, feeling bigger or bloated, that

led to sadness and negativity, often resulting in engaging in less sexual activity. This alludes to the patriarch again placing a heavy emphasis on body image and having the slim idea body, to the point where the participants let their feelings about their body dictate their mood and behaviours for the day. But, not only letting their feelings affect their day, but also their partners day, further extending this gender construct and inequality. This shows the impact of the patriarchy's very gendered ideals onto the public and how it does affect our thinking and behaviours. The negativity that the patriarchy placed on the participants continually added to their growing negativity about their body and body image. With the patriarch's constant messages about being thin and fit (Lunde & Gattario, 2017), and the participants being unable to attain this standard adds to a cycle of negativity, which can lead to unhealthy eating behaviours, excessive exercise, or an eating disorder in an attempt to attain the patriarch's standard.

It is noncontroversial to say that patriarchal understandings of gender powerfully dictate what individuals wear and how they choose to portray themselves. All participants in this study used clothing to hide certain body parts that they did not find desirable according to the patriarchy. The types of clothing each participant chose to wear were gendered. The female participants opted for looser fitting clothing to hide their "large" or "bloated" stomachs, instead of tight fitting clothing which could cling to their skin, showing off their stomachs or belly areas where the female participants were most concerned over. The gender construct here is women wanting to portray their bodies as slim and beautiful so they adhere to patriarchal standards of being a beautiful and desirable woman (Grogan et al., 2013). Many of the female participants spent extra time during their day making sure their clothing, hair, and makeup were all done well to look

beautiful. Which is another gender role associated with women, to make sure they are beautiful constantly (Uhlmann et al., 2018). It goes without saying, that the time spent by women on making the body conform to patriarchal views of gender, could be better spent perhaps on other matters. The male participants in this study also spent time on their clothing and appearance. Similar to the female participants, the male participants opted for clothing that would make them appear slimmer, for example Participant C wearing black almost all the time because he believed it was a slimming colour. Keep in mind, that for men, stylize in the body in a way that conforms to hegemonic masculinity is a way to avoid being bullied and harassed. Males, for example, who are perceived to be overweight, are often ridiculed and bullied (Lee, Dale, Guy, & Wolke, 2018) Again, clothing and appearance can show the inequality within marginalized groups found in the patriarch and the gender roles that are reinforced and often followed (Brooks & Hesse-Biber, 2007; Grogan et al., 2013).

Gender relations showcase the inequality that the participants faced. Gender roles influenced the female participants to have a perfect body and to be beautiful constantly. And gender roles influenced the male participants to maintain a toned, lean and muscular body constantly. Because of the patriarch's high standards of body image and the constant reminders that if this body image is not attained that that individual is a "failure" and is not desirable to the patriarchy or to a romantic partner. The feelings of being undesirable or their body type not fitting into these standards can marginalize the individual leading them to become negative about their body image, and sometimes going to extreme lengths (like restriction, purging, binging, excessive exercise) to achieve the high, and near impossible) to maintain these gender standards (Uhlmann et al., 2018).

Gender roles in a patriarchal society show the body image injustices that individuals face on a daily basis and shows the power difference between the powerful and influential, and the individual being powerless and easily influenced by the patriarch (Martino, 2008; Fryer, 2010). It is through feminist theory that these studies themes can be explained, and it is through feminist theory that can help stop the injustice of body image shaming.

Feminist theory also represents oppressed groups, for this study the two male participants (Participant C and Participant D) both fall under oppressed groups. Starting with Participant C referring to himself as a bigger boy and not an “alpha” male places him in a different gender role going against the traditional patriarchy. This role includes men who have a more caring and emotional side, and have strong relationships with the women in their lives. Similar to Participant D he represents someone fighting for gender equality as a gay male. In past years it has been more publicized for gay men to be more vocal about their gender roles and equality within the patriarch (Connell, 2005). Both of these participants had a unique position within the patriarch since both went against the traditional norm of men. Participant C and D both reinforced the fact that they are still oppressed within the patriarchy, a community made for men to dominate, but show the growing movement to accept different gender roles in the community and show that their ideas and beliefs about body image matter just as much as a females opinion.

Using a feminist standpoint gave the participants the rare opportunity to share their story about their body image in a safe environment and let their voice be heard. Feminist theory gave the participants an opportunity to voice the patriarchy’s ideal body weight and image and how it might be a skewed idea. It also showed how strong of a grip the patriarch still has on society (Harding, 1986), still dictating what society and the

media has to portray to be beautiful: a woman being slim, and a man being toned and muscular.

Conclusion

This study was important to conduct because few recent studies have explored the relationship between EDs and body image with sexual activity. Because of the growing population of individuals being diagnosed with EDs, more information will be needed to help treat and understand the disorder and furthering the treatment to understand how EDs and body image can affect sexual activity. Also, educators can use their platform to teach more on the variety of gender roles, and slowly move away from reinforcing the traditional roles. Future implications for this study extend to both researchers and educators. Researchers can duplicate or improve this study since it was conducted on a small scale. Researchers, clinicians, and educators could use this study to teach others in the sexual health and ED field that this often overlooked topic is very pressing for individuals who have an ED and their partners.

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APPENDICES

Appendix A: List of Clinics and Help Lines

Appendix B: Letter of Information

Appendix C: Letter of Consent

Appendix D: Recruitment Flyer

Appendix E: Guiding Interview Questions

APPENDIX A: List in Clinics and Help Lines

Free Mental Health Clinics in Windsor-Essex

Bulimia Anorexia Nervosa Association (BANA)

Eating disorder treatment for all individuals

1500 Ouellette Avenue, Suite 100

Windsor, Ontario

N8X 1K7

Telephone: (519) 969-2112

Toll free telephone: 1-(855) 969-5530

Email: info@bana.ca

Community Crisis Centre

Mental illness or acute psychosocial treatment available for all individuals

1st Floor Jeanne Mance Building

1030 Ouellette Avenue

Windsor, Ontario

N9A 1H9

Program Manager phone: (519) 254-3486

Program Coordinator phone: (519) 973-4411 ext. 31403

Windsor Regional Hospital Ouellette Campus

1030 Ouellette Avenue Emergency Department

Windsor, Ontario

N9A 1H9

Family Services Windsor-Essex

Counselling and support services to all individuals, couples, and families

1770 Langlois Avenue

Windsor, Ontario

N8X 4M5

Telephone: (519) 966-5010

Email: info@fswe.ca

Mental Health Connections

Psychosocial rehabilitation for all adults

370 Erie Street East

Windsor, Ontario

N9A 3X3

Telephone: (519) 256-4854

Student Counselling Centre at the University of Windsor

Counselling services available for all registered University of Windsor students

401 Sunset Avenue

University of Windsor Student Counselling Centre

2nd floor Room 293 CAW Centre

Windsor, Ontario

N9B 3P4

Telephone: (519) 253-3000 ext. 4616

Email: scc@uwindsor.ca

The Canadian Mental Health Association

Mental health treatment for all ages

24 hour Crisis Line: (519) 973-4435

Downtown Location

CMHA Windsor-Essex County Branch

1400 Windsor Avenue

Windsor, Ontario

N8X 3L9

Telephone: (519) 255-7440

Email: info-referral@cmha-weeb.on.ca

Transitional Stability Centre Location

744 Ouellette Avenue

Windsor, Ontario

N9A 1C3

Telephone: (519) 257-5224

Email: patricia.thomas@hdgh.org

Leamington Location

215 Talbot Street East

Leamington, Ontario

N8H 2X5

Telephone: (519) 255-7440

Windsor Essex Community Health Centre: Teen Health Site

Physical and mental health treatment available for individuals between the ages of 12-24

1361 Ouellette Avenue #101

Windsor, Ontario

N8X 1J6

Telephone: (519) 253-8481

24 hour Crisis Telephone Line: (519) 973-4435

APPENDIX B: Letter of Information

LETTER OF INFORMATION FOR CONSENT TO PARTICIPATE IN RESEARCH

Examining the Impact of Eating Disorders on Sexual Activity

Title of Study: Examining the Impact of Eating Disorders on Sexual Activity

You are asked to participate in a research study conducted by Ms. Emma Foong and Dr. Christopher Greig from the Department of Education at the University of Windsor. The results of the study will be contributed to Ms. Foong's masters' thesis.

If you have any questions or concerns about the research, please feel to contact Ms. Foong through email at foonge@uwindsor.ca. Or contact Dr. Greig through email at cgreig@uwindsor.ca or by telephone at (519) 253-3000 (ext. 3819).

PURPOSE OF THE STUDY

The purpose of this study is to explore the relationship between eating disorders, body image, and sexuality. This research will explore the relationship and between sexual intimacy and eating disorders. This study also hopes to explore if a positive body image leads to an increase in sexual activity. The desire behind most individuals with eating disorders is to achieve a "perfect body" (Barth & Starkman, 2016). Which prompts the question if having a "perfect body" would lead to a positive body image, which would result in more sexual activity. No recent studies, in the past 10-15 years have researched this particular topic. Which is why this is a problem in the eating disorder research community. I hope that this study educates and closes the gap in the research on this topic, while educating the public and eating disorder professionals to bring more light on this serious mental illness.

PROCEDURES

Participants will talk about their personal experiences regarding eating disorders and sexual activity in a one-on-one interview with Ms. Foong. The interview will be recorded but only Ms. Foong and Dr. Greig will have access to the interviews, to analyse them later for the study. Questions about eating disorders, disordered eating, and sexual activity will be asked. The interview will take between 30 minutes to 90 minutes, depending on the how much the participants will share on their experiences and examples given. All interviews will take place on the University of Windsor campus and will be set up by Ms. Foong and the participant to find an appropriate time for the interview to happen. There will be no follow-up sessions in this study.

POTENTIAL RISKS AND DISCOMFORTS

The participants will be interviewed on two vulnerable topics: sexual activity and mental illness. Participants might perceive risk when they are sharing their vulnerable experiences with the researcher. Only Ms. Foong and the participant will be in the room at the time of the interview. Ms. Foong will remind them of their rights as a participant, and if the participant feels uncomfortable or no longer wants to participate, the participant has the right to leave. All data will be stored in a locked office and only the listed investigators will have access to the data. One year after the study is completed, the data will be destroyed. All participants will stay anonymous by being assigned a number, and only be identified by that number during the coding and analyzing process. This anonymity keeps the participants identity protected, and not possible to link any results to one participant.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

There may not be a direct benefit to the participants from this study, but the participants may gain a better understanding of their disordered eating and how it might affect their body image and sexual activity. No recent study has examined the link between eating disorders and sexual activity, so this proposed study may contribute to future literature. Participants may gain a better understanding of how their perceived body image, based on their disordered eating, may affect their sexual activity.

COMPENSATION FOR PARTICIPATION

Participants will have the opportunity to enter a draw for one of three \$25 Devonshire Mall gift cards. Participants will fill out a ballot for the draw after they sign the consent forms. When the study is completed, a third party will draw two ballots to determine the winners of the draw. Winners will be selected through a random drawing, and will be contacted by telephone by January 30, 2019 notifying them of their win.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission.

During the research process, all data will be kept in a locked cabinet within a locked office. Only the listed investigators will have access to the data during the whole research process. When the data collection process is complete each participant will be given a number and will be referred to by that number. The analyzed data will be password protected and only the listed investigators will have access to that data. When the study's findings are released, that number will identify the participants' results. The anonymity of the number will make it not possible to link the results to any specific participant. All written consent forms and the audio recordings of the interviews will be kept in a locked office, which only the listed investigators have access to. One year after the completion of the study, all data will be destroyed. Participants and their corresponding data will be assigned a number, and will only be referred to by that number in the study to ensure anonymity. Only the listed investigators will have access to the audio recordings. Participants have the right to review and edit the audio recording of the interview. If the participant desires to take certain information out of the interview that they disclosed, the investigators will honour their requests. The audio recordings will be destroyed after one-year completion of the study and will not be used for other educational purposes.

PARTICIPATION AND WITHDRAWAL

If the participant chooses to voluntarily participate in this study, they have the right to withdraw at any point in the study without penalty. If the participant chooses to withdraw from the study, their data will be removed from the study and destroyed. If the participants choose to withdraw from the study, their name will not be entered into the draw. The participants can withdraw from the study anytime before January 15, 2019.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE PARTICIPANTS

A summary of the research findings will be available to the participants. The listed investigators will contact the participants through email if they would like the summary.

Web address: _____

Date when results are available: _____

SUBSEQUENT USE OF DATA

These data may be used in publications and in presentations.

RIGHTS OF RESEARCH PARTICIPANTS

If you have questions regarding your rights as a research participant, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca

SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

Signature of Investigator

Date

APPENDIX C: Letter of Consent



CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: Examining the Impact of Eating Disorders on Sexual Activity

You are asked to participate in a research study conducted by Ms. Emma Foong and Dr. Christopher Greig, from the Department of Education at the University of Windsor. The results of the study will be contributed to Ms. Foong's masters' thesis.

If you have any questions or concerns about the research, please feel to contact Ms. Foong through email at foonge@uwindsor.ca. Or contact Dr. Greig through email at cgreig@uwindsor.ca or by telephone at (519) 253-3000 (ext. 3819).

PURPOSE OF THE STUDY

This study wants to explore if eating disorders and having a more positive body image leads to more sexual activity. This research will explore the relationship between sexual intimacy and eating disorders. This study also hopes to explore if a positive body image leads to an increase in sexual activity. The desire behind most individuals with eating disorders is to achieve a "perfect body" (Barth & Starkman, 2016). Which prompts the question if having a "perfect body" would lead to a positive body image, which would result in more sexual activity. No recent studies, in the past 10-15 years have researched this particular topic. Which is why this is a problem in the eating disorder research community. I hope that this study educates and closes the gap in the research on this topic, while educating the public and eating disorder professionals to bring more light on this serious mental illness.

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POTENTIAL RISKS AND DISCOMFORTS

The participants will be interviewed on two vulnerable topics: sexual activity and mental illness. The participants might perceive risk when they are sharing their vulnerable experiences with the researchers. Only Ms. Foong and the participant will be in the room at the time of the interview. Ms. Foong will remind them of their rights as a participant, and if the participant feels uncomfortable or no longer wants to participate, the participant has the right to leave. All data will be stored in a locked office and only the listed investigators will have access to the data. One year after the study is completed, the data will be destroyed. All participants will stay anonymous by being assigned a number, and only be identified by that number during the coding and analyzing process. This anonymity keeps the participants identity protected, and not possible to link any results to one participant.

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CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission.

During the research process, all data will be kept in a locked cabinet within a locked office. Only the listed investigators will have access to the data during the whole research process. When the data collection process is complete each participant will be given a number and will be referred to by that number. The analyzed data will be password protected and only the listed investigators will have access to that data. When the study's findings are released, that number will identify the participants' results. The anonymity of the number will make it not possible to link the results to any specific participant. All written consent forms and the audio recordings of the interviews will be kept in a locked office, which only the listed investigators have access to. One year after the completion of the study, all data will be destroyed. Participants and their corresponding data will be assigned a number, and will only be referred to by that number in the study to ensure anonymity. Only the listed investigators will have access to the audio recordings. Participants have the right to review and edit the audio recording of the interview. If the participant desires to take certain information out of the interview that they disclosed, the investigators will honour their requests. The audio recordings will be destroyed after one-year completion of the study and will not be used for other educational purposes.

PARTICIPATION AND WITHDRAWAL

If the participant chooses to voluntarily participate in this study, they have the right to withdraw at any point in the study without penalty. If the participant chooses to withdraw from the study, their data will be removed from the study and destroyed. If the participants choose to withdraw from the study, their name will not be entered into the draw. The participants can withdraw from the study and withdraw their interview information anytime before January 15, 2019.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE PARTICIPANTS

A summary of the research findings will be available to the participants. The listed investigators will contact the participants through email if they would like the summary.

Web address: _____
Date when results are available: _____

SUBSEQUENT USE OF DATA

This data may be used in subsequent studies, in publications and in presentations.

RIGHTS OF RESEARCH PARTICIPANTS

If you have questions regarding your rights as a research participant, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario, N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca

SIGNATURE OF RESEARCH PARTICIPANT/LEGAL REPRESENTATIVE

I understand the information provided for the study **Examining the Impact of Eating Disorders on Sexual Activity** as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

Name of Participant

Signature of Participant

Date

SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

Signature of Investigator

Date



University
of Windsor

RESEARCH PARTICIPANTS NEEDED

Do you have a positive body image OR disordered eating?

AND are between the ages of 18-30?

You may be eligible to participate in a research study about disordered eating and sexual activity

What does this study involve?

- One 30-90 minute interview where the participants answer questions on their disordered eating and how it might effect their sexual activity.

All queries and interviews are confidential. Participants will be compensated for their research through a draw for 3 \$25 Devonshire Mall gift cards.

This study has received clearance from the University of Windsor Research Ethics Board

For more information, please contact Emma Foong by email at foonge@uwindsor.ca

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APPENDIX E: Guiding Interview Questions

1. How would you describe disordered eating? How would you describe eating disorders?
2. How would you describe sexual activity? What does sexual activity mean to you?
3. How would you describe a positive body image? Tell me times you had a positive body image.
4. How would you describe a negative body image? Tell me times you had a negative body image.

Skip questions 5-7 if there is no disordered eating/eating disorder.

5. What does positive body image mean to you when you have disordered eating or an eating disorder?
6. What does negative body image mean to you when you have disordered eating or an eating disorder?
7. Tell me about your disordered eating/eating disorder story. How it started and how it has progressed to now. If you do not have disordered eating or an eating disorder, please go to question 8. When telling me your story also answer these following questions:
 - a. Are/were you in a romantic relationship? Describe how that romantic relationship was/is and how it shaped your journey for your disordered eating/eating disorder and sexual activity
 - b. What was your sexual activity like before your eating disorder/disordered eating? Explain and give examples. Did you feel positive after the sexual experiences
 - c. How did your body image shape your story?
 - d. What was your sexual activity before your eating disorder/disordered eating?
 - e. Did you prefer to have the lights on or off while engaging in sexual activity?

Skip question 8 if question 7 was answered

8. In what ways does body image shape your life emotionally, physically, and sexually?
Tell me about your body image story. When telling me your story, also answer these following questions:
- a. Are/were you in a romantic relationship?
 - b. Describe how that romantic relationship was/is and how it shaped your journey for your body image and sexual activity
 - c. What does body image mean to you? How do you control your weight? Why was your body image more negative when you were 20 years old?
 - d. Did you prefer to have the lights on or off while engaging in sexual activity?
9. How would you describe a “target weight”? If you had or have a target weight, tell me some times it affected you on an emotional, physical, and sexual level. **If there is no target weight, please go to question 11.**
10. Does/Did reaching or maintaining your “target weight” or “target body” shape your sexual activity? How so?
11. Reflecting on your own experiences, if you felt you had a positive body image on any given day, would you have been more likely to be sexually active? Please explain and give examples or share your experiences.
12. Reflecting on your own experiences, if you felt you had a negative body image on any given day, would you have been more likely to be sexually active? Please explain and give examples or share your experiences.
13. Can you tell me times when your disordered eating, eating disorder, or body image directly affected your romantic relationship or relationships?

VITA AUCTORIS

NAME: Emma Foong

PLACE OF BIRTH: Halifax, NS

YEAR OF BIRTH: 1994

EDUCATION: Maranatha Christian Academy, Windsor, ON, 2012

University of Windsor, [H] BA, Windsor, ON, 2016

University of Windsor, M.Ed., Windsor, ON, 2019