The Social, Relational and Political Context of Eating Disorders:
A Feminist-Informed Grounded Theory Analysis

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Abstract

Although subclinical eating disorders are more common than clinical eating disorders, they have received significantly less empirical attention. Subclinical symptoms of eating disorders often surface during adolescence and young adulthood and are far more common among females than males. Despite knowledge that the larger sociocultural context may contribute to the development of eating disorders, few studies have examined feminist-informed factors that may serve as protective mechanisms for young women who are influenced by Western capitalist culture and exhibit some symptomology, but do not develop clinically disordered eating. Using the feminist-relational model (feminist-relational Model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991) as a guide, this study sought to fill this gap. Informed by feminist grounded theory methodology, this study qualitatively examined socio-relational and socio-political contexts as potential protective factors for young women ages 18-25 whose subclinical eating disorder symptoms had not yet developed into a clinical eating disorder. Using constructivist grounded theory methodology, an emerging model was developed which demonstrates how participants spoke of their eating disorder symptoms in an externalized way. This was termed the "eating disorder voice." Findings highlight how feminist-informed protective factors helped participants resolve the tension between their genuine voice and eating disorder voice, and act in accordance with their preferred values. Participants were then more likely to be open about their symptoms and invest in their relationships. The main protective factors that emerged included, support people who provide emotional and tangible support, support people who challenge the eating disorder, a personal sense of agency, and community activism and involvement. The present

study adds to the feminist theory and the feminist-relational model by providing a conceptualization of the symbiotic relationship between feminist-informed protective factors, suggesting through supportive relationships, individuals experience increased empowerment and agency. Clinical findings indicate that protecting symptoms, misperceptions regarding subclinical symptoms, and stigma served as barriers to seeking treatment. Implications for future research and practice are discussed.

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General Audience Abstract

Eating disorder are a diagnosable mental health condition that greatly impacts physical and emotional functioning. While 20 million people live with clinical eating disorders, many more individuals suffer from subclinical eating disorders. Subclinical eating disorders are similar to eating disorders, but behavioral symptoms such as limiting food intake and vomiting to control weight, shape and size occur with less frequency. Subclinical eating disorders are less studied, and as a result, less understood. Additionally, most research focuses on risk factors for clinical and subclinical eating disorders. Therefore, the present study examined the experiences of living with subclinical eating disorder from a protective standpoint. Feminist theory was used to examine how factors such as voice, empowerment and gender may serve as factors that help stop subclinical symptoms from developing into full blown clinical disorders. Fifteen women between the ages of 18 to 25 who were living with subclinical eating disorder symptoms were interviewed. Through the interviews, women spoke of their symptoms as if they were a separate person or voice, which was labeled the "eating disorder voice" in the analysis process. Findings show how risk factors influenced participants to follow their eating disorder voice (ie., isolate, restrict food) while feminist-informed factors helped participants act in ways that were consistent with what was important to them (ie., spending time with others, not using eating disorder symptoms). The main protective factors included, support people who provide emotional and tangible support, support people who challenge the eating disorder, a personal sense of agency, and community involvement. These findings were applied to help clinicians who work with women at risk for eating disorders.

Dedication

This project is dedicated to the fifteen brave women who shared their stories. Your perseverance

in the face of a society that is still permeated with gender-based oppression was inspiring. Thank

you for letting me laugh with you, cry with you, and make meaning of your experiences for the

betterment of others struggling with disordered eating.

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Chapter 1: Introduction

Statement of the Problem

Eating Disorders

Eating disorders constitute a pervasive societal problem, which has caught the attention of researchers, clinicians and concerned others due to the destructive nature of the disorder on physical and emotional health (APA, 2013; Weaver, Wuest, & Ciliska, 2005; World Health Organization, 1992). Very simply, eating disorders are considered disturbances in eating behavior (APA, 2013). Eating disorders will impact approximately 18 million individuals in the United States and have the highest mortality rate of any mental illness (Forbush & Hunt, 2014). Clinical mortality rates encompass Bulimia (BN), Anorexia (AN), and Eating Disorder Not Otherwise Specified (EDNOS) and range from 3.9%, 4.0% and 5.2% respectively (Crow et al., 2009). The medical complications of eating disorders resulting in mortality include, but are not limited to, heart failure, organ failure, malnutrition, and dehydration (Crow et al., 2009). Compared to the general population, suicide rates are also higher among those who suffer from eating disorders and have been considered one of the main causes of death in this population (Harris & Barraclough, 1997; Sullivan, 1995). Additionally, eating disorders are associated with significant psychological distress, psychosocial impairment, quality-of-life deficits, and medical morbidity (Forbush & Hunt, 2014).

In a National Comorbidity Survey of adolescents, Merikangas and colleagues (2010) found that 2.7% of 13 to 18 year olds had struggled with a "severe" eating disorder at some point during their lives. A severe eating disorder was defined using the diagnostic criteria for AN, BN, and EDNOS from the Diagnostic and Statistical Manual of Mental Disorders, fourth edition

(DSM IV; APA, 2000). Unfortunately, these rates do not account for the numerous cases that go undocumented due to the secretive nature of the disorder, as well as those with subclinical, yet still problematic and potentially dangerous, levels of eating disorder symptoms.

The single greatest risk factor for developing an eating disorder is being female. Researchers have found rates of eating disorders to be twice as common among females, with moderate increases with age (Merikangas et al., 2010). In terms of subclinical symptoms of eating disorders, weight dissatisfaction, dieting for weight control, and the use of purging are higher among females compared to males (Anderson & Bulik, 2004; Lewinsohn, Seeley, Moerk & Striegel-Moore, 2002). In a study utilizing the population-based Virginia Twin Registry (Kendler & Prescott, 1999), 1510 females and 1111 males were surveyed regarding compensatory behaviors for weight gain or loss (Anderson & Bulik, 2004). Results demonstrated that weight gain methods were endorsed almost exclusively by men, with 21.5% enrolled in weight gain program compared to .06% of women. In contrast, weight loss program usage within the sample was almost exclusively endorsed by females (17.2%) compared to males (3.8%), as well as a significant discrepancy in the use of dietary restriction between females (50.6%) and males (34.6%) (Anderson & Bulik, 2004).

Subclinical Eating Disorders

Disordered eating can be placed on a spectrum with subclinical level symptoms on one end and clinical level symptoms on the other (Franko & Omiro, 1999; Lewinsohn, Striegel-Moore, & Seeley, 2000; Striegel-Moore & Marcus, 1995). A variety of professionals have called for heightened awareness of the full spectrum of eating disorders as a public health issue, due to "their serious impact on mental health and well-being, demonstrated by their strong association with symptoms of depression and anxiety, high levels of anger, low self-confidence, and an

alarming rate of suicide ideation" (Flament et al., 2015, p. 408). Researchers have also suggested

that subclinical eating disorders, though considered less severe, are still associated with clinically

significant impairments in functioning, including co-morbidity with other psychiatric disorders,

higher rates of suicide attempts and lower scores on global assessment of functioning when

compared to those without eating disorder symptoms (Lewinsohn et al., 2000). Previous research

on relationships and eating disorders suggests those with subclinical symptoms can still maintain

healthy relationships, but demonstrate interpersonal distrust and a fear of being hurt, which

prevents them from seeking the support they need (Kirsten & Du Plessis, 2008).

Historically, the DSM has utilized criterion for eating disorders that are organized into

affective, behavioral and cognitive symptoms. In a large study of adolescents, a significant

number of youth, 32% of females and 20% of males, had DSM IV symptoms that were clinically

severe, but still did not meet the criteria for a clinical eating disorder (Field & Camargo, 1999).

In a different study, participants were assessed on the individual criterion from the DSM IV

definitions of eating disorders (APA, 2000), and more youth endorsed a single criterion than a

full threshold eating disorder (Ackard, Fulkerson & Neumark-Sztainer, 2007). Even with the

transition to the DSM 5, the clinical definitions of eating disorders do not capture the spectrum

and complexity of disordered eating (Ackard et al., 2007), and those who suffer with some

clinical symptoms but do not meet the full diagnostic criteria are rendered invisible. The

continuity hypothesis suggests the difference between clinical and subclinical symptomology is

quantitative in nature, and those with subclinical eating disorders have the same type of physical

symptoms as those with a clinical diagnosis, but these symptoms differ in terms of severity

(Franko & Omiro, 1999). However, there is little difference in severity of psychological

symptoms between the two groups (Bunnell, Shenker, Nussbaum, Jacobson & Cooper, 1989; Franko & Omiro, 1999).

Despite the high prevalence rates, subclinical eating disorder symptoms may be underestimated due to their secretive nature (Wei-wei, et al., 2015). Additionally, subclinical symptoms are difficult to operationalize and appropriately screen for at the onset of treatment (Ackard et al., 2007; Croll, Neumark-Sztainer, Story & Ireland, 2002). As a result, those with subclinical symptoms who are at risk for a clinical eating disorder may be ineligible for treatment or go undiagnosed, despite having problematic psychological symptoms and physical symptoms that border clinical significance (Ackard et al., 2007). Several researchers have suggested that the diagnostic thresholds for eating disorders in the DSM are too stringent and those with both clinical and subclinical symptoms should be included in studies of eating disorders (Herzog & Delinsky, 2001; King, 1989). Clearly, the rigid specificity of the diagnostic criteria for eating disorders has likely resulted in an underestimation of the true prevalence of subclinical eating disordered behaviors among women (Sullivan, Bulik & Kendler, 1998).

Beyond underestimating the prevalence of subclinical eating disorder symptoms, little is known about the nature and scope and these disorders (Beals & Manore, 2000). Existing research has focused on developing explanatory models or finding predictors of subclinical symptoms, as well as distinguishing subclinical and clinical symptoms (Kirsten & Du Plessis, 2008). As a result, there is limited research that explores the subjective process and experience of those living with subclinical symptoms. While it is important to identify subclinical eating disorder behaviors for the purposes of proper assessment and treatment, "the lived experiences of those with SEDs cannot be adequately quantified" (Kirsten & Du Plessis, 2008, p. 561) and, therefore, require more attention. Those with eating disorders have been defined by societal assumptions of

the condition, resulting in "meanings and experiences that are largely hidden from health care professionals and thus are poorly represented in clinical and academic discourse" (Weaver, Martin-McDonald & Spiers, 2012). As a result, there is also limited understanding of the best ways to treat subclinical eating disorder symptoms. Additionally, recovery from an eating disorder is directly related to the severity of the disorder (Thompson & Sherman, 1993). Thus, if symptoms are detected early, treatment efforts can begin earlier with higher success rates (Beals & Manore, 2000).

As noted previously, subclinical eating disorder symptoms can have a detrimental impact on physical health, psychological well-being, and hinder the relationships of those who suffer (Bunnel et al., 1989; Franko & Omiro, 1999; Herzog & Delinsky, 2001). Given the almost exclusive focus that has been given to clinical eating disorders, little is known about those who live with subclinical symptoms and how they have managed to keep their symptoms from escalating. Research is needed on factors that might decrease susceptibility to clinical level symptoms. This study attempted to address this gap by interviewing women who were currently experiencing subclinical eating disorder symptoms, to identify factors that might mitigate their development into full blown disorders. Greater understanding of this process and identification of protective factors provides information needed to decrease rates of clinical eating disorders and to improve overall quality of life for the affected individuals and their relationships.

The Larger Context of Eating Disorders

In the past several decades, there has been a movement to understand the spectrum of eating disorders as a cultural and societal issue (Bordo, 1993; Bordo, 1997; Faith, Pinhas, Schmelefske & Bryden, 2003). Historically, etiological models of eating disorders sought to define and explain their development as a means of pinpointing primary causes. Early research

focused on individual personality characteristics (Casper, 1990; Vandereycken & Van Vreckfield, 1992) and dysfunctional family systems (Minuchin, Rosman & Baker, 1978) as the primary cause. However, when considering the etiological development of eating disorders, no single correlative factor can be understood in isolation (Robin, Bedway, Siegel & Gilroy, 1996). The best explanation for eating disorders currently utilizes the biopsychosocial model to understand gene-environment interaction and susceptibility to the disorder (Southgate, Tchanturia & Treasure, 2005). The theory posits that various biological, psychological and sociological factors merge to create the greatest vulnerability to disordered eating. For example, specific personality traits associated with AN include a temperamental disposition toward emotional and behavioral restraint and decreased sociability and dominance (Casper, 1990; Vandereycken & Van Vreckem, 1992). However, these personality traits need to exist in the right context, and in combination with other psychological or sociological factors to increase risk of disordered eating (Southgate et al., 2005).

Additionally, while specific factors such as body dissatisfaction, internalization of the thin ideal and dieting behaviors are strongly correlated with eating disorders, they do not accurately explain problem development. These variables merge with families who may already be vulnerable to eating disorder development due to biological, psychological or environmental factors, and this collusion creates the complexity of disordered eating (Polivy & Herman, 2002). In fact, the Academy for Eating Disorders (AED) recently took a position against an etiological model of eating disorders, suggesting families and other social relationships could be influential, but not the primary cause of the disorder (Couturier, Kimber, & Szatmari, 2013; Le Grange, Lock, Loeb, & Nicholls, 2010). While social relationships can contribute to the development of eating disorders, they are rarely the sole cause of the condition (Thode, 1994). Intrapersonal

factors such as personality characteristics, behaviors, and relationships can only be examined as risk factors for eating disorders if the context in which they exist is also understood (Weaver et al., 2005). Thus, this study focuses on the "social" aspect of the biopsychosocial model of disordered eating to explore the social context in which eating disordered behaviors are expressed.

This "social context" of eating disorders involves the social, relational, and political environments of those who suffer from eating disorder symptomology. In particular, the socio-relational context involves relationships, support and connection to facilitate healthy psychological development and growth (Jordan, 1997). The socio-political context involves the Western capitalist consumer culture in which females can experience gender-based oppression and social inequity (Brown & Jasper, 1993; Orbach, 1978, 1985, 1986). Together, these two contexts suggest that individuals are always shaped by their social and political environments (Gutwill, Gitter & Rubin, 2010). As such, this study sought to examine the socio-relational and socio-political aspects of subclinical eating disorders as a means for understanding how these two contexts might positively or negatively influence the risk of disordered eating.

The Socio-Relational Context

The secretive nature of disordered eating often requires sufferers to seclude themselves and limit contact with others, which has an adverse effect on relationships (Holt & Espelage, 2002). This is unfortunate, given that supportive relationships are linked directly to positive recovery outcomes (Linville, 2011). Previous research found higher rates of relational difficulties and lack of social support in those living with eating disorders. For example, women with eating disorders have been found to have social impairments in relationships (Herzog, Norman, Rigotti & Pepose, 1986) and decreased social interactions (Grissett & Norvell, 1992). Women with

clinical BN tend to spend more time alone and are less likely to seek out social support than those without eating disorders (Troop, Holbrey, Trawler, & Treasure, 1994). When those with BN do seek support, they are often dissatisfied with the type of social support they receive (Tiller et al., 1997). This was partially explained by the fact that those with BN, compared to those with AN and a control group, were the least likely to receive actual support (Tiller et al., 1997). Additionally, in a study on college women, researchers found a direct positive relationship between the frequency of bulimic behaviors and the level of social impairment (Herzog et al., 1986). The majority of research on the importance of social support and eating disorders has examined individuals living with clinical BN from a deficits perspective, focusing on social isolation and relationship dissatisfaction as risk factors for symptom development (Garner & Olmsted, 1984; Herzog et al., 1986; Jacobson & Robins, 1989; Slater, Grissett, & Norvell, 1988) and not considered the potential for relationships to be protective.

The limited research on social support as a protective factor has highlighted the importance of relationships in the recovery process from clinical eating disorders (Garrett, 1997; Linville, 2011; Nilsson, Engström, & Hägglöf, 2012; Weaver et al., 2005). The process of recovery involves self-development and reflexivity, which allow individuals to experience a sense of agency in their lives and relationships. In one study, the process of self-development was adversely affected in women with eating disorders whose environments lacked social and therapeutic support (Weaver et al., 2005). In this study, women described their most supportive relationships as characterized by others who were open-minded, listened empathically and took the time to understand the various experiences of suffering (Weaver et al., 2005). With the socio-relational context being key in clinical recovery, in makes conceptual sense that positive social relationships might also serve as a protective mechanism for those with subclinical

symptoms of eating disorders. However, there is limited research that examines how social support and positive relationships might influence those with subclinical eating disorders. This study addressed this limitation by exploring the role of connection and social support as mitigating factors in the development of clinical eating disorders.

The Socio-Political Context

Due to the high prevalence rates of both clinical and subclinical eating disorders among females, the concept of gender cannot be ignored. Gender can be defined as a socially constructed phenomenon, which dictates learned roles, characteristics and ways of being to either the male or female biological sex (Johnson, 2006). In Western capitalist cultures, both men and women are enculturated to view thin women as self-disciplined, hard-working, healthy and attractive, and having used willpower to reject the hunger, sexuality, and needs of the body (Guilfoyle, 2009). These attributes are highly valued in Western society, constructing the belief that thinness in females provides individuals with strength, achievement, success, and social value (Guilfoyle, 2009). Therefore, women who do not embody this socially acceptable thinness are constructed as lazy, deficient in self-discipline, unattractive, and having lost the battle with their bodies. Any attempts by these women to construct themselves in socially valued ways are undermined and discounted by the dominant discourse (Guilfoyle, 2009). As long as society accepts thinness as a sign of self-discipline, achievement, and success among women, the power inequities remain, both between men and women, and between women with smaller and larger body sizes.

A large amount of feminist scholarship suggests that eating disorders are a result of gender based-oppression and social inequality (Brown & Jasper, 1993; Brush, 1988; Chemin, 1981; Orbach, 1978, 1985, 1986). That is, the tenuous relationship many women have with food

and body image is the result of the sociopolitical oppression women face in all areas of their lives (Affleck, 1999). This oppression makes it particularly difficult for females to express themselves directly, leaving numerous unmet needs within themselves and their relationships. In an attempt to meet these needs, women seek alternative ways to satiate their desires, often through food and body weight preoccupation (Orbach, 1978, 1985, 1986). For example, in the United States, gender harassment has been found to increase during grades 6 through 8 (McMaster, Connolly, Pepler, & Craig, 2002). This is thought to be associated with adolescence and the onset of puberty, which involve a greater understanding of sexuality, development of reproductive organs and increased mixed-gender socialization (McMaster et al., 2002). Additionally, high rates of harassment and abuse in the school and workplace have been found in those with eating disorders (Sundgot-Borgen, Fasting, Torstveit, & Berglund, 2003). Thus, examining social relationships and "improving general social conditions for women might not only aid their recovery but may prevent them [eating disorders] from developing in the first place" (Weaver et al., 2005, p. 201-202).

A Feminist Perspective on Eating Disorders

Feminist theorists and researchers have gone so far as to call disordered eating a social epidemic, stemming from gender-based oppression and unrealistic standards of beauty in Western capitalist cultures (Malson & Burns, 2009). According to feminist theory, gender and power are considered basic organizing principles in society (Foucault, 1983) and an unequal distribution of power between the sexes has silenced the voices of women (Bordo, 1993). Gender disparities based on power result in many women expressing their emotional pain through their bodies, rather than using their voice (Maine & Bunnell, 2008). As women navigate the struggles

of life while in a subordinate societal position, the eating disorder becomes a metaphor to articulate their grief and pain to others, as their power is limited in terms of expressing this pain.

Philosopher Michel Foucault considers power not a tangible construct, but a process which occurs at the micro level of all social relations (Foucault, 1983). When oppression exists within society or a particular social group, the result is an inequitable distribution of power between groups or amongst two people. For example, the organization of gender privileges men and oppresses women. Therefore, gender inequalities differentially influence the amount of power individuals receive within society. Results of this power imbalance include the metaphorical silencing of women's voices, invisibility of their achievements, the downplaying of their experiences, devaluation of femininity, and gendered hierarchies which position men above women in every aspect of social life (Andersson, 1995). This devaluation further results in a sense of powerlessness, guilt, shame, rage and self-blame on the part of women (Andersson, 1995). According to feminist theory, equitable distribution of power between the genders should result in an increased sense of agency, utilization of voice and feelings of empowerment for women (Bordo, 1993).

This study utilized a feminist lens to explore the experiences of women with subclinical eating disorders within their sociopolitical context. Unfortunately, this context can be toxic for women, as capitalist and patriarchal notions often enforce the idea that self-worth is determined by physical appearance (Orbach 1978). It has been suggested that the most prominent issues related to gender-based oppression today involve the objectification of females in the mass media, the increase in rape, molestation and sex slavery worldwide, and the assault on female reproductive rights (Gutwill et al., 2010). Western capitalism has created a toxic "consumer culture" in which females strive to fulfill the impossible role of the "perfect woman" and never

measure up, leaving them "malleable and hungry" and striving for something more (Gutwill et al., 2010, p. 154). A byproduct of consumer culture has resulted in teaching individuals, particularly females, to hate their own bodies. Body dissatisfaction and a disturbed body image are both predictive factors in the development of eating disorders (Calogero, Davis, & Thompson, 2005; Greenleaf and McGreer 2006; Leon, Fulkerson, & Cudeck, 1993; Prichard & Tiggemann 2005; Stice 1994; Tiggemann & Kuring 2004; Tylka & Hill 2004). Some of the major players contributing to this toxicity include the mainstream media, the fashion industry, and multi-national corporations that rely heavily on advertising to succeed (Gutwill et al., 2010). Gender-based oppression is evident in advertising via the hyper-sexualized images of women and young girls, objectifying them for the entertainment of others while simultaneously offering them products to modify their bodies according to Western notions of femininity and beauty (Gutwill et al., 2010)

Feminist theory has been particularly influential in unveiling sociopolitical toxicity and helping doctors, mental health professional, families, and those who live with eating disorders to critically examine how the capitalist consumer culture may encourage disordered eating (Guilfoyle, 2009; Malson, 2009; Piran, 2010). As noted previously, it is now widely accepted that gender is a risk factor for disordered eating (Guilfoyle, 2009; Malson, 2009; Piran, 2010). However, the 'gender-as-a-risk-factor' focus has produced an argument that young women, including those who are experiencing subclinical symptoms of eating disorders, are "victims of gender subordination" (Currie & Kelly, 2006, p. 419). The danger in viewing women through one identity, that of victim, is that the majority of young women who successfully navigate adolescence, despite their susceptibility to gender-based oppression, are forgotten (Currie & Kelly, 2006). Instead of viewing adolescence as a time of 'crisis' in which girls are "victims" of

their circumstances, a discourse emerged surrounding 'girl power' (Currie & Kelly, 2006, p. 420). From this perspective, girls are portrayed as actively constructing their experience of girlhood using equality-seeking discourses and other aspects of feminism to buffer them from the effects of gender-based oppression (Currie & Kelly, 2006; Lamb 2001; Mahaffy 2004). For example, body image acceptance was more likely to occur in young women who felt empowered in their day-to-day lives (Peterson, Grippo & Tantleff-Dunn, 2008).

In the past, clarifying the specific factors that protect women from eating disorders have served as an important tools for feminist intervention programs. This clarification helped to more effectively target risk factors and enhance protective factors for those at risk for eating disorders (Peterson et al., 2008). Feminist protective factors highlighted in intervention programs include but are not limited to, voice, connection and empowerment (McVey, Lieberman, Voorberg, Wardrope, & Blackmore, 2003; Piran, Levine, & Irving, 2000; Seaver, McVey, Fullerton, & Stratton, 1997; Sjostrom & Steiner-Adair 2005). Voice can be defined as an aspect of psychological empowerment, which occurs through the relational collaborative process of expressing oneself in relation to others (Belenky, Clinchy, Goldberger, & Tarule, 1986). Feminist theory seeks to de-pathologize connection (Jordan, 1997), suggesting healthy relationships, both with loved ones and with food, and are key protective factors for disordered eating. In feminist research, empowerment has been defined as "the connection between a sense of personal competence, a desire for and a willingness to take action in the public domain" (Rogers, Chamberlin, Ellison, & Crean, 1997, p. 1042). In a study of 276 undergraduate women, feelings of empowerment were hypothesized to reduce self-objectification (Peterson et al., 2008), which has been correlated with body dissatisfaction, a primary risk factor for disordered eating (Fairburn et al. 2003). Within the same study, powerlessness was conceptualized as a lack of

control over societal and personal decisions (Rogers et al., 1997). Experiences of empowerment

and powerlessness were significantly related to eating disordered symptoms, such that lower

rates of empowerment and higher feeling of powerlessness were both correlated with higher

levels of body image disturbance (Peterson et al., 2008). Specifically, the present study utilized

the feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991) to further

examine feminist-informed protective factors in the lives of women with subclinical eating

disorders. The feminist-relational model developed through an understanding of the relational

self (Miller, 1984) and the idea that self can exist only in relation to other selves (Mead, 1924,

1968). Miller (1984) along with other feminist theorists, were critical of models of human

development that did not seem to adequately explain women's experience or appreciate the

relational nature of the female sense of self (Chodorow, 1978; Gilligan, 1982). From a feminist-

relational perspective, connection and supportive relationships are the keys to liberating women

from the perils of disordered eating (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991).

Additionally, risk and protective factors change in relation to context (Walsh, 2003). This

conceptualization supports a primary focus of this study, which is to situate subclinical eating

disorders within the context of a patriarchal capitalist society in which females are at greater risk

for disordered eating due to gender-based oppression. Additionally, feminist theory has mainly

been used to facilitate understanding the development of clinical eating disorders and how

gender oppression may encourage disordered eating (Guilfoyle, 2009; Malson, 2009; Piran,

2010). An important next step in advancing the field is to understand factors within feminist

theory that may serve as protective mechanisms for young women who are indoctrinated into a

toxic culture, experience some symptomology, but do not develop clinical disordered eating.

Researchers suggest focusing specifically on supportive relationships, feelings of power, and a

sense of agency, as they have consistently shown to be protective factors against eating disorders (Bergsma 2004; Zimmerman 1995). More needs to be understood regarding the importance of empowerment as a buffer against eating disorders from the subjective experience of those with subclinical eating disorders. To address these gaps, this study utilized the feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991), to understand protective factors including connection, voice, gender and empowerment and what purpose, if any, they serve in the lives of those with subclinical eating disorder symptoms.

Purpose Statement

Protective factors for those at risk vary based on developmental stage and cultural-historical context (Masten, 2004; Masten, Burt & Coatsworth, 2006). However, several adaptive systems in which protective factors develop appear to be universal (Masten, 2001; Masten, 2004). These systems include: learning and the human brain, attachment, mastery motivation, stress response, self-regulation, family, school and cultural/societal. This study focused on the cultural-societal adaptive system, as limited scholarship has examined factors that may serve as protective mechanisms for young women in a Western capitalist society, who are exposed to a toxic culture and exhibit some symptomology, but do not develop clinically disordered eating. This focus on the cultural-societal adaptive system supports the biopsychosocial model of eating disorders, suggesting that genetic or psychological vulnerability to eating disorders is most likely expressed in combination with sociological risk factors, such as a toxic Western capitalist culture. However, the cultural-societal adaptive system focuses on sociological aspects that may be protective rather than risk factors.

Additionally, little is known regarding subclinical symptoms in terms of why some people overcome these symptoms, while others stay the same, or move into clinical

symptomology. There are many individuals with a vulnerability to eating disorders who also exist within this toxic culture and demonstrate resiliency. This study sought to develop this understanding by using feminist-informed grounded theory methodology (Charmaz, 2006) to qualitatively examine aspects of the socio-relational and socio-political context as potential protective factors for those with subclinical eating disorder symptoms. Informed by the feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991), this study examined feminist-informed factors in the lives of young women ages 18-25 with subclinical eating disorder symptoms who had not yet experienced a clinical eating disorder. More specifically, this study addressed the following research question: "In what ways and under what circumstances have young women with subclinical eating disorder symptoms navigated the difficulties of their relationship with food and body image, in order to cope with their subclinical symptoms and prevent them from getting worse?"

Chapter 2: Literature Review

This chapter provides a detailed discussion of eating disorders at both the clinical and subclinical level. Definitions and statistics are provided, as well as a summary of at risk populations, namely adolescents, young adults, and females. Risk factors will be explored at the individual, familial and cultural level. Due to the dearth of research on subclinical eating disorders, the majority of this review focuses on clinical populations. However, with overlap between subclinical and clinical symptoms, the literature is still informative. The feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991) will be introduced in order to critically examine eating disorders from a social and political perspective, highlighting relevant feminist-informed protective factors for subclinical eating disorders. The primary purpose of this literature review was to present the need for more research on feminist-informed

protective factors that might mitigate the development of subclinical symptoms into clinical eating disorders.

<div align="center">**Eating Disorders**</div>

Clinical Definitions

Eating disorders are characterized as disturbances in eating that impact the individual on a behavioral, physical, cognitive, and affective level (Ackard et al., 2007; APA, 2013). To date, most research has focused on individuals with clinical-level symptoms who meet the diagnostic criteria for an eating disorder and are receiving inpatient care (Benninghoven, Tetsch & Jantscheck, 2008; Honey, Clarke, Halse, Kohn, & Madden, 2006; Karwautz, et al., 2003). Clinical symptoms vary based on the type of eating disorder. The International Statistical Classification of Diseases and Related Health Problems (ICD-10; World Health Organization, 1992) recognizes Anorexia Nervosa (AN) and Bulimia Nervosa (BN) as two important and clear-cut syndromes that constitute the majority of eating disorder diagnoses. Other diagnosable eating disorders include Atypical AN, Atypical BN, Overeating Associated with Other Psychological Disturbances, Vomiting Associated with Other Psychological Disturbances, Other Eating Disorders, and Eating Disorders Unspecified (ICD-10; World Health Organization, 1992). These categories are similar to the definitions of eating disorders as described in the Diagnostic and Statistical Manual of Mental Disorders fifth edition, which is more commonly used in the United States (APA, 2013; DSM-V, 2013). The DSM-V was the first version to incorporate Binge Eating Disorder (BED) as its own diagnosable eating disorder.

According to the DSM-V, AN is described as a condition in which an individual fails to maintain a body weight of at least 85% of what is expected for his or her age and height (APA, 2013). Symptoms also include fear of gaining weight, starvation and a disturbed body image. BN

involves inappropriate methods of maintaining or losing weight through the use of bingeing and purging. Bingeing is characterized by eating large amounts of food even when not physically hungry, eating more rapidly than normal and feeling uncomfortably full afterwards (APA, 2013). Psychological components of bingeing involve eating alone due to embarrassment of the amount of food and feeling guilty or depressed after the binge. Purging generally includes the use of self-induced vomiting, laxative use, or excessive exercise (APA, 2013). In the previous version of the DSM, DSM-IV, the category of Eating Disorder Not Otherwise Specified (EDNOS) had the highest rates of diagnoses, likely because those with BED were placed in this category. The DSM 5 now includes BED as a separate diagnosis (APA, 2013). DSM-V has replaced the EDNOS category with Other Specified Feeding and Eating Disorders (OSFED) and Unspecified Feeding or Eating Disorders. This represented an attempt to add more specificity to the diagnostic categories so those with clinical-level symptoms could be accurately diagnosed, even if they did not fit into the most common categories of AN, BN or BED (APA, 2013). The DSM-V also includes three other eating disorders which typically have their onset in childhood. The physical and psychological symptoms of these disorders are also quite different from subclinical AN and BN, which will be the focus of this study.

Subclinical Eating Disorders

Disordered eating can be placed on a spectrum with subclinical level symptoms on one end and clinical level symptoms on the other (Franko & Omiro, 1999; Lewinsohn et al., 2000; Striegel-Moore & Marcus, 1995). The two levels of symptoms do not represent separate types of eating disorders, but rather variation in the degree of severity. Therefore, in order to assess subclinical status, many researchers utilize a clinical screening tool and determine a cutoff score, which distinguishes individuals into categories of normal, abnormal and clinically significant

eating disorder symptomology (Mintz & O'Halloran, 2000). For example, previous research has shown that individuals who score 20 or above on the Eating Attitdues Test (EAT-26; Garner, Olmsted, Bohr, & Garfinkel, 1982) are likely exhibiting subclinical eating disorders, and are moving in the direction of a clinical disorder, but do not yet meet all of the diagnostic criteria for AN or BN (Mintz & O'Halloran, 2000). Additionally, there is little difference in severity of psychological symptoms between those with subclinical and clinical symptoms of eating disorders (Bunnel et al., 1989; Franko & Omiro, 1999).

Psychological symptoms most prevalent in individuals with subclinical eating disorders include a preoccupation with food and weight, distorted body image, an intense fear of gaining weight, and a conflation of self-worth with weight status (Beals & Manroe, 2000). Behavioral symptoms include restricting food intake, guilt after eating, attempts to lose weight in pathogenic ways or in combination with compensatory behaviors. In one study, individuals with subclinical AN and those with clinical AN, had comparable levels of psychological distress. However, those with clinical AN had restrictive eating behaviors that were more severe and greater in frequency (Bunnel et al., 1989). Thus, the only difference between clinical and subclinical levels of AN were the severity and duration of behavioral and physical symptoms.

In examining BN, previous research considered participants to have subclinical BN if they reported both binge eating and compensatory behaviors that did not meet the frequency threshold for a clinical BN diagnosis according to the DSM, as well as moderate overconcern with body shape and weight (Stice, Ziemba, Margolis & Flick, 1996). This study compared eating disorder symptoms by differentiating individuals based on clinical BN, subclinical BN and a control group and examined the three groups across varying behavioral and psychological eating disorder symptoms (Stice, et al., 1996). Those with clinical and subclinical BN and similar

levels of family pressure, friend pressure, body dissatisfaction, hostility, and anxiety. However, those with clinical BN had higher levels ideal-body internalization, dietary restraint, and guilt after eating. The results support the continuity hypothesis, suggesting the groups differed quantitatively, rather than qualitatively (Stice et al., 1996). Thus, subclinical and clinical eating disorders result in categorically similar conditions that differ in frequency and severity of behavioral symptoms.

In a sense, because the physical symptoms have not escalated to the point of hospitalization, those with subclinical symptoms are rendered invisible, even though they may be suffering emotional and psychological symptoms at a clinical level (Bunnel et al., 1989; Franko & Omiro, 1999). As a result, those with subclinical symptoms may not get the treatment they need for their psychological symptoms, making it far more likely that, if left untreated, their symptoms would escalate into a clinical eating disorder. For example, in a longitudinal study of 33 women with subclinical symptoms requesting eating disorder treatment, half of the women were found to have developed a clinical eating disorder at a later time (Herzog, Hopkins & Burns, 1993).

Alarmingly, subclinical eating disorders are more common than clinical eating disorders, but significantly less understood (Wei-wei, et al., 2015). For example, an estimated 1% to 4% of female college students meet the clinical diagnostic criteria for AN and BN, but an additional 35% to 70% of female college students report subclinical symptomology (Edwards-Hewitt & Gray, 1993; Heatherton, Nichols, Mahamedi, & Keel, 1995; Kurth, Krahn, Nairn, & Drewnowski, 1995; Schwitzer, Bergholz, Dore, & Salimi, 1998; Winzelberg et al., 1998). Subclinical eating disorders have been associated with a higher likelihood of developing a

clinical eating disorder, poor health-related quality of life, and higher rates of mood disorders (Wei-wei, et al., 2015).

Additionally, some outcome measures showed significantly more psychopathology in the subclinical group compared to those with full clinical eating disorders (Garfinkel & Lin, 1996; Lewinsohn et al., 2000). This is related to the overlap in clinical and psychosocial characteristics between those with clinical and subclinical symptoms, and the difficulty in distinguishing the two groups diagnostically (Kendler et al., 1991). In fact, many individuals who present for clinical eating disorder treatment are actually exhibiting subclinical symptom cutoff scores (Bunnell et al., 1989). Thus, subclinical symptoms are serious enough to warrant clinical attention, but those exhibiting subclinical symptoms are much less likely to receive the attention and treatment they need. The present study sought to close this gap by drawing attention to those with subclinical symptoms, a high-risk group of individuals who have been historically neglected within the field of eating disorders.

Gender and Eating Disorders

Longitudinal research across the United States and Europe has identified gender as a primary risk factor for disordered eating (Sancho, Arija, Asorey, & Canals, 2007). Epidemiological studies of adults have shown significantly higher rates of clinical AN and BN among women (2.1%) compared to men (.03%) (Hudson, Hiripi, Pope & Kessler, 2007; Woodside et al., 2001). Within the general population, the prevalence of any type of binge eating is roughly comparable between women (4.9%) and men (4.0%). Although BED is now considered a legitimate condition warranting clinical attention (APA, 2013), the present study focuses on subclinical symptoms more consistent with AN and BN, due to the high rates of these symptoms among females. The overall ratio of clinical eating disorders in females compared to

males is 10:1 (Hoek & van Hoeken, 2003). However, during adolescence, the female–male ratio is smaller, varying from 3:1 to 10:1 (Kjelsas, Bjornstrom, & Gotestam, 2004; Morande, Celada, & Casas, 1999, Patton, Selzer, Coffey, Carlin, & Wolfe, 1999). Thus, if subclinical rates between males and females are more similar during adolescence, but women have higher clinical levels later, this suggests that something may happen after the onset of subclinical symptoms in females. What might be happening during this process that makes it statistically more likely that symptoms for adolescent females will move from subclinical to clinical levels of an eating disorder, while males tend to adapt and avoid developing a clinical disorder? Due to these unanswered questions, understanding factors that might protect females from an escalation of symptoms into the clinical range is of great importance.

Additionally, while both clinical and subclinical eating disorders are more prevalent in females compared to males, the gender discrepancy is not well understood (Hautala et al., 2008). One hypothesis is that boys may struggle with disordered eating behaviors at similar levels, but these rates go undetected (Anderson & Bulik 2004). Research to support this suggests that males tend to under-report eating disordered behaviors due to the stigma that it is a "female problem" (Franco, Tamburino, Carroll & Bernal, 1988). Another explanation for the gender discrepancy in the prevalence of eating disorders may be that girls are more likely to be stigmatized when they eat "normal" or larger portions of food. In one study examining boys and girls who ate the same amount of food in the same amount of time, the boys' behavior was more likely to be labeled as "normal", while girls were labeled as engaging in binge eating behavior (LaPorte 1996). This suggests that compared to males, eating disordered behavior among females is more likely to be noticed and reported as abnormal.

In one outdated argument, researchers hypothesized that, due to the rarity of eating disorders in men and boys, the nature of the illness must be atypical for those with biologically male sex characteristics (Cobb, 1950). However, in studies comparing men and women with clinical eating disorders, their symptom presentation and response to treatment are very similar (Crisp & Burns, 1990; Sharp, Clark, Dunan, Blackwood & Shapiro, 1994; Woodside & Kaplan, 1994), which lends support to the idea that eating disorders are not biologically a female disorder. Instead, societal constructions of beauty and the extra pressure on women to conform to the thin ideal are more plausible explanations for the gender discrepancy (Cash & Ancis, 1997; Tiggemann & Stevens, 1999).

Other researchers have argued that gender is not necessarily a primary risk factor for eating disorders, as both males and females are equally susceptible to developing symptoms (Hautala et al., 2008; Patton et al., 1999). Relatedly, other primary risk factors for eating disorder development include higher body mass index (Sancho et al. 2007), thin-ideal internalization and body dissatisfaction (Fairburn et al. 2003), and depression (Measelle, Stice, & Hogansen, 2006). In a study examining recurrence of eating disorders in adolescents ages 15 to 17, females outnumbered males five to one (Hautala et al., 2008). However, when examining temporary disordered eating that resolved over time, the gender discrepancy was smaller, with females outnumbering males two to one. Thus, if males and females are both susceptible to disordered eating, but females are more likely to develop recurrent symptoms that do not eventually resolve, this indicates something unique to the female experience (Hautala et al., 2008).

Adolescence

Both clinical and subclinical forms of eating disorders are highly prevalent among adolescents, which is typically when they emerge (Flament et al., 2015; Lewinsohn et al. 2000).

The typical age of onset for clinical AN is between 10 to 19 years, compared to 20 to 39 years for clinical BN (Turnbull, Ward, Treasure, Jick, & Derby, 1996). One study found a total of 2.2% of adolescent males and 4.5% of adolescent females met the DSM-5 criteria for a clinical eating disorder, with an additional 1.1% of adolescent males and 5.1% of adolescent females identified with subclinical symptoms (Flament et al., 2015). Other research has shown a greater range, with prevalence rates of subclinical symptoms in adolescent girls alone estimated as high as 44% (Ackard et al., 2007). With the change in eating behaviors and increased body weight, nearly 40% to 60% of girls and 25% to 30% of boys experience body dissatisfaction during puberty (McCabe, Ricciardelli & Banfield, 2001). Researchers have also found that 56% of ninth grade females and 28% of 9th grade males reported disordered eating behaviors with slightly higher rates among 12th grade females (57%) and males (31%) (Croll et al., 2002). Additionally, 30% to 60% of adolescent girls and 17% to 30% of adolescent boys use unhealthy weight control behaviors, including dietary restraint, self-induced vomiting, and other purging methods (Larson, Neumark-Sztainer & Story, 2009).

Given that subclinical symptoms are often antecedents to full clinical eating disorders, the onset of subclinical symptomology is likely even earlier. Across Europe, the United States and Australia researchers have found high rates of eating disordered behavior during adolescence, but low stability of the symptoms over time (Croll et al., 2002). For adolescents who develop subclinical eating disorders, about 50% to 60% of these individuals continue to have symptoms for 1 to 2 years, with symptoms stopping spontaneously (Sancho et al. 2007; Santonastaso, Friederici, & Favaro, 1999). However, approximately 10% of individuals who develop eating disorder symptoms during adolescence will maintain these symptoms into adulthood (Graber & Brooks-Gunn, 2001; Patton, Coffey, & Sawyer, 2003).

There have been several explanations posed for the increase in eating disordered behavior during adolescence. One theory suggests the amount of physical change that happens during puberty is correlated with body dissatisfaction and increases in body size that go against societal messages which promote thinness, particularly for females (McCabe et al., 2001). Additionally, adolescence has historically been identified as a time period in which youth are developing autonomy (Blos, 1979). This movement toward independence can alter dynamics within the family, as adolescents take more control over their own diet and eating behaviors (Giarelli, Bernhardt, Mack, & Pyeritz, 2008). As a result, it is more difficult for parents to notice or intervene if adolescents engage in unhealthy eating behaviors (Giarelli et al., 2008).

Another explanation relates to changes in cognitive and social maturation that happen during this time. In adolescence, the frontal lobe is not fully developed, resulting in higher impulsivity and lower levels of self-reflexivity and insight when compared to adults (Abrams, Hazen, & Penson, 2007). Thus, adolescents may be more likely to engage in destructive health behaviors such as purging or restricting, without the foresight to consider the impact these actions might have on their physical functioning later in life (Taddeo, Egedy, & Frappier, 2008). Additionally, during the transition from childhood to adolescence, fitting in with peers becomes increasingly important. Adolescents are more susceptible to modeling unhealthy behaviors learned by their peers. Thus, adolescents are at risk for falsely assuming the perceived short-term social benefits of fitting in may outweigh the long-term consequences of poor health choices (Taddeo et al., 2008). Due to the high risk for disordered eating in adolescence, professionals have advocated for screening for both clinical and subclinical eating disorders as a part of routine medical assessments in adolescent females, particularly for those with a history of depression, anxiety, and substance use disorders (Lewinsohn et al., 2000).

Young Adulthood

Even after adolescence, young women between the ages of 18 and 25 are at an increased risk of engaging in compensatory weight control behaviors, which can develop into diagnosable eating disorders in some individuals (Shisslak, Crago, & Estes, 1995). During this developmental period, and the transition from adolescence to adulthood, the increase in autonomy can place individuals at an increased risk of unhealthy or maladaptive behaviors, often without the supervision associated with living with parents or guardians. For example, college campuses have historically been known for fostering poor body image and eating disorders (Mintz & Betz, 1988). Researchers suggest subclinical eating disorder symptoms may be present in 25% to 40% of college women (Choate, 2010).

In female college students receiving treatment for psychological and/or eating problems, the most common symptoms included frequent bingeing, occasional purging, and daily exercise, along with a tendency to minimize the seriousness of these behaviors (Schwitzer et al., 2008; Schwitzer, Rodriguez, Thomas & Salimi, 2001). Additionally, significant problems can occur later in life if these behaviors are left untreated during this developmental period (Bankoff, Valentine, Jackson, Schacht, & Pantalone, 2013). The developmental period of young adulthood is also characterized by developments in identity (Erikson, 1968) and epistemological developments in moral reasoning and questioning of one's worldview (Belenky et al., 1986). As discussed earlier, during adolescence and young adulthood, the importance of appearance becomes so engrained that it may become a part of their core belief system (Cash & Ancis, 1997; Tiggemann & Stevens, 1999). During this developmental period, individuals are at an increased risk for the harmful effects of media exposure, internalization of the thin ideal, and body dissatisfaction to become core components of identity. Due to their high risk, this study narrows

in on females between the ages of 18 and 25. The majority of previous work on subclinical

eating disorders has focused on adolescents, and this study sought to fill that gap. Additionally,

the developmental period between ages 18 and 25 was chosen, as the typical age of onset for

clinical AN is between 10 to 19 years, compared to 20 to 39 years for clinical BN (Turnbull et

al., 1996). Therefore, the present study represents a timespan that overlaps the age of onset for

both AN and BN.

Risk Factors and Eating Disorders

A wealth of research examines the development of eating disorders by exploring various

risk and protective factors. Conceptually, risk factors for eating disorders are considered

"health-compromising" behaviors, which increase the risk of developing an eating disorder

(Croll, et al., 2002, p. 167). On the other hand, protective factors alter responses to adverse

events so that potential negative outcomes can be avoided (Masten, 2001). Overall, risk and

protective factors can be grouped into individual, family, and socio-cultural explanations of

eating disorders. The majority of the existent literature on risk and protective factors tends to

focus on identification of those at risk for clinical disordered eating. Understanding how to

prevent subclinical eating disorders from developing into clinical eating disorders is an important

public health issue, as it may help researchers and practitioners understand how to prevent eating

disorder development in the first place (Flament et al., 2015; Wei-wei, et. al., 2015).

Individual Risk Factors

An argument has been made that distinct personality traits may exist in those with eating

disorders. Specific personality traits associated with AN include a temperamental disposition

toward emotional and behavioral restraint and decreased sociability and dominance (Casper,

1990; Vandereycken & Van Vreckem, 1992). One study compared individuals who had

recovered from clinical AN to their non-affected biological sisters and a control group of age-matched women with no history of an eating disorder. Those with AN were less spontaneous and less impulsive than both control groups, even after being in recovery for 8 to 10 years (Casper, 1990; Vandereycken & Van Vreckem, 1992). Due to the rigid nature of AN, characterized by strict adherence to specific ways of eating and exercising, it would seem appropriate that this sample exhibited less spontaneity and less impulsivity than the control groups. Those with AN also scored lower than their sisters on tests of dominance, sociability, and self-acceptance (Casper, 1990). This can be explained by the fact that having an eating disorder is often secretive and time consuming, and tends to detract from time spent with others. However, while those with AN scored the lowest on dominance, sociability and self-acceptance, sisters also scored lower on these traits than the control group (Casper, 1990). Findings suggest that those with eating disorders and their non-affected sisters do not have categorically different personalities, but rather exhibit different levels of the same personality traits (Casper, 1990).

One hypothesis is that personality traits can be thought of as a continuum with those with eating disorders on one end, the control group on the other end and sisters in the middle. The best explanation for eating disorders currently utilizes the biopsychosocial model to understand gene-environment interaction and susceptibility to the disorder (Southgate et al., 2005). The theory posits that various biological, psychological and sociological factors merge to create the greatest vulnerability to disordered eating. Therefore, personality traits need to exist in the right context, and in combination with other psychological or sociological factors to increase risk of disordered eating (Southgate et al., 2005). In summary, individuals may exhibit more extreme versions of personality traits correlated with eating disorders (ie., rigidity) but without other psychological or sociological variables, the personality traits alone will not lead to disordered eating.

Besides personality traits, there are numerous individual health characteristics associated with an increased risk of disordered eating. Being overweight is thought to increase the risk for binge eating, unhealthy weight control behaviors, and bulimic behaviors in adolescents (Kaltiala-Heino, Rissanen, Rimpela, & Rantanen, 1999, Neumark-Sztainer & Hannan 2000). However, some researchers consider perceived weight as a more important risk factor than actual weight status (Patton et al. 1999, Wade, Bergin, Martin, Gillespie, & Fairburn, 2006). For example, numerous studies have shown that the subjective perception of being overweight and dissatisfaction with one's appearance are associated with subclinical eating disorder symptoms, regardless of an adolescent's actual weight (Button, Loan, Davies & Sonuga-Barke, 1997; French, Story, Downes, Resnick, & Blum, 1995; Gardner, Stark, Friedman, & Jackson, 2000; Neumark-Sztainer, Wall, Story & Perry, 2003; Wertheim, Koerner & Paxton, 2001;). These results were consistent in a sample of girls ages 6 to 14 (Gardner et al., 2000), adolescent females in grades 7 to 10 (Wertheim et al., 2001), and females in high school, ages 15 to 16 (Button et al., 1997). In a study of 4,746 adolescents, unhealthy weight control behaviors explained 76% of the variance among females and 63% of the variance among males (Neumark-Sztainer et al., 2003).

In adolescence, disordered eating is also associated with a higher likelihood of having an emotional disorder, including but not limited to, depression and anxiety (Fairburn et al., 1998: Gardner et al., 2000; Lewinsohn et al., 2000; Measelle et al., 2006; Neumark-Sztainer & Hannan, 2000; Wade et al., 2006). In the majority of these studies, disordered eating was not defined using clinical measures from the DSM or ICD, but rather through self-report measures assessing participants' dieting behaviors and body dissatisfaction. For example, in one study, disordered eating was defined as a self-reported binge-purge cycle and negative attitudes toward current

weight status (Neumark-Sztainer & Hannan 2000). The frequency of bingeing and purging did not need to meet clinical requirements to be considered disordered eating. Instead of relying on self-report alone, this research indicates the need for a more stringent evaluative process for measuring subclinical eating disorders, similar to the diagnostic standards for clinical eating disorders.

Substance use and other high risk behaviors have also been correlated with disordered eating. For example, in several studies of both male and female adolescents, smoking was associated with weight concerns and weight loss behaviors, both antecedents to eating disorders (Croll et al., 2002; French et al., 1995). Additionally, several studies report a connection between disordered eating and alcohol intake (Croll et al., 2002; French et al., 1995; Lewinsohn et al., 2000; Neumark-Sztainer & Hannan, 2000). For example, in a study of 81,247 high school students, the most significant risk factors for disordered eating among both males and females included cigarette smoking, appearance concerns, and alcohol use (Croll et al., 2002). Finally, and unsurprisingly, there is a consistent pattern related to high-risk eating behaviors and disordered eating. Adolescents are at an increased risk for disordered eating when they attend family meals less frequently (Neumark-Sztainer, Wall, Story, & Fulkerson, 2004), or skip meals with the intention to lose weight loss (Ross & Ivis, 1999). For example, 18.8% of female adolescents engaged in extreme weight loss behaviors when they had one to two family meals per week, compared to 8.8% of female adolescents who had three to four family meals per week (Neumark-Sztainer et al., 2004).

Family and Peer Risk Factors

Socialization theory suggests that families of origin, particularly parents, are the primary socialization agents in child development (Kandel, 1980; Kandel & Davies, 1992). According to

this theory, social reinforcement and modeling are the two main processes in which socialization

agents promote behaviors and actions. Social reinforcement involves the internalization of values

and behaviors deemed important by significant others (Kandel, 1980). Thus, children likely

internalize behaviors, attitudes, beliefs and values of their parents and families.

In previous empirical work, the three most important familial behaviors and attitudes that

tend to influence the likelihood of disordered eating are body dissatisfaction, promotion of the

thin ideal, and modeling of dieting behavior (Mills & Miller, 2007; Stice, 1998). The thin ideal is

the concept of promoting values which suggest being "thin" is a marker of being a more valuable

and worthwhile individual. An extensive amount of correlational and experimental research has

documented that internalization of the thin ideal is related to body dissatisfaction and to

subsequent manifestations of disordered eating, such as restrictive eating and bulimic symptoms

(Grabe, Ward, & Hyde, 2008; Groesz, Levine, & Murnen, 2002; Stice, 2002; Stice, Mazotti,

Weibel, & Agras, 2000). When parents unknowingly and indirectly promote the thin ideal, it has

a significant impact on the immediate family's internalization of these values (Stice, 1998).

Additionally, pressure from families to adhere to the thin ideal (Canals, Sancho & Arija, 2009),

parental social values that encourage dieting (Davis Shuster, Blackmore & Fox, 2004), and

weight-related pressure from family members (Young, 2004) have all been associated with

higher rates of eating disordered behaviors in children.

The second piece of socialization theory relevant to eating disorders is modeling, which

involves directly copying a behavior performed by someone else (Bandura, 1969). For example,

mothers of adolescents with eating disordered behaviors showed greater modeling of eating

pathology and dietary restraint than control mothers (Pike & Rodin, 1991). A longitudinal study

demonstrated both aspects of socialization theory, social reinforcement and modeling, as risk

factors for eating disorders. Specifically, 1,336 males and females with a mean age of 11.3 years were examined with their parents over a two-year period (Canals et al., 2009). Over time, drive for thinness, bulimic behavior and body dissatisfaction in parents increased the likelihood for development of eating disorders in their children. Additionally, higher rates of cognitive and behavioral aspects of eating disorders in parents were associated with severe forms of clinical eating disorders in their children (Canals et al., 2009).

Adolescents who report low levels of family connectedness, communication and parental caring appear to be at an increased risk of disordered eating (Button et al. 1997; Croll et al. 2002; French et al. 1995; Wade et al. 2006). These researchers hypothesize that the disconnection from important family members within the family system places individuals at a heightened risk for eating disorders, highlighting that relational connections may serve as a protective mechanism for those at risk.

Overwhelmingly, family eating disorder research tends to focus on either parenting or mother involvement as causal components (Kog & Vandereycken, 1985; Strober & Humphrey, 1987). Early work showed that mothers and fathers in "eating disordered" families appeared to have distinct styles of relating to their children (Strober & Humphrey, 1987). Overprotection from mothers was commonly associated with AN. Mother-daughter relationships were also found to be impaired. In previous research, mothers and daughters tended to have lower rates of task accomplishment, communication, and affective expression, with high rates of role confusion (Kog & Vandereycken, 1985). Historically depicted as "refrigerator mothers," it was thought that increased rates of depression in mothers and a lack of warmth and love contributed to the development of eating disorders (Dally, 1977; Strober, 1981). This has led to a sense of "mother-blaming" in the field of eating disorders (Dally, 1977). This trend in blaming mothers is not

unlike earlier work, which problematized mothers in schizophrenia and autism research and has now been debunked (Stace, 2010). Additionally, the casual research on the role of mothers has been scrutinized as only being a small part to a much larger puzzle (Polivy & Herman, 2002; Strober & Humphrey, 1987).

In examining the family as a whole, those with eating disorders tend to rate family functioning as significantly worse than their family members (Holtom-Viesel & Allan, 2014). Family functioning is multidimensional and involves constructs including, but not limited to, family problem solving, emotional engagement and role fulfillment (Miller, Ryan, Keitner, Bishop, & Epstein, 2000). In one study, 35 adolescents with clinical AN perceived their families as highly controlling and conflictual, which did not match the perceptions of members within the same family (Gowers & North, 1999). Over time, as the adolescents improved clinically, their perception of family functioning did not improve (Gowers & North, 1999). Conflicting research shows that when compared to controls, families with eating disorders tend to rate themselves as functioning significantly worse in terms of communication and interpersonal factors (Emanuelli et al., 2004). The research seems to indicate that family functioning is worse in those with eating disorders (Emanuelli et al., 2004; Gowers & North, 1999.) However, due to the differences in perceptions between members and the difficulty in assessing the entire family system, there is no unified view of functioning among families with eating disorders (Holtom-Viesel & Allan, 2014).

Social risk factors for eating disorders are not limited to the family environment; risks in peer relationships include teasing and dysfunction in relationships. Weight-based teasing at the hands of peers and by family members is common among adolescents and the common focal point is physical attributes (Neumark-Sztainer et al. 2002; Shapiro, Baumeister, & Kessler,

1991). Regardless of actual weight, teasing increases the risk for unhealthy weight control and binge-eating behaviors in adolescents (Kaltiala-Heino et al., 1999; Neumark-Sztainer et al., 2002; Wade et al., 2006; Wertheim et al., 2001). These behaviors are precursors for the development of disordered eating and the effects can extend into adulthood. For example, in one study of 152 college women, a reported history of appearance-related teasing or criticism during childhood was associated with negative evaluation of their bodies and high rates of dieting and weight concerns, both risk factors for eating disorder development (Rieves & Cash, 1996).

Another risk factor, dysfunctional peer relationships, are often studied by examining social skills, relationship quality and attachment (Ferriter, Eberhart, & Hammen, 2010). In one study, perceived incompetence in social domains was significantly correlated with disordered eating behaviors for college-aged women (Ferrier & Martens, 2008). Several studies have found that young women with subclinical eating disorder symptoms report elevated levels of conflict and dissatisfaction in peer (Grisset & Norvel, 1992; Schutz & Paxton, 2007) and romantic relationships (Thelen, Farmer, Mann, & Pruitt, 1990).

Research on the role of family and peers in the development of eating disorders has been heavily criticized for basing results on simplistic correlations that are merely associations with limited theoretical backing (Treasure et al., 2008). In addition, researchers have taken a strong stance that family factors are not primary causative agents (Polivy & Herman, 2002). While specific factors such as body dissatisfaction, internalization of the thin ideal, and dieting behaviors are strongly correlated with eating disorders, they do not accurately explain problem development. These variables merge with families who may already be vulnerable to eating disorder development due to biological or environmental factors and this collusion creates the complexity of disordered eating (Polivy & Herman, 2002; Strober & Humphrey, 1987). As

suggested previously by the biopsychosocial model (Southgate et al., 2005), to completely understand risk for disordered eating, individual, psychological and sociological factors must be understood together.

Socio-Cultural Risk Factors

Critically examining the larger culture in which these individual and family risk factors exist, allows for a more comprehensive understanding of eating disorders from an etiological, treatment, and prevention perspective. Sociocultural pressures to be thin are often used to describe aspects of the social environment that reinforce messages regarding thinness and beauty, especially for girls. Current societal standards can perpetuate disordered eating by objectifying girls and placing undue emphasis on the size and shape of female bodies, encouraging females to reach unattainable standards of beauty and thinness (Bordo, 1993). These messages come from media, family members and peer groups, and reinforce societal messages regarding body shape and size, suggesting that self-worth is based on unattainable physical standards (Coomber & King, 2001; Tsiantas & King, 2001).

Females are particularly vulnerable to these messages, and one effect of trying to reach these unattainable standards is development of disordered eating behavior. Internalization of the thin ideal is especially salient in Western industrialized countries like the United States, where there is easy access to the media and consistent socio-cultural pressure from friends and family members regarding appearance (Tsiantas & King, 2001). As suggested previously, socialization theory (Kandel, 1980; Kandel & Davies, 1992) suggests these societal standards may be further reinforced within families that emphasize the importance of appearance and weight (Mills & Miller, 2007; Stice, 1998).

Despite the higher prevalence of eating disorders among females, male adolescents are not immune from societal pressures regarding ideal body size. Although girls may receive more pressure to be thin, both boys and girls are influenced by internalization of cultural ideals. Body shape has been found to be central to definitions of attractiveness for both males and females in the United States (Epel, Spanakos, Kasl-Goodley & Brownell, 1996). However, the pressures and consequences of body image for boys are not nearly as pervasive and harmful as they are for girls, as Western culture objectifies and oppresses women and privileges male power (Bordo, 1993). While men experience pressure, they ultimately still hold privilege within society while this pressure for girls can lead to further oppression and negative consequences including disordered eating.

The social comparison theory suggests that there is an innate drive for humans to compare themselves to others on psychologically important attributes (Rieves & Cash, 1996). How people "measure up" on these attributes compared to others then influences evaluation of self-worth. Due to the emphasis on thinness and physical appearance in Western cultures, it has been suggested that comparison of appearance is a significant way to measure self-worth and is more common among females (Rieves & Cash, 1996). Social comparisons and body image dissatisfaction appear to be closely related, in that regular comparison of oneself to another person increases the risk of body image dissatisfaction and disordered eating, which often accompany one another (Tsiantas & King, 2001).

A traditional gender role encompasses looking feminine (Brownmiller, 1984), conforming to personal and societal standards of beauty (Cash & Ancis, 1997), and expressing traditional gender role values (Snyder & Hasbrouck, 1996). There has been repeated empirical support for the association between aspects of feminine gender roles and disturbed body image.

For example, adherence to a traditional female gender role is correlated with a higher risk for disordered eating (Affleck 1999; Doninger, Enders, & Burnett, 2003; Martz, Handley, & Eisler, 1995; Zone 1998). Researchers examined 122 female undergraduate students and found that women who endorsed more traditional gender roles in male–female social relations tended to have greater levels of internalization of societal standards and also tended to be more focused on their physical appearance (Cash & Ancis, 1997). One theory suggests that rigid adherence to the female gender roles, manifesting in a focus on physical attractiveness and the need for approval by others, can create significant psychological distress, which explains the disproportionate rates of eating disorders among women (Martz et al., 1995).

In summary, the majority of research on risk factors for eating disorders examines individual, family and cultural factors. Within the literature on subclinical eating disorders, more research appears to focus on reducing risk factors regarding body dissatisfaction and internalization of the thin ideal, rather than building protective factors (Kirsten & Du Plessis, 2008). While both facets are important, understanding the strengths and protective factors that might mitigate symptom development in those with subclinical eating disordered behaviors, highlights a theoretical shift from deficit-oriented to strengths-based (Masten, 2001; Walsh, 2003), which is needed in eating disorder research. This study added to the field of eating disorders through a theoretically grounded examination of potential protective factors for young women with subclinical symptoms.

Theoretical Foundation for Protective Factors: Feminist Theory

Feminist theorists (Bordo 1993; Orbach 1986) have long suggested that females are particularly vulnerable to developing disordered eating symptoms due to increased pressure to be thin, exposure to media which historically objectifies and sexualizes women, and internalization

of the thin ideal (Bordo, 1993). Feminist perspectives on eating disorders consider the varied meanings of food refusal and encourage individuals and their loves ones to listen closely to what the eating disorder is trying to "say" (Bordo, 2003). From a socio-political standpoint, the eating disorder is often considered a "protest" against the effects of gender-based oppression. Women with eating disorders can be perceived as protesting against the limiting traditional female role, the values associated with this role, and a future similar to the domestic and powerless lives of their mothers (Bordo, 2003). As women learn about and witness this feminine role, they become aware that power and rewarded are not awarded to feminine desires and attributes. The extreme control exerted in AN practices of body management could be understood as a patriarchally produced response to the lack of control afforded to girls and women in other aspects of their lives (Malson, 2009). Therefore, AN verbalizes women's resistance to the limiting feminine gender role (Saukko, 2009).

As discussed previously, individual factors commonly associated with the development of eating "disorders" include, but are not limited to, drive for thinness, body dissatisfaction, and a sense of control (Piran, 2010). However, conceptualizing eating disorders as a result of individual characteristics pathologizes individuals, and blames them for the development of the disorder while simultaneously ignoring the larger context in which they develop. Feminist theory allows researchers to examine individual behavior within the larger context, and highlights potential protective factors, such as empowerment, agency and voice, which are often overlooked within the existing literature on the female experience. Oppression results from relations between social categories, which involve discrimination, exploitation, and domination of one group over another, or one person over another (Pharr, 1997). Therefore, theoretical

models, such as feminist theory, which encourage a critical examination of power, oppression

and social structures are useful in conceptualizing eating disorders (Malson & Burns, 2009).

In particular, feminist theorists encourage researchers to examine eating disorders from a

critical-sociocultural perspective, especially in regards to dominant discourses and power

distributions as they relate to gender and oppression (Malson, 2009). However, many females

face gender-based oppression without developing a clinical eating disorder. While issues of

power and gender oppression have often been viewed as risk factors, a purpose of the present

study was to use constructs from feminist theory to examine how these factors might be

protective for women at risk for eating disorders. Feminism has long been misperceived as

wanting to elevate women to a higher social status then men. However, the preferred definition

of feminism for this study is "the struggle to end sexist oppression... It does not privilege women

over men. It has the power to transform in a meaningful way all our lives" (hooks, 2000, p. 28).

In this regard, understanding feminist protective factors for eating disorders does indeed have the

potential to alleviate suffering on behalf of women.

The Feminist Relational Model

Despite the large amount of feminist scholarship that exists regarding eating disorders,

previous feminist approaches have not always been relational in focus. This study narrows in on

a specific feminist approach which aligns theoretically with the goal of focusing on both the

relational and political spheres of women's lives. The feminist-relational model was

conceptualized by Maine & Bunnell (2008) by drawing together feminist concepts with the

relational model developed at the Stone Center (Surrey, 1991). The feminist-relational model

was developed through an understanding of symbolic interaction (LaRossa & Reitzes, 1993) and

the relational self (Miller, 1984), suggesting that self can exist only in relation to other selves

(Mead, 1924; Mead, 1968). Symbolic interaction posits that individuals create meaning out of experience through the development of a self that is both individual and socialized (Mead, 1934), and that how individuals define a situation is socially constructed.

The feminist-relational model takes social interaction a step further by applying the concepts from the theory to explicitly focus on the female experience. Miller (1984), along with other feminist theorists, were critical of models of human development that did not seem to adequately explain women's experience or appreciate the relational nature of the female sense of self (Chodorow, 1978; Gilligan, 1982). Pioneering feminist theorists explicitly and implicitly called for relational and contextual paradigms for understanding the human experience (Gilligan, 1982; Miller, 1976). Within the present study, the feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991) allowed for an exploration of relationships and connection as possible protective mechanisms for those with subclinical eating disorders. The feminist-relational model involves two overlapping spheres. The socio-relational sphere emphasizes connection and social support, while the socio-political sphere focuses on the cultural context, power and feminism. The feminist-relational model is guided by several important principles that inform this study.

Connection. What is it that liberates women from the dissatisfaction they feel with their bodies? Why do some women struggle with subclinical symptoms but do not go on to develop full-blown clinical eating disorders? The feminist-relational model would suggest that connection, or relationships and support, are the answer (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991). Connection involves both emotional and instrumental support. Emotional support involves the ability to share feelings and experience validation when going through difficulties, while instrumental support involves practical aspects such as receiving financial help (Tiller et

al., 1997). However, relationships serve as a mechanism to understand and express this resistance. Feminists argue that empowerment and autonomy are best understood within a context of interconnection between individuals and their significant others (Sherwin, 1998). Thus, the feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991) emphasizes the importance of connection as necessary for healthy psychological development and growth in all individuals, not just those afflicted by disordered eating (Jordan, 1997). While both individuality and connection are important, psychological research has historically privileged the importance of separation over connection (Andersson, 1995).

The individuality-connection conundrum is especially apparent during the crossroads of adolescence, as individuals are encouraged to develop autonomy and take steps towards a separate adult life outside of the safety of their familial context (Kerr & Bowen, 1988; Olson, 1995). This movement away from the comfort of relationships towards a more autonomous self can be painful and confusing. In order to resolve this dilemma, feminist theorists suggest that, in comparison to men, women may be more susceptible to convert their pain into disordered eating (Maine & Bunnell, 2008). During this time, women form a relationship and connection to their eating disorder, which becomes a sense of comfort, security and companionship during this difficult time (Weaver et al., 2005). The feminist-relational model does not pathologize young women for the pain they feel as they separate from supportive relationships and develop autonomy (Jordan, 1997). Establishing an individual sense of self will always entail a discovery of how one relates to others (Maine & Bunnell, 2008). That said, from the feminist-relational perspective, healthy relationships are key to protecting women from disordered eating and in helping women develop psychological health and well-being as they transition from adolescence to adulthood.

Social Support. Feminist theory seeks to de-pathologize connection (Jordan, 1997), suggesting healthy relationships, both with loved ones and with food, and are key to protecting women from disordered eating. This is thought to be particularly important during adolescence and other developmental crises or life transitions, as "young women are pushed to be separate and to move away from the comfort of relationships, they may convert their pain and confusion into disordered eating and body image despair" (Maine & Bunnell, 2008, p. 188). In addition, perhaps eating disorder symptoms become a way to cope with feelings of isolation and loneliness, which pervade in a society that privileges autonomy over connection (Andersson, 1995; Pike & Rodin, 1991).

Social support is a nuanced component of connection that involves emotional and tangible help from others. Currently, the majority of research on social support is limited to those with clinical BN and deficit-based, focusing on social isolation and relationship dissatisfaction as risk factors for disordered eating (Garner & Olmsted, 1984; Herzog et al., 1986; Jacobson & Robins, 1989; Slater et al., 1988). However, there are two known studies which examined the perceptions of social support in women with subclinical eating disorders, and each found conflicting results. In the first study, researchers compared relationship quality and perceived social support self-report scores in 39 women who scored above the clinical cutoff on the Eating Attitudes Test-26 (EAT-26) with 39 matched controls who exhibited no eating disorder symptoms (Holt & Espelage, 2002). Results from the first study found that women with subclinical eating disorders perceived themselves to have adequate social support and relationship quality with significant others (Holt & Espelage, 2002). The researchers recommended utilizing these positive social networks as a resource to help mitigate symptom development for the women with subclinical symptoms. Recommendations from the researchers

included identifying characteristics of the supportive relationships, including perceived support and constructive resolution of conflict, that might have served as protective factors for developing clinical disorders.

A second study utilized phenomenology to understand the lived experience of those with subclinical eating disorder symptoms and found that participants perceived themselves as alone and fearful of connection (Kirsten & Du Plessis, 2008). However, the perceived sense of aloneness appeared to be related to isolation from others and not a result of poor relationship quality in existing relationships. This makes conceptual sense, given that eating disorders often isolate sufferers, making relationships and connection difficult. These results suggest those with subclinical symptoms can still maintain healthy relationships, but demonstrate interpersonal distrust and a fear of being hurt, which prevents them from seeking the support they need (Kirsten & Du Plessis, 2008).

Given these conflicting findings, more research is needed to examine the role that support might play in protecting young women at risk for disordered eating (Weaver et al., 2005). More specifically, what is it about the process of eating disorder development that works to disconnect individuals from their support systems, and what type of support offered by concerned others towards is needed to stop this disconnection from occurring? This study sought to answer this by exploring the role of social support as a protective factor for women with subclinical eating disorders.

Voice. Voice can be defined as an aspect of psychological empowerment, which occurs through the relational collaborative process of expressing oneself in relation to others (Belenky et al., 1986). During the adolescent developmental task of shifting from a relational life to an autonomous one, research has found that women who develop eating disorders during this time

often metaphorically lose their voice (Olson, 1995). Gender based oppression may limit the ability of females to speak up regarding their experiences of injustice, limiting their sense of agency and power over their own lives (Bordo, 1993). As a result, women learn to express their emotional pain through their bodies, rather than using their voice (Maine & Bunnell, 2008). As women navigate the struggles of life while in a subordinate societal position, the eating disorder becomes a metaphor to articulate their grief and pain to others. This loss of voice is experienced both within the self and between others, as these young women become disconnected from their own experiences and their relationships (Olson, 1995).

The feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991) seeks to move from the either-or conceptualization of autonomous versus relational. Instead, a both-and perspective acknowledges that, within supportive relationships, women have the power to utilize their voice (Olson, 1995). Therefore, voice and connection are interwoven and considered key factors in women's health. It is through supportive relationships that women can find the courage to speak out regarding their experience of the eating disorder and, through this process, individual growth occurs. In this regard, women do not have to choose autonomy over relationships or vice versa, as the healthy development of both cannot be separated. It is suggested that an increased sense of empowerment, agency and voice improves relationships with others and the overall sense of self, and improvement in one domain will influence the others. Therefore, this study sought to explore feminist-informed protective factors further, not at an individual level, but as a protective factor in terms of how they are experienced in relation to others.

Context. The feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991) contextualizes disordered eating within the sociocultural environment. Individual risk

factors for disordered eating are still relevant, but more emphasis is placed on understanding how the symptoms of the individual are a response to unhealthy pressures, societal expectations, or gender roles (Sesan, 1994). The social-political context involves the Western capitalist consumer culture in which females can experience gender-based oppression and social inequity (Brown & Jasper, 1993; Orbach, 1978, 1985, 1986) and suggests that individuals are always shaped by their social and political environments (Gutwill et al., 2010). Exploring and understanding the meaning and function of disordered eating behavior in context can help decrease the shame and embarrassment that many woman feel, even when their symptoms have not reached a clinical level (Maine & Bunnell, 2008). The ability to explore these symptoms within the context they develop also increases consciousness of the societal role in eating disorders, which may serve as a protective factor for subclinical eating disorders.

Power. The feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991) also pays special attention to the role of power. Disciplinary power is most relevant to a feminist understanding of eating disorders, as it is defined as a mechanism that regulates the behavior of individuals in the social body (Foucault, 1983). For example, the use of disciplinary power in a patriarchal society may result in female conformity to gender norms and striving for a culturally prescribed, and often unattainable, beauty ideal (Bordo, 1993). For example, women's access to power and privilege is often tied to their accommodation of mainstream beauty ideals and their ability to ascribe to feminine gender roles (Hurtado, 1990). For white, heterosexual women in particular, buying into feminine ideals can help them gain economic and social advantage with powerful men. In order to gain power, women must give into practices that further oppress them, placing them in a position where they are "simultaneously privileged and disadvantaged" (Martin & Nakayama, 1999, p. 18). These findings led researchers to further

explore aspects of feminism, such as agency, voice and activism, that might help women gain power in society without colluding with oppressive practices that keep women subordinate to men (Peterson et al., 2008). Thus, this model seeks to minimize power differentials by encouraging aspects of feminism such as utilization of voice, agency and empowerment. Agency is an aspect of psychological empowerment that is evidenced by self-expression and self-directed actions (Currie & Kelly, 2006).

In terms of subclinical eating disorders, according to feminist theory, the dominant discourse regulating power and how men and women attain power within society is currently organized in such a way that thin women are given more freedom than larger women to develop culturally favorable identities, which simultaneously provides thin women with more power (Guilfoyle, 2009). Feminist theory posits that gender, age and body size are intrinsically connected to power. For example, in a study of women across three age spans, 18 to 29 years, 40 to 49 years and 50 to 59 years, women ages 40 and above were more likely to possess a feminist identity and less likely to express concerns about their weight (Tiggemann & Stevens, 1999). It has been suggested that the importance of appearance becomes so engrained in young women during adolescence and young adulthood, that it may become a part of their core belief system (Cash, & Ancis, 1997; Tiggemann & Stevens, 1999). Thus, young women are sent the message that the only way to maintain power, albeit a false sense of power, is to remain attractive. However, because older women are less likely to express concern regarding their weight, this provides support that the core belief system which equates beauty and thinness with self-worth (Cash & Ancis, 1997; Tiggemann & Stevens, 1999) has the power to be challenged and changed. In addition, a sense of self-worth outside of appearance and weight status may serve as a protective factor for eating disorders.

Feminist identity. "Feminist attitude" is the term used to describe women who subscribe to nontraditional or feminist views regarding women's roles (Tiggeman & Stevens, 1999, p. 104). These views include equality between the sexes, subjective identification with the women's movement, and engagement in activism for gender-based oppression. Women who identify as having feminist attitudes are less likely to evaluate themselves on physical appearance alone (Affleck 1999; Dionne, Davis, Fox, & Gurevich, 1995; Doninger et al. 2003; Martz et al. 1995; Tiggemann & Stevens 1999; Zone 1998). Evaluating self-worth based on physical appearance is a common precursor to disordered eating. In one study examining female athletes, women with a higher affiliation towards feminist identities and more egalitarian gender roles had lower levels of eating disorder risk (Doninger et al., 2003). This lower level of risk was also predicted by lower levels of body dissatisfaction and less drive for thinness (Doninger et al., 2003).

What is it about a feminist identity that might inoculate young women from the perils of disordered eating? One theory is that a feminist attitude helps develop critical consciousness, skepticism of the dominant culture, and a voice women can use "to struggle against the oppression they face in the body domain" (Affleck, 1999, p. 279). In other words, a feminist identity allows women to challenge sexism within Western capitalist culture and, by standing against the emphasis placed on physical appearance as a determinant of value or worth (Brown & Jasper, 1993; Seid, 1994), they reduce their risk for eating disorders. Feminist consciousness can also create heighted awareness of the relationship between female body objectification and disordered eating, conceptualizing objectification as a form of social control which prevents women from achieving in other areas of their lives (McKinley & Wojszwilo, 1999). With its emphasis on context, power and feminism, the socio-political sphere of the feminist-relational

model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991) served as a useful way to conceptualize societal factors that may protect women with subclinical eating disorders.

In a qualitative study of 18 interviews with six self-identified feminist women ages 19 to 24, feminist consciousness regarding the connection between female oppression and body dissatisfaction appeared to be important in helping participants cope with the social pressure related to body size and shape (Affleck, 1999). The author suggested that feminist identity may serve as an important protective factor to reduce the risk of eating disorders. However, the findings also indicated that women's experiences of struggling with body image is a complex process that is impacted by more than just the presence of absence or feminist values (Affleck, 1999). For example, in a study of 25 self-identified feminists, participants reported that feminism promoted an intellectual understanding of the toxicity of culture and helped put their own struggles with body image into context (Rubin, Nemeroff & Russo, 2004). However, this cognitive understanding did not appear to change participants' personal feelings about the importance of beauty and their appearance. Thus, intellectual knowledge from a feminist perspective of the role society plays in female objectification and body dissatisfaction was helpful, but did not translate into behavior changes (Rubin et al., 2004). The conflict that participants experienced can be explained in relation to the existing power inequities related to gender and physical appearance. Thus, the present study sought to examine how to turn intellect into action, by exploring how safe and supportive relationships may relate to empowerment, voice, and a critical stand against the larger culture which promotes disordered eating.

Empowerment. Empowerment is a considered a central tenent of feminist approaches to preventing eating disturbances; it has been studied in the context of eating disorder prevention programs as a factor that can reduce the likelihood of body image disturbances (Peterson et al.,

2008). From a feminist perspective, empowerment is a verb. It involves the process of "gaining control over one's life and influencing the organizational and societal structure in which one lives" (Rogers et al., 1997, p. 1042).

Programs informed by the notion of empowerment include "Girl Talk" (McVey et al. 2003), "Every BODY Is A Somebody" (Seaver et al. 1997), "Full of Ourselves" (Mckinley Steiner-Adair et al., 2002; Sjostrom & Steiner-Adair 2005;), and "Go Girls" (Piran et al. 2000). Though not always studied as an independent variable, in most feminist-informed prevention programs discussed here, aspects of empowerment serve as protective factors for those at risk for disordered eating (McKinley Steiner-Adair et al., 2002; McVey et al. 2003; Piran et al. 2000; Seaver et al. 1997; Sjostrom & Steiner-Adair 2005). All of these programs seek to teach women about societal objectification of their bodies and develop feelings of empowerment by increasing personal competence and critical consciousness to stand against societal pressures from the dominant culture. "Every BODY is a Somebody" includes a peer support group, which has had a positive influence on body image and eating behaviors in both middle and high school girls (Seaver et al., 1997). Major components of these intervention programs related to empowerment include media literacy regarding the negative impact of the thin ideal, and development of life skills to build positive body image, manage stress, and increase healthy peer relations (McKinley Steiner-Adair et al., 2002; McVey et al. 2003; Piran et al. 2000; Seaver et al. 1997; Sjostrom & Steiner-Adair 2005).

Empowerment is more highly correlated with lower levels of eating disturbance than feminist identity. The researchers theorized that those who feel powerless in regards to their bodies may passively internalize societal standards of beauty more so than others, resulting in a disturbed body image (Peterson et al., 2008). Internalization of the thin ideal is likely to result in

a disturbed body image, which is predictive of the development of eating disorders (Calogero et al. 2005; Greenleaf and McGreer 2006; Leon et al., 1993; Prichard & Tiggemann 2005; Stice 1994; Tiggemann & Kuring 2004; Tylka & Hill 2004). While powerlessness might serve as a risk factor for disordered eating, more research is needed from a strengths-based perspective in terms of how empowerment may serve as a protective factor for those at risk for disordered eating. Specifically, researchers have suggested that more studies should focus on enhancing and empirically testing girls' feeling of power over their own lives, whether that be body image, education, employment or relationships (Peterson et al., 2008). These researchers theorize that feeling empowered across various domains of life may reduce risk factors for disordered eating including, self-objectification and body image disturbance. Thus, in the present study, an entire section of interview questions was devoted to exploring participants experience of voice and empowerment.

Of additional importance is experience over intellect in inoculating females against eating disorders (Peterson et al., 2008). Body image acceptance was more likely to occur in those who felt empowered in their day-to-day lives (Peterson et al., 2008). Protective factors such as empowerment and voice are not just things to hand over to girls in a pep talk and expect them to use (Davies 1997; Ward & Benjamin, 2004). From a feminist perspective, these constructs are experienced in relation to others. Therefore, it is within safe and supportive relationships where vocalization of injustice and critical reflexivity to challenge dominant discourses can occur (Currie & Kelly, 2006). Girls need space to name their experiences of gender inequality and the possibilities they have for standing against it. Providing young women this space to "critically interrogate" their experiences of gender oppression moves them from object to subject in a world that has historically objectified their embodied experience (Currie & Kelly, 2006, p. 434).

Experiencing the self as a subject versus object is important, as societal and self-objectification are risk factors for disordered eating (Peterson et al., 2008). Feminist researchers trust girls and women to be experts in their own lives and health experiences (Keddy, Sims & Stern, 1996; Weaver et al., 2005). In qualitative research on empowerment, girls themselves have described "rational individualism" as a factor in combating the limiting confines of femininity. Rational individualism involves an ideology that emphasizes the moral worth of the individual, often resulting in a sense of independence and self-reliance to achieve personal goals (Wood, 1972). For example, in one study of female adolescents and identity development, many participants described 'me, myself and I' as that which helped them stand against gender-based oppression and maintain their true sense of self (Currie & Kelly, 2006, p. 431). However, the discourse of rational individualism also limits girls' ability to experience a sense of agency and empowerment, because the confidence to stand against patriarchy and utilize their voice often happens in relationships (Currie & Kelly, 2006). This study sought to explore empowerment further, not at an individual level, but as a protective factor in terms of how it is experienced in relationship to others.

Summary and Rationale for the Study

The dangers of disordered eating are clearly established within the empirical literature. Alarmingly, subclinical eating disorders are more common than clinical eating disorders, but significantly less understood (Wei-wei, et al., 2015). Unfortunately, there is very limited research on subclinical eating disorders in general, and even less on protective factors for this population. Greater understanding of subclinical eating disorders, from the perspective of those who experience them directly, will help practitioners and researchers to develop intervention and prevention programs specific to subclinical symptoms.

Limited research on feminist protective factors have found aspects of empowerment to be important in eating disorder prevention (McKinley Steiner-Adair et al., 2002; McVey et al. 2003; Piran et al. 2000; Seaver et al. 1997; Sjostrom & Steiner-Adair 2005). Therefore, understanding the strengths and protective factors through the lens of the feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991) is an important way of extending previous findings. From a social-relational perspective, social support can be a powerful resource in clinical eating disorder recovery (Marcos & Cantero, 2009). However, there is limited research that examines the role of social support as a protective factor for those with subclinical eating disorders. Additionally, the majority of literature on subclinical eating disorders and social support examines the phenomenon through a deficit framework by examining etiological and risk factors (Garner & Olmsted, 1984; Herzog et al., 1986; Jacobson & Robins, 1989; Slater et al., 1988).

From a social-political perspective, the experience of feminism, rather than intellectual knowledge of feminist ideals, was most helpful in decreasing disordered eating behaviors (Rubin et al. 2004). Thus, this study combined the findings from both the socio-relational and socio-political spheres by exploring the connection between empowerment and voice as they relate to safe and supportive relationships, in order to protect eating disorder symptoms from escalating (Currie & Kelly, 2006; Peterson et al., 2008). This study helped describe the process of what might mitigate symptom escalation from a feminist perspective using the feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991) as a guide. More specifically, this study addressed the following research question: "In what ways and under what circumstances have young women with subclinical eating disorder symptoms navigated the difficulties of their relationship with food and body image in order to cope with their subclinical symptoms and prevent them from getting worse?"

Chapter 3: Methodology

Research Design

The qualitative method of constructivist grounded theory (Charmaz, 2006) was chosen to qualitatively examine social-relational and social-political contexts for the purposes of developing a feminist-informed theory of factors that may mitigate eating disorder development for young women who exhibited some symptomology, but did not develop clinically disordered eating. Constructivist grounded theory moves beyond the description of a phenomenon to develop a theory when one is not available or fully developed enough to explain a process (Charmaz, 2006). In terms of the data analysis process, this method is less structured than original grounded theory, allowing for more flexibility on the part of the researcher (Strauss & Corbin, 1998) and takes a social constructivist framework, which is consistent with the theoretical framework guiding the present study. Social constructivists and feminist theorists acknowledge the existence of multiple realities and emphasize that reality is constructed through lived experience (Gergen, 2009).

In addition, constructivist grounded theory draws on research participants as sources of knowledge to provide rich descriptions of these realities (Charmaz, 2000). Social constructivists also assert that reality is mutually created by the observer and the observed (Charmaz, 2000). Social constructivists and feminist theorists encourage a critical examination of power and social structures, which have been identified as useful in conceptualizing eating disorders (Malson, 2009). Thus, feminist constructivist grounded theory was utilized in this study to help the researcher gain an interpretive understanding of the participants' subjective experience of living with subclinical eating disorder symptoms. However, the research design went beyond a description of the participants' experiences, and identified discrete categories, which linked

together to form a theory (Charmaz, 2006) of social-relational and social-political contexts as potential protective factors for young women whose subclinical eating disorder symptoms had not yet developed into a clinical eating disorder.

Participants

For the present study, 15 women were interviewed. Participants were between the ages of 18 and 25, and currently experiencing subclinical eating disorder symptoms that had not yet developed into a clinical level eating disorder, with no history of a clinical diagnosis. Most eating disorder research focuses on those with clinically diagnosable AN and BN (Downs & Blow, 2013), though those with subclinical eating disorders have emotional distress levels similar to those with clinical disorders (Franko & Omiro, 1999). Therefore, for the purposes of this study, only those participants with subclinical eating disorder symptoms were included. To determine subclinical status, participants were screened using the Eating Attitudes Test (Garner et al., 1982) and needed to meet the cutoff score of 20. The Eating Attitudes Test, as well as differentiating participants between clinical and subclinical status, is described in more detail in the instrumentation section. Participants could have been in mental health therapy at the time of the interview, but the primary focus of treatment should not have been eating disorder issues. Additionally, a previous clinical diagnosis of an eating disorder made participants ineligible to participate. Prior experience in treatment or therapy was not a requirement.

The smallest acceptable sample size for most qualitative research is 15 participants (Bertaux, 1981), though qualitative grounded theory studies typically employ at least 20 to 30 participants (Creswell, 1998). However, Green and Thorogood state that, "the experience of *most qualitative researchers* (emphasis added) is that in interview studies little that is 'new' comes out of transcripts after you have interviewed 20 or so people" (2009, p. 120). Therefore, this study

began with the aim of interviewing 20 participants, with a final sample size of 15 once the data reached saturation. The data reached saturation when the analyses yielded no new information (Creswell, 2012). Theoretical sampling (Charmaz, 2006) was used by incorporating concepts from participant responses in previous interviews into questions for the next interviews. When the concepts that emerged from theoretical sampling (i.e., participant as separate from the eating disorder) no longer produced new information or properties, the data was thought to have reached saturation (Charmaz, 2006). This process is explained in more detail in the data analysis section.

The developmental timespan of young adulthood was chosen as a primary focus, and to qualify, individuals needed to be between the ages of 18 and 25 at the time of the interview. Due to increases in frontal lobe formation and cognitive development (Belenky et al., 1986), compared to an adolescent sample, those in young adulthood may have a greater cognitive capacity to reflexively consider their behaviors and what factors may have influenced or mitigated their own symptom development. Young adults also provided a longer time period in which they had struggled with eating disorder symptoms, and providing increased knowledge regarding their ability to resist the development of a clinical disorder.

Recruitment

The sample was considered a purposeful criterion sample (Howell, 2010), as only female participants between the ages of 18 and 25 with subclinical eating disorder symptoms were included in the study. One ineligible participant scored above 45 on the measurement tool, and was provided referrals for local eating disorder treatment centers via email. The specific inclusion criteria helped identify a sample with participants that had enough similarities between them, ensuring the results were applicable to the population of study, and increasing the

transferability of the findings overall. A snowball and convenience sampling approach was implemented, as participants were recruited via word of mouth from professionals and other study participants.

　　To recruit study participants, I constructed a recruitment flyer, which was IRB approved, and described the study in simple terms (see Appendix A). My recruitment began by connecting with professionals in private practice and eating disorder treatment centers in a large metropolitan area via phone, email and mail (see Appendix B for an example of the recruitment letter sent to professionals). This involved calling or emailing professionals to see if they would be interested in sharing study info with their clients. Additionally, after searching for therapists on *Psychology Today* who specialized in working with young adult women in the metropolitan area in which the study took place, flyers were mailed to these therapy professionals. However, this approach yielded a limited response. Only a small number of therapists responded and were willing to share study information. For those who posted flyers in their office for clients, no interested participants reached out to be included in the study. Therefore, recruitment efforts shifted to target colleges and local coffee shops. With permission, IRB-approved posters were hung in local coffee shops and educational buildings on college campuses. Additionally, participants were recruited via word of mouth from professors, graduate students, and other study participants. Specifically, an IRB-approved announcement (see Appendix C), which detailed the study requirements and eligibility criteria, was emailed to professors and student club leaders at local colleges. Professors and club leaders posted the announcement on class list servs and social media websites for campus student groups.

　　Beyond these recruitment methods, I also advertised online, as individuals between the ages of 18 to 25 are primary users of social media outlets such as Facebook, Tumblr and Twitter.

Professional sites such as the American Associate for Marriage and Family Therapy (AAMFT)

also have forums where professionals can post information regarding research. In both the social

media and online professional formats, I used information from Appendix C and posted details

of the study to spread the word to other professionals or individuals that might qualify for the

study. No participants were recruited via professional sites, but several interested individuals

reached out when information was posted to relevant Facebook groups. Several acquaintances of

the researcher posted information on the study in Facebook groups in which they were members.

Administrators of relevant social media groups, were given the same information, and posted

study requirements on their group sites. These social media groups included Facebook pages for

various college majors and women's resource centers on local campuses. In the final sample,

three participants were recruited via Facebook groups.

Data Collection Procedures

Data collection for the study involved three steps. The first was establishing participant

eligibility, the second was collecting demographic information, and the third involved an in-

depth qualitative interview. I utilized self-report data for all of the eligibility information. To

establish if participants were eligible to participate, they contacted me via email or telephone and

a prescreening tool (see Appendix D) was utilized to ensure participants met the criteria of

exhibiting subclinical disordered eating. To determine subclinical eating disorder status,

participants were screened using the Eating Attitudes Test (EAT-26) (Garner et al., 1982) and

needed to score between 20 to 45 on the self-report measure.

Screening participants for eligibility happened over the telephone. After providing a brief

summary of the study, I asked participants the 26 questions from the EAT-26 (Garner et al.,

1982) and scored their responses as they answered. I cross-checked the scoring on the EAT-26

(Garner et al., 1982) website (http://eat-26.com/Form/index.php) to ensure that the scoring was correct. If a participant qualified for the study, I also asked for their height and weight in order to calculate their BMI. The EAT-26 Garner et al., 1982) concludes with five behavioral questions more consistent with clinical eating disorders, and only participants who qualified for the study were asked these questions at the conclusion of the screening. These questions asked participants if they have engaged in any of the following behaviors in the past six months: eating binges, vomiting to control weight or shape, use of laxatives or diuretics, exercising more than 60 minutes per day, and losing more than 20 pounds over the past six months. Participants answered these using six different options, never, once a month or less, two to three times per month, once a week, two to six times per week and once a day or more. If participants were ineligible due to symptomology more consistent with a clinical diagnosis, they were provided referral sources for eating disorder treatment centers in the area. Approximately 35 participants were screened while only 16 qualified for the study. Fifteen of the ineligible participants had EAT-26 (Garner et al., 1982) scores that were below 20 and one participant had a EAT- 26 score just above 45. Two participants had a history of eating disorder treatment, one participant was older than the maximum age requirement, and one participant qualified for the study but chose not to participate.

After establishing eligibility, I set up a time for the participant to complete the interview. To ensure confidentiality and safety, interviews were conducted in my office at the outpatient therapy center where I work ($n = 4$), participant's homes ($n = 4$), or renting out space in a public facility such as a library ($n = 7$). When they arrived for the interview, participants were given a copy of the informed consent form (Appendix H), which explained the risks and benefits of participation. In the consent form, participants were also asked if they would be willing to be

contacted at a later date, in order to facilitate the process of member checking. For this process,

participants read the findings of the study to ensure accuracy of the findings, which enhanced the

overall rigor of the study. A copy was made of the informed consent form, so that one stayed on

file and the other was sent home with the participant. After the informed consent process, but

prior to the beginning of the interview, participants filled out a demographic questionnaire,

which is detailed in Appendix I.

Individuals then participated in an open-ended, face-to-face interview (see Appendix J),

which lasted an average of 145 minutes (2 hours and 25 minutes) with a range of 95-205

minutes. Interviews were audio recorded and, once completed, transcribed verbatim. Each

participant was compensated with a $20 Target gift card for her participation in the study. After

completing the interview, the audio recorder was turned off and participants were debriefed

regarding their experience with the interview. Before leaving, all participants were provided

eating disorder referrals and resources. See Appendix L for a document which includes

debriefing questions and resources.

Instrumentation

EAT-26. Previous research has shown that individuals who score above 20 but below 45

on the EAT-26 (Garner et al., 1982) are likely exhibiting subclinical eating disorders, and are

moving in the direction of a clinical eating disorder, but do not meet all the diagnostic criteria for

AN or BN (Mintz & O'Halloran, 2000). In previous research, the EAT-26 has been used with

nonclinical samples as a measure of abnormal, disturbed, or exaggerated eating patterns (Mintz

& O'Halloran, 2000). As a whole, the EAT-26 (Appendix E; Garner et al., 1982) includes three

components: 26 self-report items, a BMI calculation to determine underweight status, and five

behavioral items related to eating disorders symptoms which assess for severity and frequency of

eating disordered behaviors in the past six months. Generally, a referral to an eating disorder specialist is recommended if a respondent scores "positively" or meets the "cut off" scores or threshold on one or more criteria. The EAT-26 is one of the most widely used self-report instruments for eating disorder research (Koslowsky et al., 1992; Patton & King, 1991). The original EAT (Garner & Garfinkel, 1979) was a 40-item measure designed to assess eating attitudes and behaviors of individuals at risk for disordered eating. A factor analysis of the original 40-item scale produced a 26-item abbreviated measure, the EAT-26 (Garner et al., 1982). With the EAT-26, participants were asked to indicate how often they engage in certain behaviors on a six point scale ranging from zero (never) to five (always). The EAT-26 is divided into three subscales including: 13 items related to dieting, such as an avoidance of fattening foods and a preoccupation with being thinner, six items related to BN and food preoccupation, and seven items related to oral control regarding eating and the perceived pressure from others to gain weight. A sample item from the dieting subscale includes "I am preoccupied with the thought of having fat on my body." A sample item from the BN and food preoccupation subscale includes, "I feel that food controls my life." A sample item from the oral control subscale includes, "I avoid eating when I am hungry." The EAT-26 also includes a BMI measure and five behavioral questions reflective of clinical eating disorders.

In previous psychometric research, the EAT-26 has consistently demonstrated high reliability and validity (Garfinkel & Newman, 2001; Garner et al., 1982; Mintz & O'Halloran, 2000). The EAT-40 has been validated with anorexia nervosa patients but has also been useful in identifying eating disturbances in non-clinical samples (Button & Whitehouse, 1981; Garner & Garfinkel, 1980; Thompson & Schwartz, 1982). In transferring the original 40 item version to a 26-item scale, the EAT-26 was highly correlated with the EAT-40 ($r = 0.98$) and three factors

form subscales were meaningfully related to bulimia, weight, body-image variables and psychological symptoms (Garner et al., 1982). The EAT-26 displayed acceptable criterion-related validity by significantly predicting group membership, and the reliability (internal consistency) of the measure is high (alpha = .90) (Garner et al., 1982). When using the measure to differentially diagnose individuals with and without DSM-IV defined eating disorders, the EAT-26 had an accuracy rate of 90% (Mintz & O'Halloran, 2000)

Demographic questionnaire. The demographic questionnaire included basic questions related to age, gender, education and various other factors. The questionnaire also included a list of behavioral and psychological eating disorder symptoms, drawn from the EAT-26 (Garner et al., 1982). Participants marked symptoms they had experienced, both currently and in the past. The survey also included questions regarding past or current treatment and whether or not the treatment was helpful. See Appendix I for the demographic questionnaire. See Table 1 on page 122 in article 1 for a demographic summary of participants.

Interview protocol. The interview script (Appendix J) was created based on the research question for the study, and was informed by the literature review, which has highlighted several potentially important protective factors for eating disorders. The interview questions were also shaped by the primary investigator's training in narrative therapy (White & Epston, 1990), an approach rooted in feminist and social justice values. Narrative therapy and feminist theory have many similarities. For example, both are grounded in the belief that reality is socially constructed and language shapes reality (Combs & Freedman, 1994). Additionally, both narrative therapy a feminist theory are considered emancipatory, in that exposing exploitative social arrangements and suggesting alternatives to these arrangements can help reduce oppression (Scott, Hanstock, & Patterson-Kane, 2013). With the emphasis on identifying dominant discourses and freeing

individuals from the destructive effects of these discourses through a new story, this feminist-informed narrative lens (White & Epston, 1990) was ideal given the framework and purpose of the study, which focused on feminist-informed protective factors.

The interview questions were divided into sections including an overview of the participant's symptoms, connection and social support, voice and empowerment, and gender and power dynamics. A sample question under the overview section included, "Eating disorders tend to quietly get worse and worse. What do you think has helped you to avoid more serious measures when it comes to your eating disorder?" Under connection and social support, participants were asked questions about their support people, such as, "How comfortable do you feel going to person XX for support when you are struggling with the eating disorder symptoms?" Under voice and empowerment participants were asked questions related to their own sense of agency, such as "Do you feel like you can speak up to people? What is it like for you?" Under gender and power dynamics, participants were asked questions about gender and eating disorders. For example, "How (if at all) do you think your gender influences how you feel about your body?"

Data Analysis

The guiding framework for the analysis was constructivist grounded theory (Charmaz, 2006), which involves a "zigzag" process in which the researcher moves back and forth between the field and the analysis to discover the "truth" within the object of study (Creswell, 2012). This means that data collection and analyses happened simultaneously. This process also involved gathering rich data, coding the data, and memoing, all while emphasizing the values, beliefs, feeling and assumptions of the participants (Charmaz, 2006). Constructivist grounded theory is an analysis which emphasizes individuals' perceptions of their experiences and honors

participants as the experts in their own lives (Auerbach & Silverstein, 2003; Charmaz, 2006). For

this study, the overall goal of the data analysis process was to move from a rich description of

participants' experiences, toward a conceptual framework of a feminist-informed theory on

factors may mitigate symptom development for those with subclinical eating disorders.

Sensitizing Concepts

The first part of data analysis was the identification of sensitizing concepts, which are

assumptions and theoretical perspectives from the researcher's experience or discipline that

might help inform the development of the theory (Charmaz, 2003). It has been suggested that

researchers use the following questions as a guide when identifying sensitizing concepts: "(a)

What, if anything, does the concept illuminate about these data? (b) How, if at all, does the

concept specifically apply here? (c) Where does the concept take the analysis?" (Charmaz, 2003,

p. 319-320). The sensitizing concepts were identified prior to conducting interviews and included

the concepts of voice, connection, empowerment and agency. The concepts are described, in

detail, in Chapter 2. The interview questions were developed to reflect the sensitizing concepts,

and each concept represented a different section of interview questions. This helped guide the

analysis and coding, as initial concepts were grouped according to interview section and

sensitizing concept. Additional sensitizing concepts emerged during the iterative process of data

collection and analysis through theoretical sampling (Charmaz, 2006) and the process of

interviewing, transcribing, and re-checking the data. More specifically, after the first few

interviews, it became apparent that participants were speaking about their subclinical eating

disorder experience in an externalized way. This externalization involves speaking about a

problem or condition as if it is separate from a person, in the study this was termed the "eating

disorder voice." Therefore, when analyzing the data, I began to look for ways that participants

separated themselves from the "eating disorder voice". I also added a question to the interview

script inquiring about the separation the participant experienced between herself and her eating

disorder symptoms. Separation between the participant and the eating disorder eventually

became a larger category within the grounded theory model. Saturation of this concept was

complete when no new properties or ideas emerged from the category. In this way, theoretical

sampling and theoretical saturation worked in tandem.

Open Coding

To begin the open coding process, interviews were transcribed verbatim and then

checked, read, and reread to ensure accuracy of the data. Myself and one other person with

professional transcription experience transcribed the interviews. Inclusion of an additional

person to help with transcription was included in the informed consent and approved by the IRB.

See Appendix S for the Transcription Protocol, which ensured consistency across transcribers.

Next, I began to categorize the phenomenon being studied by segmenting information

from the interview transcripts into codes. Open coding occurred as the interviews were

completed and transcribed and involved an initial line-by-line process of reading each transcript

meticulously to identify concepts or "meaning units" (Charmaz, 2000) within each interview. I

utilized the process suggested by Charmaz (2006), of creating a table in which the transcript is in

one column and the coding of actions is placed on the other side of the column. Using constant

comparative analysis, interviews and open codes were compared against one another. That is, I

transferred the open codes into their own document and, as I went through each interview, open

codes from the next interviews were added, so all the analytical information could be in one

document and compared together. It is recommended that open coding stays close to the data

and that during this phase, coding of actions is more important than identifying theoretical

constructs (Charmaz, 2006). For example, during this process I coded experiences and behaviors that were not directly reflective of my sensitizing concepts. This allowed for an openness to the ideas that emerged during this process, rather than adopting a premature theory before the necessary analytic work was done. I used the following questions as a guide during open coding, "(a) What does the data suggest, and from whose point of view? (b)What process(es) is at issue here and how do I define it? (c) How does the research participant act while involved in this process? (d) When, why and how does the process change? (Charmaz, 2006, p. 47-51). See Appendix U for an example of the open coding process using the sensitizing concept of gender as it relates to development or mitigation of eating disorder symptoms.

Focused Coding

After the completion of open coding, the researcher takes the most significant open codes and organizes them into concepts that might represent emerging themes within the data (Charmaz, 2003; 2006). As focused coding is more abstract than open coding, I began by reviewing the open codes across all the interviews to create themes within the data (Charmaz, 2006). To accomplish this, it was helpful to read through the master document with the open codes from each interview. From there, the codes were organized into focused codes. This process involved reviewing all the codes that resulted from open coding, and determining which of them "spoke" to the research question best. To do this, a table was created which included open codes in one column and the resulting focused codes on the left. Open codes that related to one another were placed together in the open code column. The process of collapsing these open codes together produced a focused code which was then placed in the left-hand column of the table, in the same row as the open codes. To the right of the open codes, there was a column which included the participant, transcript page number and potential subtheme relating to the

focused code, in order to identify where the information came from. For constructivist grounded theory, it is also recommended that focused codes are organized, reorganized, and collapsed together until there is a master list of approximately 40 to 80 focused codes (Auerbach & Silverstein, 2003). Due to the amount of data and length of the interviews, the final table with focused codes originally had over 100 focused codes. Afterward, all the focused codes were moved into a master document (Auerbach & Silverstein, 2003). The focused codes were continually collapsed together until they eventually became larger themes and subthemes of the study. Appendix V provides an example of the focused coding process for the present study using concepts related to gender as an example.

Axial Coding

While focused coding involved identifying themes and subthemes from the codes, axial coding involved examining the relationships between the different themes, for the purposes of developing larger categories and the emerging grounded theory (Charmaz, 2006). Axial coding helps write a "story-line" which connected the themes and began the process of piecing the data back together to develop a larger theory (Charmaz, 2006). Thus, the focused codes identified in the previous step were grouped into categories (Kelle, 2007). To do this, I simply moved the focused code themes into a separate document and grouped them with other themes that fit together logically and conceptually as a category. See Appendix W for an example of the axial coding process for the present study.

Theoretical Coding

My final goal was to develop a substantive-level feminist-informed theory of protective factors for young women with subclinical eating disorder symptoms, based on the themes and categories that emerged during coding. Theoretical coding is a "drawing together of theoretical

categories that are arranged to show how the theory works" (Creswell, 2012, p. 85). A

"theoretical category" represents the summation of a category, theme and subtheme (Kelle, 2007.

In the example below, the "theoretical category" is the summation of the category (participant

separate from the ED), two themes (eating disorder as separate from participant and developing a

framework or metaphor to understand the ED) and 11 different subthemes.

Category: Participant as separate from the ED

Theme	Subthemes + Number of Participants
Eating disorder as separate from participant (13)	➢ Participant can distinguish ED as a separate voice from her own (first introduced by participant) (6) ➢ Participant can distinguish ED as a separate voice from her own (first introduced by interviewer using theoretical sampling) (4) ➢ Participant refers to ED as a part of her and not necessarily a separate voice (because it's been there so long) (3) ➢ Great difficulty separating herself from the ED (2) ➢ Described ED voice as regulatory (1)
Developing a framework or metaphor to understand the ED (8)	➢ Developing a larger framework to understand ED experience (3) ➢ Two separate voices/people (3) ➢ Powerful song/quote (3) ➢ Analogy (1) ➢ Quotes/Bible verses for ED recovery (1) ➢ Positive-oriented analogy for ED recovery (3)

It is helpful to think of this process as developing a theory or way to explain how the

categories identified previously during axial coding link together with one another. This process

began by creating a separate document that listed all the categories identified during axial

coding, and any subsequent themes or subthemes that went underneath them. As each category

was moved into a separate document, I reviewed previous analytic memos regarding how the

categories and their subsequent themes might link together, and how they might be related to the

sensitizing concepts identified in the first step of the data analysis (Auerbach & Silverstein,

2003).

This process was repeated until all categories, themes and subthemes were grouped together in a logical way. I continued to work through the data by combining categories and themes if necessary until each "theoretical category" was conceptually distinct from the others. The process was complete when the identified categories, themes and subthemes seemed to accurately reflect the participants' experiences and provided an overall explanation of protective mechanisms in the lives of the participants from a feminist perspective. Appendix X provides an example of theoretical coding, representing the final categories, themes and subthemes for the emerging model. The final model which developed from the grounded theory analysis is depicted in Figure 1, which is included on page 121 in article 1, and on page 318.

Trustworthiness

Qualitative researchers have developed a variety of methods to help ensure the rigor and trustworthiness of a study (Davies & Dodd, 2002). The trustworthiness of the present analysis involved the extent to which the findings had credibility, transferability, dependability, and confirmability (Dahl & Boss, 2005). See Table 1 on page 316 for a summary the methods utilized in the study to ensure rigor.

Credibility

Credibility represents the degree to which the findings are accurately drawn from the data (Charmaz, 2006). In this study, peer debriefing was a way of establishing credibility through researcher triangulation, which involved multiple researchers looking through the data (Patton, 2001). To facilitate the process of peer debriefing, my research adviser was consulted during each stage of data analysis to get input as I moved from open coding all the way through theoretical coding. She provided general feedback on the analytic process of grounded theory. In addition, a colleague with previous research and clinical experience with women with eating

disorders also served as a peer debriefer and provided feedback more specific to the concepts

within the emerging model. The peer debriefer and I met three times for one hour each time over

the course of my data analysis process. We discussed ways the model could be applicable to

clinical work and how the emerging model could build off of narrative therapy tenants, instead of

replicating what is already known about this theoretical approach. In order to enhance credibility,

it was particularly important to utilize journaling and memoing to track my self-reflexivity while

conducting the interviews and coding the findings (Davies & Dodd, 2002; Lincoln & Guba,

1985). To do this, I created audio memos after each interview that were then transcribed

verbatim. The memos allowed me to reflect on emerging themes, sensitizing concepts that

eventually led to theoretical sampling, and any potential biases I was bringing in. I was able to

go back to the memos during data analysis and before moving on to the next interview. By cross-

referencing these with my self-reflexivity statement, this enhanced credibility, as I was keeping

my experiences separate from those of the participants.

After completion of the interviews and the data analysis process, a focus group was held

with clinicians, as a means of peer debriefing to enhance the credibility of the findings through

data triangulation. See Appendices L through O for information relevant to recruiting and

conducting the focus group. Appendix P provides a summary of the questions and structure of

the focus group. The focus group consisted of six therapists with specialized training in eating

disorders, who had an average of eight years of experience working with individuals with eating

disorders, with an overall a range of two to 12 years of experience. Educational backgrounds of

the focus group participants included family therapy, social work, counseling psychology, and

theology. Four clinicians had master's degrees and two clinicians had doctoral degrees. The

theoretical orientations most frequently endorsed by focus group participants were Family Based

Treatment (FBT) (Lock, & Le Grange, 2015), Cognitive Behavioral Therapy (CBT) (Beck, 2011), and Dialectical Behavioral Therapy (DBT) (Linehan, 2014). See Table 2 on page 316 for a demographic summary of all focus group participants. During the focus group, the clinicians provided insights into the applicability of the findings and whether they were consistent or inconsistent with their clinical work. Clinicians commented on the importance of separating the eating disorder from the individual, something instrumental to their work, and that this may be easier at the subclinical level. Clinicians also provided important suggestions related to increased awareness and screening for subclinical eating disorders, such as sharing my findings with gym teachers, and guidance counselors, and providing screenings for eating disorders as a part of routine physical exams at the doctor. Appendix Q provides a summary of the findings from the focus group

Most qualitative researchers acknowledge that researchers are not blank slates, as they bring their own experiences and biases to the research process. Therefore, reflexivity is an important tool in qualitative research which can help ensure credibility (Charmaz, 2006; Davies & Dodd, 2002). It is understood that I co-constructed the participants' stories throughout the interview and, through this process, I brought in my own biases and personal experiences (Charmaz, 2006). It was important that I wrote a reflexivity statement before I began my data collection, as I was researching a topic that is important to me from both a personal and professional perspective. The reflexivity statement allowed me to identify potential biases that I had, and I wrote memos throughout the data analysis process to address these biases (Charmaz, 2006). For example, my emphasis on feminist theory and exploring the societal role in eating disorders had the potential to blind me from other explanations of how individuals navigated their symptoms. Therefore, I was intentional to phrase the question as, "What do you think has

helped you to avoid more serious measures when it comes to your eating disorder?" before

exploring feminist-informed factors. As a result, there were focused codes and categories of

protective factors that developed that were not necessarily feminist-informed. For example,

religion and having a relationship with God developed as a protective factor for eating disorders.

See Appendix R for a sample of a voice memo and Appendix T for the reflexivity statement.

Additionally, memoing was an ongoing process throughout each stage of the analysis

process, which did not necessarily occur in linear fashion (Charmaz, 2003; Charmaz, 2006). I

audio recorded notes and wrote down memos which documented my initial thoughts after each

interview. I wrote down ideas about the evolving theory throughout the process of coding. This

process helped me make sense of emerging concepts, categories and themes within and across

the individual interviews. According to Charmaz (2000; 2006), several comparisons are involved

in the process of memoing (a) comparing interviews, (b) comparing data within the same

interview, (c) comparing situations and concepts within and across interviews, (d) comparing

data with the emerging category, and (e) comparing categories to each other. See Appendix R for

an example of a voice memo.

Confirmability

Confirmability represented the extent to which participants read the description of the

findings and found it accurate and valid based on their experience and not the research agenda

(Dahl & Boss, 2005; Lincoln & Guba, 1985). Member checking enhanced the confirmability of

the data in the current study by ensuring that the information was true to what the participants

had originally stated and not misconstrued through the data analysis process (Davies & Dodd,

2002). For this process, participants were asked to read the findings of the study to ensure

accuracy of the findings. After completing open, focused and axial coding, participants who

agreed to be contacted at a later date, read through a summary of the findings and reviewed a

visual of the emerging model. See Appendix Y for a script of the email that was sent to

participants for the purposes of member checking. Three participants responded to the request to

provide feedback, and all generally agreed with the findings. I provided them with several

questions asking them to reflect on the results and describe their thoughts and feelings on the

findings. They then provided suggestions on how well the analysis seemed to accurately

represent their experience. Some changes were made to the emerging themes and final model

based on their suggestions. For example, one participant reported difficulty following the flow of

the model. Therefore, subthemes were removed from the visual depiction of the model to focus

only on larger categories and how they linked together. I then went back to the data and made

changes based on their suggestions and my discretion. This helped me conceptualize my findings

more simply, by considering how someone not well-versed in the data could understand the

results visually. This allowed for a concise and simplified model without explicitly laying out all

the categories, themes and subthemes in the visual, as this information was better explained

verbally in the results sections of my article. As an additional way to establish confirmability, a

focus group was conducted with therapists who specialized in treating young adults with eating

disorders. After reviewing the emerging model, clinicians confirmed the applicability of the

model and offered suggestions for disseminating findings.

Dependability

Utilizing an audit trail throughout data collection to keep notes on the methodological

decision-making ensured that my results were dependable and that data collection happened in a

coherent and logical fashion. If necessary, researchers could replicate the study in terms of the

process of data collection and the analyses (Creswell, 1998). In this regard, the use of the audit

trail allowed me to track my process related to how decisions for the study are being made.

Transferability

Finally, transferability reflects the extent to which the study findings apply to the

population of study. This has been described as a matter of fit and applicability, ensuring that the

findings fit into contexts outside the study situation (Sandelowski, 1986). The most important

way to maintain this standard was addressed in this study through the use of appropriate

sampling. The stringent eligibility criteria ensured that only participants with subclinical eating

disorders were included in the study. Including participants with EAT-26 scores that were below

20 or above 45 would have compromised the ability to transfer the findings to others with

subclinical eating disorders. The process of member checking which was detailed previously, is

also helpful in ensuring transferability of the findings, as participants were able to comment on

whether or not the results accurately reflected their experience of living with subclinical eating

disorder symptoms.

Chapter 4: Results - Dissertation Articles 1 & 2

Introduction

In lieu of writing traditional dissertation results and discussion chapters, I have opted to write three publishable articles. These articles detail my results and discussion in various ways. The articles will cover my empirical, clinical and theoretical findings. They also address clinical implications of the findings.

The first article, *Feminist-Informed Protective Factors for Subclinical Eating Disorders: A Grounded Theory Model* highlights the study findings pertaining to subclinical eating disorders using feminist-informed grounded theory methodology. This article will be submitted to the *Journal of Eating Disorders* (See Appendix Z for the submission guidelines).

The second article, *Barriers and Facilitators to Seeking Treatment for Subclinical Eating Disorders,* is an empirical article which highlights how supportive relationships can be utilized as a resource in seeking treatment for subclinical eating disorder symptoms. This article will be submitted to, *Eating Disorders: Journal of Treatment and Prevention*, which specifically focuses on contributions related to prevention and clinical approaches (See Appendix Z for the submission guidelines). See chapter 5 for information on my third article.

Feminist-Informed Protective Factors for Subclinical Eating Disorders:

A Grounded Theory Model

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Abstract

Background: Subclinical eating disorders have received limited empirical attention. Despite knowledge that the larger sociocultural context contributes to eating disorder development, few studies have examined protective factors for women with subclinical eating disorder symptoms. Guided by the feminist-relational model, this study qualitatively examined socio-relational and socio-political contexts as potential protective factors for the development of clinical eating disorders. Method: Fifteen women between the ages of 18 and 25, with subclinical eating disorders and no history of eating disorder treatment, were interviewed. Data were analyzed using feminist-informed constructivist grounded theory methodology. Results: Participants spoke of their eating disorder symptoms as if they were separate from them. This was termed the "eating disorder voice." Findings highlight contradictions between participants' genuine beliefs and values, and those of the "eating disorder voice." Findings also highlight how feminist-informed protective factors helped participants resolve the tension between their genuine voice and eating disorder voice, and act in accordance with their genuine voice and preferred values. Protective factors included: (1) support people who provide emotional and tangible support, (2) support people who challenge the eating disorder, (3) personal sense of agency, and (4) community activism and involvement. Conclusions: Participants experiencing subclinical eating disorders demonstrate a capacity to distinguish their own thoughts and values from those of the eating disorder voice. Additionally, it appeared that the combination of both socio-relational and socio-political protective factors worked in tandem, such that within emotionally supportive relationships, participants felt empowered and developed a sense of self-worth outside of appearance and weight status. Implications for future research and practice are discussed.

Keywords: subclinical eating disorders; protective factors; feminism; grounded theory

Feminist-Informed Protective Factors for Subclinical Eating Disorders:

A Grounded Theory Model

Background

Eating disorders constitute a pervasive societal problem, due to the destructive nature of the disorder on physical and emotional health [1, 2]. According to the National Institute of Mental Health, the lifetime prevalence rates of clinical eating disorders in adults are estimated at 0.6% for Anorexia (AN), 0.6% for Bulimia (BN) and 2.8% for Binge Eating Disorder (BED) [3] Among adolescents, lifetime prevalence rates of clinical eating disorders are estimated at 2.7% of 13 to 18 year olds [4]. Clinical mortality rates of eating disorders include BN, AN, and Eating Disorder Not Otherwise Specified (EDNOS) and range from 3.9%, 4.0% and 5.2% respectively [5].

Subclinical Eating Disorders

Emerging research suggests that subclinical eating disorders are more common than clinical eating disorders, and just as psychologically devastating. The continuity hypothesis places disordered eating on a spectrum, with subclinical level symptoms on one end and clinical level symptoms on the other [6]. Researchers have suggested that subclinical eating disorders, though considered less severe, are still associated with clinically significant impairments in functioning, including co-morbidity with other psychiatric disorders, higher rates of suicide attempts, and lower scores on global assessment of functioning when compared to those without eating disorder symptoms [7]. Additionally, the single greatest risk factor for developing an eating disorder is being female. Rates of eating disorders are twice as common among females, with moderate increases with age [4]. Specifically, weight dissatisfaction, dieting for weight control, and the use of purging are higher among females compared to males [8]. In a large study

examining subclinical eating disorder symptoms in adolescents, 32% of females and 20% of males had DSM-IV symptoms that were clinically severe, but still did not meet the criteria for a clinical eating disorder [9].

Despite the high prevalence rates, particularly among females, relatively little is known about subclinical eating disorder symptoms due to their secretive nature [10] and associated difficulties with assessment and screening (Croll, Neumark-Sztainer, Story & Ireland, 2002) [11]. Within the existing literature, there has been an almost exclusive focus on clinical eating disorders and risk factors. Thus, little is known about those who live with subclinical symptoms, particularly in terms of how they have managed to keep their symptoms from escalating to a clinical level. The purpose of the present study was to qualitatively examine socio-relational and socio-political contexts as potential protective factors for the development of clinical eating disorders.

Risk Factors

Most research on risk factors for eating disorders utilizes socialization theory [12] to examine individual, family and cultural factors. Both clinical and subclinical forms of eating disorders are prevalent among adolescents, which is typically when eating disorders emerge [7]. Even after adolescence, young women between the ages of 18 and 25 are at an increased risk of engaging in compensatory weight control behaviors, which can develop into diagnosable eating disorders in some individuals [13]. Other individual risk factors for eating disorder development include thin-ideal internalization, body dissatisfaction, and depression [14].

In previous empirical work, the three most important familial behaviors and attitudes that tend to influence the likelihood of disordered eating are promotion of the thin ideal, and modeling of dieting behavior and body dissatisfaction [15]. Additionally, adolescents who report

low levels of family connectedness, communication, and parental caring appear to be at an increased risk of disordered eating [11]. Social risk factors for eating disorders are not limited to the family environment; qualities of peer relationships have also been associated with eating disorders. Specifically, weight-based teasing and teasing based on physical attributes at the hands of peers and family members is common among adolescents and increases the risk for unhealthy weight control and binge-eating behaviors in adolescents [16]. Several studies have found that young women with subclinical eating disorder symptoms report elevated levels of conflict and dissatisfaction in peer and romantic relationships [17]. Overall, there is a large amount of research on risk factors and etiological models of disordered eating. However, research on protective factors for eating disorders represents a theoretical shift from deficit-oriented to strengths-based perspectives [18, 19] and is line with emerging research in the field.

Feminist Critique

Within the literature on subclinical eating disorders, more research appears to focus on risk factors rather than protective factors [20]. While specific factors such as body dissatisfaction, internalization of the thin ideal, and dieting behaviors are strongly correlated with eating disorders [14], they do not fully explain problem development. These variables must merge with families and individuals who may already be vulnerable to eating disorder development due to biological or environmental factors, and this intersection of risk factors creates the complexity of disordered eating [21]. In the past several decades, feminists have sought to understand the spectrum of eating disorders as a cultural and societal issue [22]. At the same time, there has been movement towards examining protective factors from a strengths-based perspective. Therefore, the next section focuses on feminist-informed protective factors for subclinical eating disorders

Feminist-Informed Protective Factors

Protective factors alter responses to adverse events so that potential negative outcomes can be avoided [18]. Understanding risk factors has been important in the field of eating disorders and may lead to understanding and advancement of protective factors. For example, evaluating self-worth based on physical appearance is a common precursor to disordered eating. However, women who endorse aspects of a feminist attitude are less likely to evaluate themselves on physical appearance alone [23]. "Feminist attitude" is the term used to describe women who subscribe to nontraditional or feminist views regarding women's roles [23]. In the past, clarifying the specific factors that protect women from developing eating disorders has served as an important tool for feminist intervention programs. Feminist-informed intervention programs for eating disorders have highlighted the importance of voice, empowerment and connection as factors which may reduce the risk of disordered eating.

To date, the majority of research on feminist-informed protective factors for women with subclinical eating disorders is theoretical in nature. Regarding empowerment as a protective factor, researchers have theorized that those who feel powerless in regard to their bodies may passively internalize societal standards of beauty, resulting in significant body dissatisfaction [24]. In previous research, experiences of empowerment and powerlessness were significantly related to eating disordered symptoms, such that lower rates of empowerment and higher feelings of powerlessness were both correlated with higher levels of body image disturbance [24]. Additionally, feminist consciousness may create feelings of empowerment through a heighted awareness of the relationship between female body objectification and disordered eating. The process of consciousness raising helps females conceptualize objectification as a form of social control which prevents women from achieving in other areas of their lives [22, 23]. An

additional feminist construct is the literal and metaphorical use of voice. Gender disparities based on power result in many women expressing their emotional pain through their bodies, rather than using their voice [25]. Voice as a protective factor in the context of previous feminist research has been defined as an aspect of psychological empowerment, which occurs through the relational collaborative process of expressing oneself in relation to others [26]. From a feminist perspective, within supportive relationships, women have the power to utilize their voice [27]. Therefore, voice and connection are interwoven and considered key factors in women's health.

Feminist-Relational Model

Examination of protective factors from a feminist-informed perspective provides a contribution to the study of subclinical eating disorders and can be done using the feminist-relational model [25, 28, 29]. According to the feminist-relational model [25, 28, 29], a cultural and societal view of eating disorders involves the socio-relational, and socio-political environments of those who experience eating disorder symptomology.

Social-relational context. The social-relational context involves relationships, support and connections that facilitate healthy psychological development and growth [28]. The secretive nature of disordered eating often requires sufferers to seclude themselves and limit contact with others, which has an adverse effect on relationships [30]. This is unfortunate, given that supportive relationships are linked directly to positive recovery outcomes for clinical eating disorders [31]. With the social-relational context being key in clinical recovery, it makes conceptual sense that positive social relationships might also serve as a protective mechanism for those with subclinical symptoms. In previous research, women with subclinical eating disorders perceived themselves to have adequate social support and relationship quality with significant others [30] but perceived themselves as alone and fearful of connection [20]. This makes

conceptual sense, given that eating disorders often isolate sufferers, making relationships and connection difficult. These results suggest those with subclinical symptoms can still maintain healthy relationships, but demonstrate interpersonal distrust and a fear of being hurt, which prevents them from seeking the support they need [20]. More research is needed on social support and the social-relational context of those with subclinical eating disorders. Therefore, this study sought to clarify aspects of the socio-relational context (ie., connection and social support) that might serve as protective mechanisms for women with subclinical eating disorders.

Social-political context. A large amount of feminist scholarship suggests that eating disorders are a result of gender based-oppression and social inequality [32]. That is, the tenuous relationship many women have with food and body image is the result of the sociopolitical oppression women face within a Western capitalist consumer culture. For example, in the United States, gender harassment has been found to increase during grades six through eight [33]. This harassment is thought to be associated with adolescence and the onset of puberty, which involve a greater understanding of sexuality, the development of reproductive organs, and increased mixed-gender socialization [33]. This oppression makes it particularly difficult for females to express themselves directly, leaving numerous unmet needs within themselves and within their relationships. To meet these needs, women seek alternative ways to satiate their desires, often through food and body weight preoccupation [32]. Thus, examining social relationships and "improving general social conditions for women might not only aid their recovery but may prevent [eating disorders] from developing in the first place" [1].

By researching risk factors such as gender based-oppression and social inequality, researchers can better theorize and examine which protective factors may counter this oppression. In many ways, risk and protective factors must be examined in tandem. If gender-

based oppression results in body dissatisfaction and a metaphorical silencing of female voices, what factors might counter this process? As an example, body image acceptance was more likely to occur in young women who felt empowered in their day-to-day lives [24]. Therefore, researchers have suggested that more studies should focus on enhancing and empirically testing the female experience of empowerment, particularly in the domains of body image, education, employment and relationships [24].

Purpose of the Present Study

Feminist theory, including the feminist-relational model [25, 28, 29], has mainly been used to facilitate a theoretical understanding of the development of clinical eating disorders and how gender oppression may encourage disordered eating [32]. An important next step in advancing the field is to understand factors within feminist theory that may serve as protective mechanisms for young women who are indoctrinated into a toxic culture, experience some symptomology, but do not develop clinical disordered eating. Researchers suggest focusing specifically on feelings of power and agency, as they have consistently shown to be protective factors against eating disorders [34]. This study sought to further develop this understanding by using feminist-informed grounded theory methodology [35] to qualitatively examine aspects of the social-relational and social-political contexts as potential protective factors for those with subclinical eating disorder symptoms. More specifically, this study addressed the following research question: "In what ways and under what circumstances have young women navigated the difficulties of their relationship with food and body image to cope with their subclinical symptoms and prevent them from getting worse?

Methods

Participants

This study employed a purposeful criterion sample [36] of 15 women between the ages of 18 and 25 who were experiencing current subclinical eating disorder symptoms, but no history of a clinical eating disorder or diagnosis. To ensure subclinical status, participants were screened using the Eating Attitudes Test (EAT-26) [37] and had to score between 20 and 45. Participants could currently be in therapy if the eating disorder was not the primary focus. Due to increases in frontal lobe formation and cognitive development that happen during this time span, those between 18 to 25 may have a greater capacity to reflexively consider their behaviors [26]. Young adults also provided a longer time in which they struggled with subclinical eating disorder symptoms, providing more insight regarding their ability to resist the development of a clinical disorder.

Participants were recruited via convenience and snowball sampling approaches [36]. Specifically, participants were recruited via word of mouth from mental health professionals, college professors, graduate students, and other study participants. An IRB-approved announcement, which detailed the study requirements and eligibility criteria, was emailed to professors and student club leaders in a large Midwestern City. If the professors and student leaders were willing, information about the study was then forwarded on to undergraduate or club listservs. Administrators of relevant social media groups, were given the same information, and posted study requirements on their group sites. These social media groups included Facebook pages for various college majors and women's resource centers on local campuses. With permission, flyers for the study were also hung in local coffee shops and on bulletin boards in the educational buildings of college campuses. A small number *(n = 2)* of participants were recruited via an acquaintance of the researcher or a previous participant.

Procedures

The present study was approved by an institutional review board. Interested participants emailed or called the researcher to set up a telephone screening. After establishing eligibility, participants set up a time to meet in person with the interviewer. Interviews were conducted in a private area of the participant's choosing, to ensure safety and confidentiality. This included participant's homes, the primary researcher's office, or a private room at a local library. Participants first completed the informed consent document and provided written consent if they were willing to be contacted later for the member checking process. Participants then completed a demographic survey and participated in an in-depth interview. Face-to-face interviews were semi-structured, but open-ended, and averaged approximately two and a half hours in length. Participants received a $20 Target gift card as compensation for their participation.

Measurement

EAT-26. The EAT-26 is one of the most widely used self-report instruments for eating disorder research [36], developed to assess eating attitudes and behaviors of individuals at risk for disordered eating [39]. A factor analysis of the original 40-item scale produced a 26-item abbreviated measure, the EAT-26 [37]. In the past, the EAT-26 has been used with nonclinical samples to measure abnormal, disturbed, or exaggerated eating patterns [40]. The EAT-26 is divided into three subscales including: 13 items related to dieting, such as an avoidance of fattening foods and a preoccupation with being thinner, six items related to BN and food preoccupation, and seven items related to oral control regarding eating and the perceived pressure from others to gain weight. Participants were asked to indicate how often they engaged in certain behaviors on a six point scale ranging from 0 (never) to 5 (always). Previous research has shown that a score between 20 and 45 on the EAT-26 indicates movement in the direction of a clinical eating disorder [37], but may not meet all the criteria for a clinical diagnosis [40]. In

previous psychometric research, the EAT-26 has consistently demonstrated high reliability and validity [37, 40].

Demographic questionnaire. The demographic questionnaire included questions related to age, gender, education, sexual orientation and relationship status. Also included was a list of behavioral and psychological eating disorder symptoms, drawn from the EAT-26 [37]. Participants marked symptoms they had experienced, both currently and in the past. On the questionnaire, participants were also asked to identify the top three emotionally supportive people, and the top three instrumentally supportive people in their lives.

Interview protocol. The interview script was developed after a thorough literature review of feminist-informed protective factors for eating disorders. The interviews were semi-structured with open-ended questions which were organized into sections. These sections included an overview of the participant's symptoms, connection and social support, voice and empowerment, and gender and power dynamics. A sample question under the overview section included, "Eating disorders tend to quietly get worse and worse. What do you think has helped you to avoid more serious measures when it comes to your eating disorder?" Under connection and social support, participants were asked questions about their support people, such as, "How comfortable do you feel going to person XX for support when you are struggling with the eating disorder symptoms?" Under voice and empowerment participants were asked questions related to their own sense of agency, such as "Do you feel like you can speak up to people? What is it like for you?" Under gender and power dynamics, participants were asked questions about gender and eating disorders. For example, "How (if at all) do you think your gender influences how you feel about your body?"

Data Analysis

The study utilized constructivist grounded theory as the guiding framework for the data analysis [35]. The iterative process between the interviews and data analysis [41] involved gathering rich data from the interviews, creating memos, coding the data, and then interviewing more participants based on the emerging ideas and themes [35]. The overall goal of the data analysis process was to move from a rich description of participants' experiences, toward a conceptual framework of feminist-informed protective factors [35, 42].

In this study, the analysis process began by identifying the sensitizing concepts of gender, voice, empowerment and connection, which were drawn from the current literature and the feminist-relational model [25, 28, 29]. Next, the interview transcripts were checked, read, and reread to ensure accuracy of the data. During the initial read through of a transcript, open coding involved a line-by-line process of reading each transcript meticulously to identify concepts or "meaning units" which became open codes [35]. All of the open coding, and other stages of the data analysis process, were completed by the first author. After the completion of open coding, the open codes were collapsed into focused codes [35, 42]. The focused codes were continually collapsed together until they eventually became larger themes of the study.

Next, axial coding involved examining the relationships between the different themes, for the purposes of developing larger theoretical categories [35]. This involved taking the themes and grouping them together in ways that made conceptual sense. This required a back and forth process of examining the different groups of themes and how they related to the research question. Finally, theoretical coding involved moving the theoretical categories into a visual diagram, and a storyline emerged [41]. As a result, a theory developed to explain how the larger theoretical categories, and their associated themes, linked together to explain feminist-informed protective factors for women with subclinical eating disorders. Participants who agreed were

contacted towards the later part of data analysis to review the results and ensure the accuracy of the findings.

       Trustworthiness. Trustworthiness of the analysis was ensured through multiple strategies. Through researcher triangulation [43], the first author worked with a colleague who provided feedback on the data analysis process and emerging model. The primary investigator also worked with a peer debriefer who had clinical and research experience with eating disorders. The first author created a reflexivity statement before data collection, which helped ensure credibility [44] by identifying potential biases and personal experiences connected to the research question. Memoing occurred throughout each stage of the data analysis process to monitor and address these biases [35, 42]. It is important to acknowledge that the primary investigator has clinical training in narrative therapy, and was sensitive to this throughout the analysis process, as this theoretical lens had the potential to bias the findings.

       Member checking helped ensure confirmability [43] of the findings and involved contacting participants towards the end of the analysis process to provide feedback on the emerging model [35]. Three participants responded to the request to provide feedback, and all generally agreed with the findings. Some changes were made to the emerging themes and final model based on their suggestions. For example, one participant reported difficulty following the flow of the model. Therefore, subthemes were removed from the visual depiction of the model to focus only on larger categories and how they linked together. After development of the emerging model, a focus group was conducted with therapists who specialized in treating young adults with eating disorders. These clinicians confirmed applicability of the model and offered suggestions for disseminating findings. Additionally, memoing and an audit trail were

implemented throughout the data collection process by keeping notes on how the methodological

decisions were made, to ensure dependability of the results [44].

Results

Sample

See Table 1 for a summary of the participants' demographic characteristics, including

their behavioral and psychological eating disorder symptoms. Participants reported that their

eating disorder symptoms began anywhere between elementary school and the start of college.

The main factors which triggered eating disordered behavior included body/weight

dissatisfaction, stress/transitions, dieting and associated weight fluctuations, and an extreme

focus on health. Participants endorsed a variety of different eating disordered behaviors and

many reported more than one symptom. Current eating disorder symptoms appeared less severe

than in the past. For example, most participants ($n = 12$) reported their current eating disorder

symptoms were not as severe as they were when the behaviors first developed.

Model Summary

Participants spoke of their subclinical eating disorder symptoms in an externalized way,

as if they were separate from them; this was termed the "eating disorder voice." The resulting

model captures the contradictions between the participants "genuine voice" and their "eating

disorder voice," and highlights how feminist-informed risk and protective factors helped

participants navigate and potentially resolve this tension. "Resolution" in the context of this

model involved participants making choices or actions that were either in accordance or

contradiction to the values and beliefs of their "genuine voice." Acting in contradiction or

accordance with preferred values and beliefs (or the "genuine voice") is a concept from narrative

therapy, which suggests that destructive internalized narratives move individuals away from their

genuine voice [45]. In this study, the "eating disorder voice" emerged as a destructive internalized narrative, while the "genuine voice" represented a congruent and more preferred internalized narrative. How participants navigated the experience of these internalized narratives, and their subclinical symptoms, depended on the varying level of risk and protective factors in their lives. Understanding the risk factors for developing this "eating disorder voice" helped to identify protective factors which could counter this vulnerability. See Figure 1 for a visual depiction of the model. In the following sections, each of the theoretical categories within the model will be described, along with supporting quotations.

Participant Separates Self from Eating Disorder Voice

Participants (*n = 13, 86%*) described an ability to separate themselves from the "eating disorder voice." During the interviews, these participants spontaneously began speaking about their eating disorder as though it was a separate entity or voice, with its own thoughts and feelings that were separate from those of the participant. The following is an example of a participant speaking about her eating disorder symptoms as a separate voice:

> "Even if I'm having a really good day, it's just—there's always that voice in the back of my head that's like, "Look at that though, look at that though." You know what I mean? In the mirror? And I feel that even if I was to lose all the weight that I wanted to, there's still always going to be that little voice."

In this example, there is a clear distinction between the individual and her "eating disorder voice," which goes with her everywhere and appears to scrutinize her body and actions. In this category, two themes emerged, one that describes the separation from the eating disorder voice and a second which demonstrates how participants used a metaphor or framework to understand

their eating disorder symptoms. See Table 2 for a description of both themes within this

category.

Contradictions between Eating Disorder Voice and Genuine Voice

Through the process of separating oneself from the eating disorder voice, a tension

emerged. Participants described the phenomenon that having an "eating disorder voice"

invariably leads to conflicts with their "genuine voice." This concept reflects three themes,

which describe the tension and contradiction between participants' "genuine voice" and their

"eating disorder voice." The most salient theme involved participants saying that, to prevent the

eating disorder from spiraling out of control, they had to *give it control* (*n* = 12, *80%*). Control in

this context meant that, to keep behavioral eating disorder symptoms from escalating,

participants would engage in eating disorder symptoms in a non-excessive way. For example,

one participant would run every day so that she would feel less guilty about the food she ate and

therefore less likely to restrict her intake in a more serious way. However, this participant

explained that, by doing this, she was giving in to the eating disorder, and thus she felt guilty.

Similarly, participants spoke of *conflicting feelings regarding self-worth* (*n* = 8, *53%*). These

women stated that their genuine voice knows self-worth should not be about appearance and

weight-status, but they still believe it. For example, one participant described the back and forth

that happens between her values and those of society as she navigates her own sense of self-

worth:

> "So, it's like if my makeup is done well and I'm wearing a cute outfit and I have lost a
>
> few pounds, I'm doing better. It's like fitting that mold better, and according to society
>
> that should make me happier. And it's scary because society is affirming what you're
>
> thinking, and when you're trying to get out of it, saying 'this isn't logical, this isn't what's

really happening, I know that this isn't my reality', but when people say things that sort of

suck into that, it's like 'is this actually true? Maybe this disorder is right.'"

This participant described how societal expectations reinforced her "eating disorder voice" and

made the contradictions between her eating disorder and genuine voice confusing. Finally, seven

participants endorsed experiencing *relational contradictions (43%)* related to their eating

disorder; for example, they described how they wanted to be open about their eating disorder

symptoms with other people (i.e., their "genuine voice"), but their "eating disorder voice" feared

judgment from significant others. One participant described this contradiction in this way:

"I think, yeah, diving into those relationships, I think I would probably would tell myself

to try talking about it [the eating disorder symptoms] with people. I know that's

something that would probably be good, it would be helpful. But at the same time, I

don't want to do it."

In this example, the participant's "genuine voice" was encouraging her to be open about her

symptoms with others, but her "eating disorder voice" was holding her back from acting on that.

Table 3 provides a description of the themes representing the various contradictions between the

eating disorder and genuine voice.

Risk Factors and Contradictory Actions

The contradictions discussed previously resulted from tension between the "eating

disorder voice" and the "genuine voice." These contradictory thoughts and feelings intersected

with environmental and relational risk factors, resulting in three themes related to risk factors.

These risk factors made it harder for participants to act in accordance with their "genuine voice,"

which fueled the "eating disorder voice," and led to four themes related to acting in contradiction

to values and beliefs. Thus, in this section, all seven themes related to the larger categories of

"risk factors" and "act in contradiction to values and beliefs" (see Figure 1) are discussed together. See Table 4 for a description of all themes and subthemes related to the category of "risk factors." Table 5 presents all themes and subthemes related to the category "acting in contradiction to preferred values and beliefs."

Lack of support leads to putting up walls. First, participants described a *lack of understanding or help from their support person* (*n* = 15, *100%*) as a risk factor, which made it difficult for them to open up about their symptoms. This included support people unintentionally encouraging eating disordered behaviors, diminishing the severity of the subclinical symptoms. and not understanding eating disorders or how to help. For example, many support people also had their own struggles with body image, and in many cases, this would result in support people minimizing the participant's experience. For example, one participant described how a support person unknowingly diminished the severity of her subclinical symptoms:

> "Um, I think when I first opened up to her about it, I just think she thought that it was, an every girl situation. She was like "Oh well of course like, a lot of girls don't like how they look, or feel like they're too big." Or something like that. But I think as we got to know each other and became friends longer, she realized that this is something I'm constantly thinking about."

One participant described her experience of disclosing her symptoms to her mother who did not seem to understand the depth of what she was experiencing:

> "For this eating thing, she's never really nipped it in the bud, and she never really was like, 'We need to deal with this.' It was just always sort of this thing where she'd listen, she'd be understanding, and then it just -- I don't know, she just never really took action."

In this case, the support person's lack of action reinforced that what the participant was struggling with was not that big of a deal. Participants who felt their symptoms were minimized were also less likely to be open about their symptoms with others. For example, one participant described sharing her symptoms with a friend who did not understand the extent of her struggle:

> I think sometimes I feel like it's minimized a little bit. And so I think that's maybe part of why I don't want to talk to her about this because I don't -- I don't want her to say that she gets it because I don't think she does.

If support people lacked understanding and minimized the experience of living with subclinical eating disorder symptoms, the first contradictory action involved individuals protecting their eating disorder symptoms by *putting up walls and isolating themselves* ($n = 15$, 100%). Although many participants valued openness and honesty, many would often not ask for the support they needed, or they would not discuss their eating disorder symptoms with support people. The eating disorder symptoms also created distress in relationships and preoccupation with food and the body, leading to the second contradictory action*, isolation and distress during social activities* ($n = 11$, 73%). Even though participants valued their relationships, participants would not go to social events if the eating disorder voice made them fear high calorie foods or others encouraging them to eat. This struggle often resulted in conflict and lying within relationships, as support people would get frustrated with the symptoms and a participant would then pull away. One participant described her experience of struggling to communicate what she was experiencing:

> "So sometimes it...the eating disorder, kind of budges in the way and makes communication a little hard. It's like how do I express this because it rationally doesn't make sense?"

In this example, the participant was referring to her fear of restaurant food, and that often trying

to vocalize these fears to those who do not struggle with eating disorders is difficult. Instead of

trying to explain something that feels real but sounds irrational when vocalized, many

participants would keep silent or not engage in social activities (i.e.., restaurants with friends) at

all.

Gender oppression leads to difficulty using own voice. A second risk factor for

listening to the "eating disorder voice" and acting in contradiction with values and beliefs

included experiences of *gender oppression* ($n = 15$, 100%). Participants described sexualization

and objectification of women as factors that would make them susceptible to listening to their

"eating disorder voice." One participant spoke about the objectification she felt as a female in

society:

> "And I think although we're aware of the objectivity that we're subjected to, it's still an
>
> objective world. We're still objectified. We can't get out of it. So even if you're aware
>
> of it, you still want to succeed in the world you live in and how do you do that, if the
>
> world you live in tells you you're wrong if you don't look a certain way? It's so hard."

This quote demonstrates the tension felt in not wanting to be objectified, but that giving into

societal notions of objectification and female beauty helped to feel successful in the world.

Other experiences of gender oppression that put participants at risk for listening to the "eating

disorder voice" and dismissing the "genuine voice" included, femininity being devalued, a

pressure to "do it all," and power imbalances, such as not being taken seriously as a woman in

the workplace.

These experiences of gender oppression resulted in the third contradictory theme,

struggles trusting self and using own voice ($n = 12$, *80%*). Many participants discussed that their

eating disorder symptoms resulted in an inability to trust themselves and their own decisions.

Many participants often needed validation from others that what they were doing or how they

looked was acceptable, instead of relying on their own self-knowledge. Participants stated a

desire to live in the moment, but worried about what would happen if they let go of the

preoccupation with food or their body. One participant described this struggle:

> "Well, you know, it's like I want to say listen to -- listen to you, listen to what you want.
>
> But then I have that like, 'well, if you do that too much are you -- are you gonna gain a
>
> lot of weight?'"

In this example, the "eating disorder voice conflates" the ability to listen to oneself with the false

notion of weight gain and lack of control. Additionally, due to the pressure that many women felt

to "have it all together," they would often not be overt about what they were going through,

which conflicts with their value of speaking up and being open in their relationships. By holding

in their feelings, the eating disorder served as a mechanism to metaphorically "speak" for them,

and as a result, silenced their "genuine voice". One participant described her experience in this

way:

> "Maybe [the ED is saying] that I have trouble dealing with my feelings, too, because I
>
> hold them in, I -- there's a lot of pressure on me to do well and I think everyone in my
>
> family thinks I can do everything, 'she can just suck it up and keep going,' and I can't all
>
> the time. I think the eating disorder was trying to say that."

Even though many participants described themselves as direct and assertive in other areas of

their lives (e.g., work, school), the eating disorder became a mechanism to internalize emotional

suffering. This resulted in both protecting the eating disorder symptoms from others, and an

inability to speak about their struggles directly.

"And I think that that was almost protecting my symptoms because I wasn't like, 'Look, I

need help. I need to get out of this.' I was like, "Look at how bad I'm being. Screw it,

like I hate this. I hate all of this. Just look at it.' And so I feel like in a way that was

protecting it because I didn't want to actually talk about what was going on."

This demonstrates the difficulty individuals have in communicating their struggle using their

genuine voice, and the way the eating disorder symptoms can become a mechanism with which

to "speak" to others.

Societal messages lead to internalizing weight or appearance as markers of self-worth. The final risk factor that emerged involved messages from media and society *equating thinness and appearance with self-worth* (*n = 15, 100%*). Participants reported that exposure to

messages from society that women should be thin, contributed to internalizing the false belief

that their appearance and weight status were significant markers of self-worth. Participants

reported internalizing these messages from various sources including the media, peers and

family, with media being the most frequently endorsed source. Participants described feeling

more vulnerable to these messages as females, because they felt that appearance and weight

status become equated with self-worth more so than they do for men. In fact, many participants

reported that appearance and weight status had a significant impact on their sense of self-worth

on a daily basis. Participants described various actions they would take to hide their bodies and

how time consuming their body preoccupations could be. For example:

"My appearance doesn't really bother me so much from a face standpoint but my body

image definitely does. There's a lot of times where I'm wearing something and I'm like I

feel like I need to wear looser clothing because I don't want people to notice that maybe I

> weigh more than I should, or that they would think that I would weigh more. So it's
>
> easier to just kind of wear clothing that maybe hides it a little bit."

Many participants also reported significant concern over what others might think if they gained

weight, and what being overweight symbolized.

> "I don't want people to think that I'm overweight. I think that, not necessarily that the
>
> number of my weight matters so much, but as that number increases, the likelihood of
>
> them seeing that maybe I weigh more than I did a year ago would be, I wouldn't like that.
>
> Like I don't want people to ever think that I'm gaining weight or like that I'm looking
>
> heavier I guess."

Many participants described how this fear of looking like they gained weight was rooted in the

belief that being overweight represented a lack of control in their lives. Particularly as women in

society, there was a desire to come across like they "had it all together." Many women

acknowledged that even though these expectations on women are unrealistic, they still strive to

achieve it.

Risk factors which reinforced thinness as a marker of self-worth and perpetuated

experiences of gender-based oppression, led to the final contradictory action theme, *thinness and*

appearance as markers of self-worth (*n = 13, 86%*). Many participants struggled with rationally

knowing that their worth has nothing to do with appearance, but not being able to internalize that

message due to societal messages equating thinness and appearance with female self-worth. For

example, one participant shared:

> "As much as I would like it not to, I think losing weight is always the ultimate goal and
>
> when I do I feel my best or when I'm in the process of losing weight. I think that my self-

worth is a lot tied into how I feel just because for so long, I've associated the two. And

so it's going to take a lot of time to disassociate the two."

Interestingly, although the participant acknowledges her strong desire to lose weight, she phrases

it in a way that suggests she is working to not equate her self-worth with weight status, a value

and belief more congruent with her "genuine voice".

Protective Factors and Consistent Actions

As participants navigated their subclinical symptoms, protective factors helped them

resolve the tension experienced between their "eating disorder voice" and their "genuine voice."

Four themes emerged within the category of protective factors, and all related to either

supportive relationships or gender and power. These protective factors would move participants

away from the "eating disorder voice" and towards values, beliefs and actions that were

consistent with their "genuine voice." Thus, four additional themes emerged under the category

of "acting in accordance with preferred values and beliefs." In the following section, both

categories and all eight themes are examined together. See Table 6 for a description of themes

and subthemes within the category of "protective factors" and Table 7 for a description of

themes within the category "acting in accordance with preferred values and beliefs."

Emotional and tangible support lead to openness about symptoms. The first

protective theme that emerged was the need for both *tangible and emotional support* for their

eating disorder symptoms from their loved ones (*n = 14, 93%*). Emotional support was defined

in the study as anyone providing empathy, love, trust and care, while tangible support included

instrumental assistance with finances or day-to-day tasks. Some participants reported that

emotional support from a loved one was sufficient, while others appreciated the combination of

both. Participants described that often going right into "fix-it" mode when they were struggling with their eating disorder symptoms was not helpful. For example:

> "I think it's just been the validation, how supportive he is. Where I think if someone were to jump down my throat every time, I would be more protective about it [the symptoms]. He used to go into "fix it" mode and then he saw it had a bad effect so now he's like, "Okay, I'll listen." Or he'll ask me, "Is this a fix it or is this a listen?"

This participant demonstrates that, depending on the day, she may need tangible support for her symptoms, such as someone holding her accountable to not over exercise but, other times, she needs validation and a listening ear. Having a partner who could provide both types of support served as a protective factor to decrease the "eating disorder voice." Participants reported that experiences of love, empathy and validation helped them to be vulnerable with their emotional support person. This vulnerability then led to an increased ability to be open and honest about their symptoms, reducing the isolation and shame that often accompanies living with a mental health struggle.

Contrary to putting up walls around the eating disorder symptoms and not asking for support, most participants truly valued their relationships and wanted to be more open about their struggles. Emotionally supportive relationships helped individuals open up about their symptoms and moved them towards the first consistent action theme of being *open about symptoms* ($n = 14$, *93%*). Participants could be open about their symptoms and ask for support due to the longevity of the relationship, and if they experienced safety and vulnerability in relation to their support person(s). Participants were also more likely to be open about their symptoms if their emotional support person(s) had a shared experience with a mental health struggle. A few participants

reported that the shared experience of struggle provided a sense of openness and nonjudgement that was not present in their other relationships.

Support person challenging the eating disorder leads to active involvement in life. A second theme within the category of protective factors was the *support person challenging the eating disorder* (*n* = 15, *100%*). The emotional support person would challenge the eating disorder in a variety of ways, often through modeling a balanced relationship with food and exercise and providing accountability to not engage in eating disorder behaviors. Examples of this accountability included participants calling their support person(s) when they had urges to use compensatory behaviors, or after they binged and were experiencing feelings of shame. Being able to express feelings of shame in the context of a safe relationship helped participants to not carry these feelings around alone, which would create further emotional distress. Many participants reported that their support person(s) was the first person to notice the eating disorder symptoms and intervene and, in hindsight, participants were appreciative that they did. This included support people stating their concerns directly to the participant, or alerting other support people. For example, one participant described her siblings intervening after she had lost so much weight she stopped menstruating:

> "So I think that, um, having my brothers as a conscience for my mom also kind of got me on my case, too, just because they really were upfront about it, like you need -- you need to get healthy, this isn't okay. And, so I think that's kind of what started the getting healthier."

This participant was reflecting on her experience two years ago, and now that she had restored weight, she was appreciative that her siblings intervened so firmly.

If a support person challenged the eating disorder, participants were more likely to do things that would challenge the eating disorder symptoms, such as eating at restaurants or going to social events instead of exercising alone. This helped move participants toward the second consistent action theme of *actively involved in life*, ($n = 10$, *66%*), as they could invest time and energy into things that were important to them (i.e., living in accordance with their "genuine voice") instead of investing in the eating disorder (i.e., following the "eating disorder voice"). One participant described her ability to challenge her "eating disorder voice" when asked to go to social events where she might be exposed to high calorie foods:

> "So even though it is kind of a nagging thought, it's kind of like I need to just push it aside because I have a lot of other things going on, and I would feel guilty about neglecting those things. These things [relationships, social events] feel more important to me right now."

Participants often described that supportive relationships were the catalyst for wanting balance in their lives and/or these relationships would help hold them accountable to stick to it. For instance, one participant describes how the start of her relationship with her partner allowed her to see her symptoms in a new light:

> "When we first started dating, we—I was still doing the excessive exercise. And that kind of stopped when I started dating him because he was really kind of brutally honest about the fact that it was too much. I think it's helped me find a balance with the exercise portion of things. So, I think that exercise is hard for me right now because I'm trying to find a balance that's normal but I don't know what normal is. So I have to figure that out."

Although this person has not yet achieved balance, she is in the process of working towards it, and her relationship with her significant other is a motivator to keep the value of balance at the forefront. Theoretically, if participants have a more balanced relationship with food and exercise they will have more time to invest in things that are genuinely important to them, and thus be actively involved in their lives.

Personal sense of agency leads to using own voice. A third protective factor was a *personal sense of agency* (*n* = 15, *100%*). This was characterized by participants' ability to vocalize their opinions and to be direct and assertive in their supportive relationships. The third consistent value that participants were then able to move toward was *using her own voice* (*n* = 14, *93%*). This involved both listening to what was genuinely important to participants, as well as communicating with their words instead of their eating disordered behaviors. As a result, participants were more likely to ask for the type of support (i.e., tangible or emotional) they needed for their eating disorder symptoms. When this occurred, participants could communicate directly with their "genuine voice" and no longer had to rely on self-destructive mechanisms, such as the eating disorder symptoms, to get their message across. For example, one participant described how her eating disorder symptoms were communicating for her when she was struggling:

> "I was like, "Somebody pay attention to me. I am struggling with this. Why doesn't anyone want to help me?" And then he [emotional support person] sort of stepped in and he was like, "Look, it's okay, we'll do this together. Let's do this." And now I feel like these are still symptoms that I have but they're no longer like so outwardly self-destructive."

This participant shows the power of a supportive relationship in creating a feeling of being understood, which led to an increased ability to use her "genuine voice" and a sense of empowerment. When participants experienced themselves as empowered in their relationships, they no longer had to use the "eating disorder voice" to communicate their needs. Participants also reported having control and agency over their lives without resorting to the eating disorder symptoms. Participants described having control in almost all avenues of their life including school, relationships, daily tasks, work, and making decisions. Participants could also do these things without resorting to the eating disorder, which often provides a false sense of control, as described previously. For example, one participant described turning control into something positive in her life:

> "I feel like now it's about trying to make the control a healthy part of my life instead of focusing it in and having it be a source of solace. You know what I mean? I feel like that's hard to explain, but I feel like the control—the definition of it has changed. I hope. That's my goal is for it to have changed for it to blossom into something positive, whereas in the past it sort of shriveled up into something very negative."

This participant described that in the past, the eating disorder symptoms used control in a very destructive way, convincing the participant that she could only succeed if she was controlling her food intake. However, her awareness of the symptoms and desire to act in accordance with her "genuine voice," allowed her to reclaim this control in a positive way in her life. The participant still experiences a sense of power and control, but this is channeled into other areas of her life and not directed towards her body.

Community involvement leads to finding worth outside of weight and appearance.
The final protective factor that emerged from the category of protective factors was *community*

activism and involvement (*n* = 13, *86%*), with many participants stating they value community, connection, and helping others. This included both traditional activism, such as student groups or volunteering, and nontraditional activism like group sports and social media. When asked about involvement in eating-disorder activism, many participants were interested but none were currently involved. The main barriers to involvement in eating disorder-related activism included fears of being "outed" as having an eating disorder and feeling like a "fraud" because they were still struggling. However, participants described "non-traditional" eating disorder activism including speaking up against negative eating disorder comments, talking one-on-one about their own experience with others who were struggling, and involvement in a positivity group for high school girls.

Participants identified values related to supporting people and giving back as the main reason for community involvement. In examining how these protective factors reinforced the ability to act in accordance with their "genuine voice," many participants reported that community involvement helped fostered a *sense of self-worth outside of appearance or weight status*, (*n* = 15, 100%), the final theme under the category of consistent actions. A few participants specifically mentioned that activism and community involvement were ways to find self-worth outside of appearance and weight status. However, even though participants were not traditionally involved in eating disorder activism, several also acknowledged the connection between gender oppression and eating disorder, and that combating the stereotypes against women was a motivating value for them in recovery. Some participants spoke of ways that combatting gender oppression could be incorporated into activities and components of identity not related to the eating disorder. One participant described her desire to combat female oppression and how she could actively accomplish this:

"I feel like I want to combat those stereotypes very passionately. I want to be educated, I

want to not just be seen, but to be a part of affirmative action, I want to be all these things

— do you know what I mean? I want to be these things."

This participant shows how activism and combatting gender-based oppression are motivating for

her, and these values lead to a sense of self-worth outside of weight status and appearance. This

participant describes an identity that is "active," to be a part of issues that she is passionate

about, rather than being passively "seen" which would be more consistent with the silence that

often encompasses gender oppression. Additionally, community involvement also encompassed

being connected and in "community" with others. Many participants reported that they found

self-worth through their relationships and this helped them stand against the societal messages

regarding the importance of appearance and weight status, a previously identified risk factor.

One participant described the importance of being a friend as a part of an internal sense of self-

worth, an action consistent with the genuine voice:

For me, being obsessive about my food or my exercise or things like that, she'd

[emotional support person] be reminding me that I'm more than that and I don't need to

consider my worth based on that. I was valuable as a friend, whether I gained 20 pounds

or not. That I was valuable as a person.

This participant described conflicting tension between where she should invest her time and how

this impacts her sense of self-worth. Investing in her friendships was a way to build a sense of

self-worth outside of her eating disorder behaviors, and her friend was there to remind her why

this was important. Again, this demonstrates the importance of supportive relationships and

being a part of a larger community of others, in helping participants act in accordance with their

genuine voice.

Discussion

The main objective of this study was to explore feminist-informed protective factors in the lives of women with subclinical eating disorder symptoms to explore what has prevented their symptoms from reaching a clinical level. In many ways, there is a symbiotic relationship between risk and protective factors, in that understanding what makes one vulnerable to an eating disorder helps to identify factors which can counter this vulnerability. In this study, both risk and protective factors emerged in the lives of women with subclinical eating disorders. The grounded theory model helped explain how the various risk and protective factors helped women act either in accordance or contradiction with their "genuine voice," which reflects a more congruent and preferred internalized narrative. A contribution of this study to the field of eating disorders was the focus on feminist-informed protective factors in the face of adversity. Additionally, the focus on women with subclinical eating disorder symptoms is greatly needed, as most existing research has focused on clinical samples. Previous research on feminism and eating disorders has also been mainly theoretical in nature. The present study provides a contribution by offering empirical research related to the importance of feminist-informed protective factors for those with subclinical eating disorders.

When considering the etiological development of eating disorders, no single correlative factor can be understood in isolation [21], and researchers are moving away from studying only risk factors. However, due to the contradictory nature of the "eating disorder voice," risk and protective factors were examined in tandem. For example, understanding how gender oppression was experienced by participants and how it contributed to their eating disorder symptoms allowed for an exploration of the protective factors that could reduce this oppression.

Using grounded theory, a model was developed which captured the tension between participants' "eating disorder voice" and "genuine voice." Risk and protective factors moved participants to act in ways that were either contradictory or consistent with their preferred values and beliefs, or their genuine voice. Using the feminist-relational model [25, 28, 29] as a theoretical guide, this study helped clarify two different types of risk and protective factors that worked in conjunction with one another, the socio-relational and the socio-political.

The Subclinical Population

Interestingly, most participants reported that their symptoms were behaviorally less severe than they had been in the past, but they were still struggling immensely with guilt and preoccupations regarding weight, shape and food. This fits with the continuity hypothesis [6], which suggests the distinguishing feature between clinical and subclinical symptoms is the severity of behavioral symptoms. The continuity hypothesis also posits that psychological impairment between the two populations are relatively similar [6]. As such, participants in the current study reported a preoccupation with food, weight and shape even though they were not engaging in their eating disordered behaviors as often or intensely as before.

As the primary investigator identifies as a narrative therapist, the use of externalization and narrative concepts were not incorporated into to analysis unless introduced by participants first. For example, almost all participants spoke of their eating disorder as if it were separate from them, and five participants initially did this without prompting from the interviewer. In the past, externalization has served as a useful tool in clinical approaches to eating disorder treatment [46]. In the context of narrative therapy, externalization is rooted in the belief that people are not problems [45]. Theoretically, the more separation or "space" that can be created between a person and a problem, the less distress they experience, and subsequently, the more

relief they feel. With this increased space individuals understand that they are not defined by their problems, and therefore have more agency to stand against the negative effects the problem may be causing [45]. In the present study, this externalization was useful, as participants were then able to develop discrepancy between their own values and beliefs and those of the "eating disorder voice", and make choices more consistent with their "genuine voice." Perhaps at the subclinical level, there is more metaphorical "space" between the individual and the eating disorder voice. In a similar fashion to the continuity hypothesis [6], it is possible that the ability to separate oneself from the eating disorder "voice" can be placed on a spectrum. Perhaps at the subclinical level, the eating disorder has less power and control, and therefore the participant can distinguish from it more easily and make choices that align with their preferred values and beliefs.

Socio-Relational Context

Feminist theory seeks to de-pathologize connection [28], suggesting healthy relationships, both with loved ones and with food, and are key to protecting women from disordered eating. Socio-relational protective factors that emerged from the study included support people who provide emotional and tangible support and challenged the eating disorder. The limited research on social support as a protective factor has highlighted the importance of relationships in the recovery process from clinical eating disorders [1, 31, 47]. In previous research on clinical eating disorders, women described their most supportive relationships as characterized by others who were open-minded, listened empathically and took the time to understand the various experiences of suffering [1]. Similarly, in the present study, participants reported that they were more likely to be open about their symptoms in the context of a strong, safe and nonjudgmental relationship. The present study adds to the existing literature by

confirming the usefulness of supportive relationships for those with subclinical eating disorders, and provides suggestions for concrete ways that support people can be helpful. For example, many participants mentioned that their emotional support person was the first person to notice and discourage their destructive behaviors and, in hindsight, they appreciated this. Perhaps at the subclinical level, and in the context of emotionally supportive and safe relationships, participants are less likely to become defensive if their support person challenges the eating disorder.

The limited research on social support and subclinical eating disorders suggests that those with subclinical symptoms can still maintain healthy relationships, but demonstrate interpersonal distrust and a fear of being hurt, which prevents them from seeking the support they need [20]. This study found similar results, with participants putting up walls around their eating disorder and not being open about their symptoms. However, most participants spoke of a desire to be more open about their symptoms and could do so in the context of relationships that demonstrated longevity, safety, and vulnerability. Therefore, this study advances the understanding of social support in relation to subclinical eating disorders by suggesting that safe relationships allow participants to use their "genuine voice" and ask for the support they need. Within the context of these safe relationships, as noted previously, participants were more open to others challenging their eating disordered behaviors and not responding in a defensive way. Additionally, approximately one-third of participants were more likely to share about their eating disorder symptoms if the emotional support person brought it up first. Thus, those with subclinical level symptoms will be open regarding their struggles if the relationship is strong, but it may be useful for support people to initiate these interactions.

Socio-Political Context

In this study, the socio-political context included protective factors such as voice, empowerment and community involvement, which helped women stand against destructive messages from a Western capitalist culture which emphasizes beauty and thinness as markers of worth [32]. In the past, the 'gender-as-a-risk-factor' focus has produced an argument that young women, including those who are experiencing subclinical symptoms of eating disorders, are "victims of gender subordination" [48]. The danger in viewing women through one identity, that of victim, is that many girls who successfully navigate adolescence despite their susceptibility to gender-based oppression are forgotten [48]. A contribution of the present study is the use of feminist theory to study oppression of women from a protective standpoint. Specifically, socio-political protective factors that emerged from the findings included a sense of personal agency, as well as involvement in community activism. These protective factors helped combat the risk factors of gender oppression and societal messages which equate thinness and appearance with self-worth.

Many participants specifically said that this was an "empowering time to be female" in society, as they described their own sense of power and control over their lives. For all the difficulties, experiences of oppression, objectification and subordination that participants described, there was still a sense of excitement that participants had when describing the current experience of being female. While most acknowledged that gender was a part of the development of their eating disorder symptoms, some found that activism and standing against gender stereotypes was a part of their healing and allowed them to act in accordance with their "genuine voice." Future research should continue to examine femininity and the female experience as protective factors against eating disorders. Researchers can continue to examine

how females successfully navigate adolescence and young adulthood without developing clinical eating disorders, and what feminist-informed factors help facilitate this process.

Previous research suggests that feminist-informed prevention programs need to move beyond intellectual knowledge of toxic culture, as critical consciousness of the media does not translate into decreased preoccupation with weight and shape [49]. This study suggests that relationships and activism may be avenues to translate knowledge and consciousness-raising into action and recovery. In the present study, a value that women endorsed was to develop a sense of self-worth outside of appearance and weight status, which served as a protective factor against the "eating disorder voice." Community involvement, activism, investment in relationships, and helping others, were all ways that participants developed an internal sense of self-worth that was not dependent on physicality. This intersects with the relational sphere of life, as it sets the participant within the context of others, whether that be through a larger community, political activism or a desire to help others. Investing in their relationships, communities, or activities that fit their "genuine voice," helped participants to see their self-worth as more than appearance and weight-status and fits with previous research which suggests that those who endorse aspects of a feminist identity are less likely to evaluate their sense of self-worth based on appearance alone [23].

Future work should continue to put intellectual knowledge of the toxicity of culture into action. Researchers should continue to find ways to raise consciousness of the dominant culture through actions that raise awareness of eating disorders, such as community involvement, activism and investment in relationships or larger comunities. Interestingly, almost all participants in the current study reported interest in eating disorder activism, but none were involved in a traditional way. Many were engaged in activism that supported women's issues,

but all were hesitant about activism related to the societal role in eating disorders. More research is needed to explore the hesitancy around eating disorder activism, and how involvement may or may not play a protective role for women with subclinical eating disorders.

According to the feminist-relational model, connection and supportive relationships are the keys to liberating women from the perils of disordered eating [25, 28, 29], but limited research has investigated relational connection as a protective factor for subclinical eating disorders. Interestingly, within this study, the socio-relational and socio-political spheres came together and provided additional depth to the results. For example, the power of emotional support also intersected with participants' ability to use their voice. Many participants described putting up walls when they felt that their subclinical symptoms were misunderstood or minimized as "normative discontent" [50]. However, participants also reported that they could be vulnerable and assertive with their emotional support person if the relationship was safe. In doing so, participants were then creating an opportunity for support people to learn more about eating disorders and how to help, and participants had the opportunity to communicate using their "genuine voice."

Relatedly, using the socio-political sphere of the feminist-relational model as a guide [25, 28, 29], through fulfilling relationships, participants experienced feelings of empowerment. For example, all participants mentioned that one of their support people was helpful with decision making, which fostered a sense of agency. Participants described the relational nature of their own sense of agency, by going to emotional support people for help with decisions and being able to speak up to their support people when something was wrong. Participants reported a hesitancy to seek treatment but also reported that emotional support people were helpful in making big decisions, by going beyond weighing the pros and cons and fostering a sense of

agency for the participant. Perhaps emotional support people can be utilized as a resource for

participants who are ambivalent about treatment, to help participants feel empowered enough to

seek professional help. These relationships can also serve as mechanisms of empowerment, by

putting the knowledge of gender oppression into action through community involvement and

challenging the dominant discourse that promotes disordered eating.

Limitations

Despite its contribution to feminist theory and protective factors for women at risk for

eating disorders, this study is not without limitations. Participants were all from the same

geographic location and the study employed a relatively small sample ($n = 15$). The sample was

also homogeneous in terms of race, ethnicity, sexual orientation and educational status.

Additionally, approximately 35 participants were screened for the study, while only 15 qualified,

due to the requirement of an EAT-26 score between 20-45. Although the EAT-26 has been

validated with subclinical populations [40], it is possible that those who scored just below 20

were still struggling with subclinical symptoms and could therefore not be included in the study.

Thus, the experience of living with subclinical eating disorder symptoms may not have been

adequately represented. Future research should seek to develop brief measurement tools that

more specifically identify subclinical eating disorder symptoms. This would help doctors and

educators quickly screen for subclinical symptoms without a time-intensive diagnostic interview.

<div align="center">

Conclusions

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This study sought to develop a grounded theory model of feminist-informed protective

factors in the lives of women with subclinical eating disorder symptoms. Results indicate that

participants at the subclinical level of symptom severity may have a capacity to separate

themselves from their eating disorders and act in accordance with their preferred values and

beliefs. The feminist-relational model [25, 28, 29] was used to examine both relational and political factors that helped participants keep their symptoms from escalating to clinical levels. Researchers in the field of eating disorders should continue to study subclinical populations due to the severe psychological impairment the symptoms can cause on daily functioning, and to intervene and treat symptoms earlier. As the field moves away from an etiological risk-focused perspective on eating disorders, research should continue to examine protective factors for those susceptible to eating disorder development. The theoretical and empirical combination of feminist-informed protective factors for subclinical eating disorders represents a shift towards examining the strengths of the female experience. Perhaps one day, femininity and identifying with the female gender will be protective, instead of the single greatest risk for eating disorder development.

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Figure 1

Grounded Theory Model of Feminist-Informed Factors for Subclinical Eating Disorders
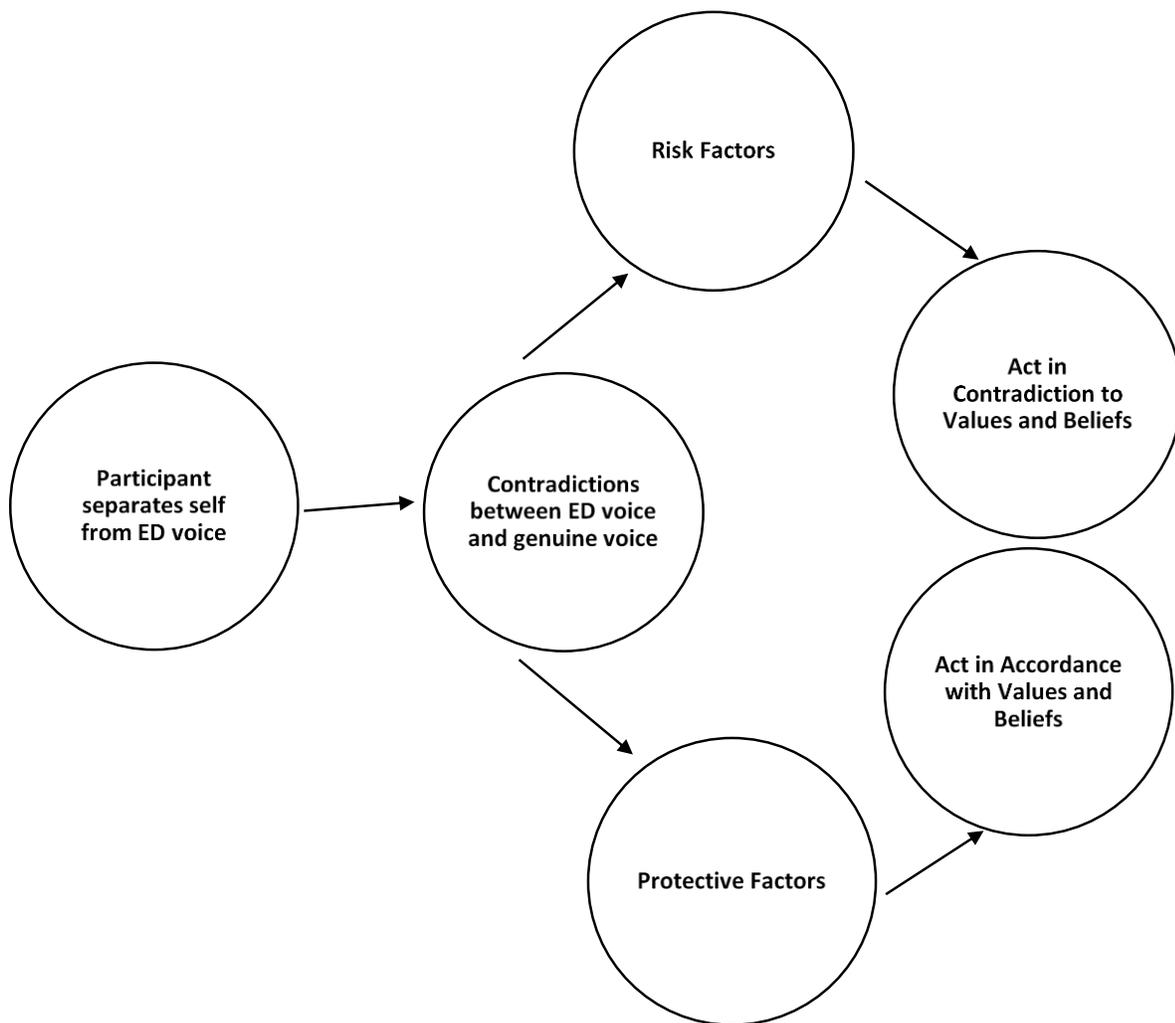
Table 1

Demographic Summary of Participants

	n (%)	M (SD)	Range
Age	15	21 (1.62)	18 – 25
Race			
Caucasian	13 (87)		
African American	1 (7)		
Asian American	1 (7)		
Educational Status			
Some College	9 (60)		
Graduated College	5 (33)		
High School Graduate	1 (7)		
Sexual Orientation			
Straight	11 (73)		
Bisexual	3 (20)		
Other	1 (7)		
Relationship Status			
Dating	8 (53)		
Single	4 (27)		
Engaged	2 (13)		
Married	1 (7)		
BMI*		24.0 (4.23)	18.2 – 30.6
EAT-26 Score		29.4 (7.89)	20.0 – 43.0
Current Psychological Symptoms**			
Feelings of inadequacy	12 (80)		
Perfectionism	11 (73)		
Anxiety	10 (67)		
Past Psychological symptoms**			
Depression	7 (47)		
Difficulty expressing emotion	5 (33)		
Anxiety	4 (4)		
Current Behavioral Symptoms**			
Preoccupied with food/dieting	15 (100)		
Guilt after eating	14 (93)		
Restricting food intake	12 (80)		
Past Behavioral Symptoms **			
Excessive exercise	7 (47)		
Emotional eating or bingeing	7 (47)		
Restricting food intake	6 (40)		

Note. *One participant did not report her weight. BMI ranges from Underweight (18.5) to Obese (30+) ** Behavioral and psychological symptoms reported here include only the top three endorsed by participants

Table 2

Participant as Separate from the Eating Disorder

Theme	N	Brief Description
Eating disorder symptoms as separate from participant	13	Participants can distinguish ED as a separate voice from her own. Other participants refer to ED as a part of them and not necessarily a separate voice because it's been there so long.
Developing a framework or metaphor to understand the eating disorder symptoms	8	Uses a larger framework, analogy, song or quote to understand ED experience

Table 3

Contradictory Thoughts and Feelings

Theme	N	Brief Description
Trying to control the eating disorder symptoms	12	To control the eating disorder symptoms and not have it spiral, participant must give it power (a false sense of control); for example, participant likes running and counting calories, but also feels that she's giving into the eating disorder, fears what letting go of the symptoms will do.
Conflict regarding self-worth	9	Knows self-worth should not be about appearance and weight-status but still believes they are a significant part of self-worth that make her worthy of love. I'm the exception to the rule. For example, others shouldn't have to struggle with this, but it's ok if she does, will speak up for others but not always herself, etc.
Relational contradictions	7	Wants to be open about her eating disorder symptoms but also does not, worries about judgement. Knows emotionally supportive people do not care about looks and weight but still feel they do.

Table 4

Risk Factors

Theme	N	Brief Description
Lack of help or understanding from support person(s)	15	Support person unintentionally encourages eating disorder behaviors, diminishes the severity of the symptoms, and/or lacks understanding regarding eating disorders and how to help
Experiences of gender oppression	15	Sexualization, objectification, body hatred as part of the female experience, power imbalances, pressure to "do it all,"
Messages from media and society equating thinness and appearance with self-worth	15	Pressure from media and society to be thin, as well as internalizing societal messages, contribute to the eating disorder

Table 5

Acting in Contradiction to Preferred Values and Beliefs

Theme	N	Brief Description
Protects the eating disorder symptoms by putting up walls	15	Is not open with emotional support person about symptoms for varying reasons (ie., doesn't want them to worry, not wanting help). Would only reach out for support if eating disorder was seriously impacting health. Lying to others about symptoms and inability to accept love and advice regarding the eating disorder creates conflict or tension in the relationship
Thinness and appearance as markers of self-worth	13	Appearance and weight status have a significant impact on sense of self-worth daily
Struggles trusting self and using own voice	12	Inability to trust herself, labels self as indecisive, will second guess herself before getting validation from others. Eating disorder behaviors communicate to emotional support person(s) that participant is struggling, needs help, is seeking validation and/or is dissatisfied with her body
Isolation and distress during social activities	11	Less time spent with others due to time spent on eating disorder symptoms. Guilt or anxiety when attending social events or eating at restaurants with friends

Table 6

Protective Factors

Theme	N	Brief Description
Support Person Challenges the eating disorder symptoms	15	Emotional support person notices the eating disorder symptoms, models and encourages a balanced relationship with food and exercise and provides accountability to decrease symptom use. Participant values the relationship more than the eating disorder symptoms Participant values meaningful relationships with self and others
Support person provides emotional and tangible support related to the eating disorder symptoms	14	Emotional support person provides love, empathy and validation, and a combination of emotional and tangible support for eating disorder symptoms. Shared experience of mental health struggles result in openness and non-judgement
Personal Sense of Agency	15	Support person helps with decision making and fosters agency. Participant vocalizes her opinions, feels it's an empowering time to be female, experiences control over her life without resorting to the eating disorder, and is direct and assertive.
Community Involvement and Activism	13	Participant values community, connection, and helping others, feels there are many ways to be an activist and is involved in activism that supports women's issues but not eating disorders yet

Table 7

Acting in Accordance with Preferred Values and Beliefs

Theme	N	Brief Description
Finding worth outside of appearance and weight status	15	Having hobbies and interests outside the eating disorder, finding aspects of identity that are not associated with eating disordered behaviors. Identifying internal markers of self-worth. Weight and appearance used to have a greater impact on self-worth than they do now
Is open about eating disorder symptoms	14	Participant will open up about eating disorder symptoms because she feels emotionally support (ie., longevity of relationship, able to be vulnerable). Eating disorder is not trying to communicate much to the emotional support person because relationship is positive and participant can use her own voice, no longer relies on self-destructive mechanisms
Listens to her own voice	14	Participants state a strong desire to not listen to the eating disorder voice and to develop a healthier relationship with food, exercise, body image. Taking things that the eating disorder symptoms made excessive and reclaiming them. For example running as empowerment instead of self-destruction or punishment
Is actively involved in life	10	Acknowledging that the eating disorder has prevented them from experiences in the past and not wanting to waste any more time. Participants go to social events and restaurants with friends, eat meals with their support people, and understand they need to nourish their bodies to accomplish what they want in life. Overall, having more important things to do besides the eating disorder

Barriers and Facilitators to Seeking Treatment for Subclinical Eating Disorders

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Abstract

Subclinical eating disorders, though considered less severe, are associated with clinically significant impairment in functioning. The purpose of the present analysis was to identify barriers and facilitators to seeking treatment for those with subclinical eating disorders. Fifteen women between the ages of 18 and 25, with subclinical eating disorder symptoms, and no treatment history were interviewed. Findings indicate that lack of openness with support system, misperceptions regarding subclinical symptoms, and stigma served as barriers to seeking treatment. Findings highlight how supportive relationships can help facilitate the process of seeking treatment. Implications for future research and practice are discussed.

Keywords: subclinical eating disorders; treatment barriers, supportive relationships

Barriers and Facilitators to Seeking Treatment for Subclinical Eating Disorders

Background

Disordered eating can be placed on a spectrum with subclinical level symptoms on one end and clinical level symptoms on the other (Franko & Omiro, 1999). The continuity hypothesis suggests that the difference between clinical and subclinical symptomology is quantitative in nature, such that those with subclinical eating disorders have the same type of physical and psychological symptoms as those with a clinical diagnosis, but these symptoms differ in terms of severity (Franko & Omiro, 1999). Psychological symptoms most prevalent in individuals with subclinical eating disorders include a preoccupation with food and weight, distorted body image, an intense fear of gaining weight, and conflation of self-worth with weight status (Beals & Manroe, 2000). Behavioral symptoms include restricting food intake, guilt after eating, attempts to lose weight in pathogenic ways or in combination with compensatory behaviors, maintaining a low body weight, and menstrual dysfunction (Beals & Manroe, 2000). These subclinical behaviors do not differ much from the definition of clinical eating disorders, but occur with less frequency (Franko & Omiro, 1999). Researchers also suggest that subclinical eating disorders, though considered less severe, are still associated with clinically significant impairments in functioning (Stice, Marti, Shaw & Jaconis, 2009). These impairments include co-morbidity with other psychiatric disorders, higher rates of suicide attempts and lower scores on global assessment of functioning when compared to those without eating disorder symptoms (Lewinsohn, Striegel-Moore, & Seeley, 2000).

Subclinical eating disorders are more common than clinical eating disorders but significantly less understood (Wei-wei, et. al., 2015). An estimated 1% to 4% of female college students meet the clinical diagnostic criteria for Anorexia Nervosa (AN) and Bulimia Nervosa

(BN), but an additional 35% to 70% of female college students report subclinical symptomology (Schwitzer, Bergholz, Dore, & Salimi, 1998). Additionally, females are at a much greater risk for symptom development, with rates of eating disorders estimated to be twice as common among females compared to males (Merikangas et al., 2010). Even with the transition to the DSM 5, the clinical definitions of eating disorders do not capture the spectrum and complexity of disordered eating (Ackard, Fulkerson, & Neumark-Sztainer, 2007), and those who suffer with some eating disordered symptoms but do not meet the full diagnostic criteria are rendered invisible.

Existing research has focused on developing explanatory models of subclinical symptoms, as well as distinguishing subclinical and clinical symptoms (Kirsten & Du Plessis, 2008). Those with subclinical eating disorders have either been absent or poorly represented within the academic discourse (Weaver, Martin-McDonald & Spiers, 2012), which limits understanding of the experiences of those with subclinical eating disorders (Kirsten & Du Plessis, 2008). Thus, health care professionals and researchers lack knowledge regarding subclinical eating disorder symptoms. Additionally, many individuals may live with subclinical symptoms but not access necessary care. Therefore, the purpose of the present analysis was to identify barriers and facilitators to seeking treatment for those with subclinical eating disorders and how this information could be applicable for clinicians. Feminist theory is utilized to critique the current literature on seeking treatment and which relational factors might be helpful to facilitate access to care.

Barriers to Treatment

Many individuals may be living with subclinical eating disorders and not accessing the care they need. The existent literature has identified a range of barriers to seeking treatment for eating disorders. A significant barrier includes a limited understanding of eating disorders

resulting in a lack of identification of symptoms (Becker, Thomas, Franko, & Herzog, 2005; Mond, Hay, Rodgers, & Owen, 2007). This may be particularly relevant to those with subclinical symptoms who may qualify for services but feel that what they are struggling with is not significant enough to warrant treatment. Additionally, many individuals may acknowledge that they are struggling, but experience feelings of guilt and shame which prevent them from reaching out for support (Akey, Rintamaki, & Kane, 2013; Pettersen, Rosenvinge, & Ytterhus, 2008). Many individuals also experience issues with insurance coverage, financial barriers (National Eating Disorders Association, 2015) or lack of readily available resources and treatment centers (Regan, Cachelin, & Minnick, 2017) which decrease the likelihood of receiving treatment

A recent comprehensive review of the existent literature on barriers and facilitators to seeking eating disorder treatment identified 31 articles, 11 of which asked participants to qualitatively identify factors that inhibited or facilitated their treatment seeking efforts (Regan et al., 2017). Across articles, participants reported various feelings of shame, including a fear of therapy itself, as well as being stigmatized by others for having an eating disorder. Problematic beliefs related to eating disorders also inhibited treatment-seeking (Regan et al., 2017). For example, the belief that eating disorders are not a "real" problem and can be handled without the help of others was a pervasive and alarming finding. Individuals also described various aspects of the treatment process as a barrier for treatment, including a lack of knowledgeable providers and overly stringent entry criteria (Regan et al., 2017). Both aspects may be particularly relevant to those with subclinical eating disorders, as providers are often not aware of what to screen for with subclinical eating disorders, and specialized programs may only offer services to those who meet the criteria for a clinical eating disorder.

Facilitators to Treatment

Compared to barriers, far less is known regarding facilitators that might promote treatment seeking. Existent research shows that high levels of emotional distress and health related concerns often prompt individuals to seek treatment (Regan et al., 2017). From a subclinical standpoint, this may be a help and a hindrance, as those with subclinical symptoms often have high levels of psychological impairment but physical symptoms that do not reach clinical criteria and may not yet be health-compromising. Additionally, a significant facilitator to treatment seeking is the encouragement of supportive friends and families. The overall quality of social support may also be particularly importance, such that positive and higher quality relationships may be more likely to result in seeking treatment (Regan et al., 2017).

Social support is a nuanced component of connection that involves emotional and tangible help from others. Previously, the majority of research on social support was limited to those with clinical BN and deficit-based, focusing on social isolation and relationship dissatisfaction as risk factors for disordered eating (Herzog, Norman, Rigotti, & Pepose, 1986; Jacobson & Robins, 1989). Other research has found that women with subclinical eating disorders perceived themselves to have adequate social support and relationship quality with significant others (Holt & Espelage, 2002). These researchers recommended utilizing positive social networks as a resource to help mitigate symptom development for the women with subclinical symptoms. Recommendations from the researchers included identifying characteristics of the supportive relationships, including perceived support and constructive resolution of conflict, that might have served as protective factors for developing clinical disorders. Given that previous research shows social support to be a facilitator to seeking treatment and a protective factor for disordered eating, more research is needed regarding the

role of social support in seeking treatment. Specifically, more understanding is needed regarding

participant experiences with seeking treatment in terms of what factors lead them to seek

treatment, including barriers and facilitators to this process

Feminist Critique

Feminist theorists (Bordo 1993; Orbach 1986) have long suggested that females are

particularly vulnerable to developing disordered eating symptoms due to increased pressure to be

thin, exposure to media which historically objectifies and sexualizes women, and internalization

of the thin ideal (Bordo, 1993). Individual factors commonly associated with the development of

eating "disorders" include, but are not limited to, a drive for thinness, body dissatisfaction, and a

sense of control (Piran, 2010). However, from a feminist perspective, conceptualizing eating

disorders as a result of individual characteristics pathologizes individuals, and blames them for

the development of the disorder, while simultaneously ignoring the larger context in which they

develop. Therefore, theoretical models that encourage a critical examination of power and social

structures are useful in conceptualizing eating disorders (Malson & Burns, 2009).

Feminist theory allows researchers to examine individual behavior within the larger

context, and highlights potential protective factors, such as connection, empowerment, agency

and voice, which are often overlooked within the existing literature on protective factors for

eating disorders (Peterson et al., 2008; Piran, Levine, & Irving, 2000). Feminist-informed

research suggests that relationships and empowerment may serve as protective mechanisms for

the gender-based oppression that contributes to eating disorders. Previous research on feminist-

informed intervention programs have hypothesized and explored specific factors that protect

women from eating disorders. As a result, risk factors were more effectively targeted and

protective factors enhanced for those at risk for eating disorders (Piran et al., 2000). The primary

purpose of these programs was to increase feelings of empowerment through increased awareness of societal objectification of female bodies and critical consciousness to stand against societal pressures related to disordered eating (Piran et al., 2000). Empowerment is a considered a central tenent of feminist approaches to preventing eating disturbances; it has been studied in the context of eating disorder prevention programs as a factor that can reduce the likelihood of body image disturbance, a precursor to clinical eating disorders (Peterson et al., 2008). Within the literature on subclinical eating disorders, more research appears to focus on reducing risk factors regarding body dissatisfaction and internalization of the thin ideal, rather than building protective factors (Kirsten & Du Plessis, 2008), such as the incorporation of empowerment and supportive relationships to reduce suffering.

Additionally, feminist theorists have critiqued previous treatment decision-making models as not always being relational or collaborative in nature (Faith, Pinhas, Schmelefske & Bryden, 2003). Therefore, a feminist approach to treatment-seeking advocates for client choice and empowerment, along with critical awareness of practices that could be oppressive in the provision of care (Brown, 1994; Lerman & Porter, 1990; Sherwin, 1992). Feminist theory seeks to de-pathologize connection (Jordan, 1997), suggesting healthy relationships, both with loved ones and with food, and are key to protecting women from disordered eating. A feminist-informed framework for treatment-seeking and decision making also argues that autonomy and empowerment are best understood within a context of interconnection and significant relationships (Sherwin, 1998). That is, safe and supportive relationships may help individuals make empowering decisions, such as seeking treatment. Therefore, the present study sought to examine aspects of feminist-theory, such as social support and empowerment, that might serve as facilitators to seeking treatment for women with subclinical eating disorders.

Purpose of Present Study

As noted previously, subclinical eating disorder symptoms can have a detrimental impact on physical health, psychological well-being, and may be significantly underreported (Franko & Omiro, 1999; Herzog & Delinsky, 2001). Less is known about these conditions in comparison to clinical eating disorders, and many individuals may be living with subclinical eating disorders but not accessing the care they need. Previous research suggests social support, and the quality of these relationships may be important factors in facilitating access to treatment. Therefore, the present study utilized feminist theory to examine barriers to treatment, and how aspects of feminist theory, primarily social support and empowerment, might serve as facilitators to treatment. Drawing on data from a larger study focused on feminist-informed protective factors for those with subclinical eating disorders, the present study addressed the following research questions: 1) What barriers might prevent individuals with subclinical eating disorders from seeking treatment? 2) How might supportive relationships help facilitate the process of seeking treatment for those with subclinical eating disorder symptoms? Findings from the study can help clinicians identify subclinical eating disorder symptoms and implement supportive relationships as a part of the treatment-seeking process.

Methods

The present analysis utilized data drawn from a larger study guided by feminist theory (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991), which qualitatively examined feminist-informed protective factors in the lives of women at risk for clinical eating disorders.

Participants

For the present study, a purposeful criterion sample (Howell, 2010) of 15 women between the ages of 18 and 25 was interviewed. Participants were required to be currently

experiencing subclinical eating disorder symptoms that had not yet developed into a clinical

level eating disorder, and to have no history of a clinical diagnosis. To determine subclinical

eating disorder status, participants were screened using the Eating Attitudes Test (EAT-26)

(Garner, Olmsted, Bohr, & Garfinkel, 1982) and needed to score between 20 and 45 on the self-

report measure.

Participants were recruited via convenience and snowball sampling (Howell, 2010) from

mental health professionals, professors, graduate students and other study participants.

Professors and graduate students from local colleges and universities were contacted and asked

to share study information with their students. These professionals taught in varying disciplines

including, but not limited to, psychology, family studies, health sciences, and communication.

Leaders of college groups such as sports teams, sororities and student clubs were also contacted

and asked to share study information. With permission, IRB approved flyers were hung in

educational buildings of college campuses and local coffee shops. In the final sample,

participants were recruited via a college listserv announcement from a professor or club leader (n

$= 5$), flyers in coffee shops or college buildings ($n = 5$), via acquaintances of the researcher or

previous participants ($n = 3$), and through postings on social media ($n = 2$).

Procedures

Interested participants emailed or called the researcher, and a telephone screening was

scheduled to review eligibility requirements. After establishing eligibility, participants then

participated in an open-ended interview. To ensure confidentiality and safety, interviews were

conducted in the principal investigator's office at an outpatient therapy center, a private room in

a local library, or at the home of the participant. Upon arrival, participants completed the

informed consent form, and indicated if they would be willing to be contacted later, to facilitate

the process of member checking (Davies & Dodd, 2002). Participants then completed a basic

demographic survey and participated in a semi-structured, open-ended, face-to-face interview,

which averaged approximately two and a half hours in length, but ranged from 95 to 205

minutes. Interviews were audio recorded, and transcribed verbatim. Each participant was

compensated with a $20 Target gift card for her participation in the study.

Measurement

EAT-26. In previous research, the EAT-26 has been used with nonclinical samples as a

measure of abnormal, disturbed, or exaggerated eating patterns (Mintz & O'Halloran, 2000).

The self-report measurement asks participants to indicate how often they engage in certain

behaviors on a six-point scale ranging from 0 (never) to 5 (always). These behaviors include

dieting, avoiding certain foods, preoccupation with being thinner, compensatory behaviors, self-

restraint related to eating, and pressure from others to gain weight. In past studies (Garner et al.,

1982), individuals who scored 20 or above on the EAT-26 were considered to be exhibiting

subclinical eating disorders, and moving in the direction of a clinical eating disorder, but did not

meet all the diagnostic criteria for AN or BN (Mintz & O'Halloran, 2000). Those scoring above

45 were thought to have symptoms more consistent with a clinical eating disorder, though a

comprehensive diagnostic interview is needed to ensure appropriate diagnosis. The EAT-26 has

consistently demonstrated high reliability and validity in previous research (Garner et al., 1982;

Mintz & O'Halloran, 2000).

Demographic questionnaire. The demographic questionnaire was created for the

purposes of the study and included basic questions related to age, gender, and educational status.

It also included a list of behavioral and psychological eating disorder symptoms. Participants

marked past and present symptoms they were currently experiencing (last 30 days) or had

experienced at any time in the past. Examples of behavioral symptoms included bingeing, guilt after eating, or restricting food intake. Examples of psychological symptoms included fears of gaining weight, feelings of inadequacy, and depression. These behavioral and psychological symptoms were drawn from the EAT-26 as well as from the subclinical eating disorder symptoms most frequently endorsed in the literature. Additionally, participants identified their top three emotional and instrumental support people.

Interview. Interviews were face-to-face and utilized a script with semi-structured, open-ended questions. Feminist theory, specifically the feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991), was the primary framework for the development of the research question and subsequent interview script. Information for the present article was drawn from sections of the interview that focused on seeking treatment and supportive relationships. Example interview questions included, "How involved have you been in seeking professional help or treatment for your eating disorder symptoms? Why or why not?", "What do you think it would take for you to seriously consider treatment?" and "Have your support people ever encouraged you to seek treatment?" The last two questions were added through the process of theoretical sampling (Charmaz, 2006), after it became apparent that there were significant barriers and hesitations regarding seeking treatment.

Data Analysis

Feminist-informed constructivist grounded theory was implemented as the guiding framework for the analysis (Charmaz, 2003; Charmaz, 2006). This iterative process required interviewing participants, creating memos, coding the data, and then interviewing more participants based on the emerging themes (Charmaz, 2006; Creswell, 2012;). Sensitizing concepts were identified prior to conducting interviews and helped inform the analysis. These

included the concepts of voice, connection, empowerment, and agency (Peterson et al., 2008; Piran et al., 2000).

Data analysis began with open coding, which involved a line-by-line reading of the transcripts to identify "meaning units," which became open codes (Charmaz, 2003; 2006). Using constant comparative analysis, interviews and open codes were compared against one another and collapsed into focused codes, which eventually became larger themes within the study. Axial coding involved examining the relationships between the themes in order to develop larger categories. Finally, theoretical coding involved creating a "story line" which explained how the categories and themes related to the larger research question (Creswell, 2012). The first author was the primary investigator and completed all interviews, coding and analysis.

Trustworthiness. Researcher triangulation, reflexivity and memoing were implemented to ensure credibility of the analysis. As a means of triangulation, the primary investigator worked with a mentor and a peer debriefer at each stage of the analysis. To facilitate the process of peer debriefing, the mentor was consulted during each stage of data analysis to provide input on movement from open coding all the way through theoretical coding. The mentor provided general feedback on the analytic process of grounded theory. In addition, a colleague with previous research and clinical experience pertaining to women with eating disorders served as a peer debriefer, and provided feedback more specific to clinical concepts within the emerging model. The peer debriefer helped develop ideas regarding how the emerging model could build off of narrative therapy tenants, instead of replicating what is already known about this theoretical approach. A reflexivity statement was created by the principal investigator before data collection, which identified potential biases and personal experiences connected to the research question. For example, the primary investigator identifies as a feminist-informed

narrative therapist and was sensitive to this throughout data collection and analysis, so as not to bias the findings. After each interview, the researcher would return to the reflexivity statement during the data analysis process to address these biases (Charmaz, 2006). Memoing involved post-interview audio notes and written memos which documented the initial thoughts of the researcher after each interview (Charmaz, 2003). This process helped make sense of emerging concepts, categories and themes within and across the individual interviews. Memoing occurred throughout the entire data collection process by keeping notes on how methodological decisions were made to ensure dependability of the results. Confirmability of the findings was ensured through member checking, and involved contacting participants towards the end of the analysis process to provide feedback on the findings (Davies & Dodd, 2002). Additionally, a focus group was conducted with therapists who specialized in treating young adults with eating disorders. These clinicians reviewed the emerging model, confirmed findings with their own clinical experience and offered suggestions for disseminating the results.

Findings

Demographic Summary

Participants were women between the ages of 18 and 25, with a mean age of 21 ($SD =$ 1.62). The majority ($n = 13$) of participants were Caucasian, with one participant identifying as Asian-American, and one participant identifying as African-American. One participant was a high school graduate, nine were still in college, and five had graduated from college. Participants' BMI status ranged anywhere from underweight (18.2) to obese (30.6), with the average BMI for participants being 24 ($SD = 4.34$), which is within the normal range. Categorically, the breakdown of participants based on BMI included: underweight ($n = 1$), normal ($n = 8$), overweight ($n = 2$), and obese ($n = 3$).

The top three behavioral eating disorder symptoms that participants were currently experiencing included a preoccupation with food and dieting (n = 15), guilt after eating (n =14), and restricting food intake (n = 12). The most common psychological symptoms currently endorsed by participants included feelings of inadequacy (n = 12), perfectionism (n = 11), and anxiety (n = 10). On the EAT-26 (Garner et al., 1982), scores ranged from 20 to 43, with an average score of 29.4 *(SD* = 7.89). Two participants were presently seeking treatment from a counselor and three participants had in the past, but none of this treatment was related to eating disorder symptoms. Both participants currently seeking non-eating disorder related therapy reported that their therapists had approached eating-related concerns very gently, but participants were not open to it at the time. Two other participants reported that they were considering seeking an eating disorder evaluation after an emotionally supportive person vocalized concerns.

Barriers to Treatment

In the present study, the first set of themes involved participant-identified barriers to seeking treatment for subclinical eating disorders. These themes included avoiding treatment for personal reasons, lack of openness with support system, participants' misperceptions of subclinical eating disorders and stigma (see Table 1).

Avoiding treatment for personal reasons (n = 15). There were many personal reasons for avoiding treatment. For instance, several participants described not wanting help for their symptoms, and a subset of these participants discussed specifically not wanting help because they were not yet ready to give their symptoms up. These participants were frustrated with the amount of emotional energy that their symptoms consumed, but they still had a strong desire to lose weight. On the one hand, participants cognitively knew that they were struggling, but the

benefit of their eating disorder symptoms outweighed the perceived cost of letting it go. One

participant described this back and forth between the pros and cons of seeking treatment:

> "I think that I, the rational part of me, knew that I shouldn't be less than what I was, but I
>
> still wanted to lose weight, and so I think that's why I kind of never saw somebody. Like
>
> I knew that I was not healthy, but I still wanted it [my weight] lower, but I thought it was
>
> fine. And so I think that was kind of it more than anything."

This participant demonstrates how the perceived fear of gaining weight, despite knowing that she

was struggling, and the fear that asking for help may have resulted in weight gain.

Participants also felt that they could control their eating disorder symptoms well enough

on their own, and they had confidence in their ability to go to others if the symptoms escalated.

For example, one participant described her experience in this way:

> "I wasn't really sure how extreme, you know, I knew that what I was dealing with wasn't
>
> really as extreme as, what probably most of the people getting treatment are dealing with,
>
> so that's why I decided to wait, because I was like, well, if it gets worse I will, but as of
>
> now like I feel like I have it under control for the most part."

In this way, the participant felt that she could struggle on her own because her eating disorder

symptoms were not extreme enough. This then leads to the false perception that one can only be

open about a struggle if it is severe enough to need treatment, a subjective concept that keeps the

symptoms hidden and allows them to continue.

Finally, participants reported not seeking treatment due to difficulties related to accessing

services. Some participants reported not having the ability to access treatment due to a lack of

financial resources, a lack of affordable health insurance, or not knowing where to find help.

These factors provided reasons for participants to continue to live with their symptoms without seeking treatment.

      Lack of openness with support system (n = 10). The second theme that arose was a lack of openness with support people regarding the eating disorder struggle. Many participants spoke about not sharing their symptoms with others, demonstrating one of the many ways the eating disorder symptoms had a relational impact on the participants and their support systems. Without the relational support and openness around discussing symptoms, participants were less likely to seek treatment. In general, participants had difficulty being completely open with their support system. Five participants reported that her emotional support system was completely unaware of the eating disorder symptoms, while eight participants reported their support system knows about the symptoms, but not the extent of the struggle. The other two participants reported that they are completely open about their eating disorder symptoms with their support system. Reasons that participants were not open about their eating disorder symptoms included not wanting others to worry or feel burdened by the symptoms and feelings of concern about the reaction that emotional support person(s) would have. When asked about discussing her symptoms with a support person, one participant described a sense of guardedness and protection:

      "It's hard for me to open up to her just because I know she's so anxious and depressed already that I don't want to add to the burden. So I think the relationship, even though it's still open, I wouldn't say it's wide open, it's kinda like halfway."

In addition to feeling like a burden, some participants feared emotional support people would get angry, blame themselves, or feel bad. Participants also reported concern that if they were completely open about their struggles, their support system would force them to get treatment.

Openness and communication around the eating disorder struggles represent a way of

participants reaching out for help from their support people. Even if they were not explicitly

asking for help, participants were opening the door to a discussion about the struggle they were

living with. By protecting others from the symptoms, participants cut off an opportunity for help

and support. Participants discussed that they would likely not seek treatment unless their support

person(s) mentioned or encouraged it. Thus, not talking about symptoms with support people

prevents the possibility of treatment and within this isolation, the symptoms continue to thrive.

Participants' misperceptions of subclinical eating disorders (n = 10). In the third

theme, participants themselves had internalized potentially harmful beliefs and misinformation

about their eating disorder symptoms that prevented them from seeking treatment. For instance,

participants reported that their behaviors were not extreme enough to need treatment. For

example, one participant explained her hesitancy to get treatment when she said:

> "I don't look like I have a problem, clearly I'm not wasting away, I guess, I don't know.
>
> People would probably think I'm making it up, people aren't going to believe me. I feel
>
> like if someone were to look at me, she'd be like, 'You just, you don't look like it.' I feel
>
> like I would just get totally laughed at if I were to go seek help."

When asked, what would make symptoms "extreme enough" to need treatment, several

participants reported that they would consider seeking help if their symptoms were "seriously

impacting" their [own] lives. "Seriously impacting" their lives was defined by participants as

having a BMI that was considered underweight or extremely underweight, excessively restricting

(less than 500 calories per day), or excessively exercising. Similarly, many participants reported

that they had only conceptualized eating disorders as behaviors that would meet the criteria for

AN or BN. Thus, many participants described the phenomenon of "not being sick enough" to

warrant help. Two participants specifically described not "looking" like they had an eating

disorder. Similarly, to normalizing their symptoms, many participants were hesitant to admit that

what they were doing was problematic. When asked what had prevented her from considering

treatment, one participant responded:

> "I think, one, I don't want to admit it, I think that's a big thing. And two, I'm trying, not
>
> to make it normal, but to realize that everyone struggles with some type of image issue, at
>
> least the people I know. So trying to realize that like it doesn't have to be this huge
>
> extreme."

This participant demonstrates how denial served as a barrier to treatment. Admitting her

symptoms were problematic would bring a reality to the situation, so equating her struggle with

normal "image issues" that others in her life struggled with kept her from seeking treatment.

Stigma (n = 9). In the final barrier to seeking treatment, several participants reported

shame and embarrassment regarding their symptoms, which interfered with their ability to talk

about these behaviors with supportive people and seek treatment. A few participants also

reported concerns that admitting they were struggling equated to being "weak." One participant

simply described her association between vulnerability and weakness:

> "Interviewer: You both have the shared depression component, but there still is
>
> something that doesn't allow you to be fully open about your own mental health?
>
> Participant: Yeah, I don't want people to see me as weak and vulnerable."

Related to stigma, participants also reported concerns about being judged or labeled for their

eating disordered behaviors. One participant spoke of her fear in this way:

> "I hide that part of me, for sure, I mean as much as I can. I mean, he's [boyfriend] aware
>
> of it. I tell him like, "yeah, I've been – I've been bingeing." But I don't say more than

that. I don't wanna talk about it, it's like when I really talk about it it's just like, 'wow,

you're messed up.'"

Many participants discussed the stigma around mental health, both related to mental illness in

general and eating disorders specifically, and their fears of judgement associated with this

stigma. Similarly, several participants reported a desire to "portray that I have my life together"

and that seeking treatment would symbolize the opposite.

Facilitators for Treatment

The second category that emerged from the data relates to the second research question,

"How might supportive relationships help facilitate the process of seeking treatment for those

with subclinical eating disorder symptoms?" Four themes emerged related to participant's

descriptions of their own emotional support systems and how these individuals might increase

the likelihood of seeking treatment (see Table 2).

Relational empowerment (n = 15). The first theme from this category represents

experiences of relational empowerment and ways that supportive relationships can help facilitate

openness to treatment. Many participants reported that they valued their relationships with their

emotional support people, and these supports were often the first people to voice concerns about

the eating disorder symptoms. Participants reported that honesty about their eating disorder

struggles with supportive people, had the potential to decrease engagement in symptoms. This

was due to support people learning about the symptoms and challenging the individual to not

engage in eating-disordered behaviors. One participant described her experience when she was

finally able to be completely honest with her support person about her symptoms:

"Honestly, I think that (fiancé name) values me more than anybody, but that's because

I've been 100 percent honest, and so I know that some of my relationships could be

stronger if I were more open, because it kind of goes both ways, because if I'm more

open, then they're more open."

Support people can draw on this value of honesty as a protective mechanism against the eating

disorder. Many participants also reported that they valued relationships and connection, which

was often counter to the isolative nature of the eating disorder. Participants reported that their

emotional support system encouraged them to lead a balanced and lifestyle and challenged their

eating disorder. For example, emotional support people challenged the notion that there are

"good" foods and "bad" foods. These kinds of food rules often promote eating disorder

behaviors, but participants reported they were less likely to follow these food rules if someone

they trusted was challenging them as well. For example, one participant described her

experience of eating restaurant food:

> "Being with him [my partner] and having that mindset of just being with him and being
>
> so happy with him it kind of takes away from whatever I might be eating or the options I
>
> have. It puts less stress on me and the options I have and if I decide to go against what --
>
> the rules I have set for myself, it's not as big of a deal as it would be if I was on my
>
> own."

This participant described how challenging eating disordered behaviors, such as eating higher

calorie restaurant food, is easier to do with the support of a loved one. This demonstrates that

support people may be able help the individual to engage in activities that challenge the eating

disorder, such as seeking treatment.

Using shared experiences and self-disclosure (n = 13). The next theme was the use of

shared experiences and self-disclosure to decrease shame and increase openness. A surprising

number of participants reported that at least one person from their support system struggled with

a mental health disorder at some point during their lives. Several participants also reported that

at least one of their emotional support people had struggled with an eating disorder, and due to

these shared experiences, it was easier to be open about their eating disorder struggles.

Participants felt that support people who had a history of an eating disorder were more likely to

be nonjudgmental, and thus these participants felt comfortable going to them when struggling.

One participant described this phenomenon in this way:

> "I think she is -- she's my main support on this because she gets it and I don't feel
>
> embarrassed about talking about it because we both have this problem. I think we don't
>
> encourage eating disorder behavior in each other, but, um, we get it. And I never feel like
>
> she would judge me. Partly because I know that she's been there and I know that she
>
> thinks those things, too."

The shared experience of mental health struggles decreased feelings of shame and increased the

likelihood of reaching out for support. Support people with a history of mental health issues can

draw on these lived experiences to help their loved ones, as the process of self-disclosure will

likely increase openness about symptoms.

Understand the seriousness of the issue at hand (n = 13). Another theme that emerged

in exploring facilitators to seeking treatment relates to the lack of understanding around

subclinical eating disorders. Many participants reported frustration that one of their emotional

support people did not understand the seriousness or extent of their eating disorder symptoms.

For example, one participant described reaching out to her mother when she was considering

seeking treatment:

> "I think that, it was probably a year ago where I was honestly asking her, "I don't know if
>
> this is to the point where I need to go see someone? Or I'm just being overdramatic this

week?" And then I think she was like, "Oh you're, it's just you're being overdramatic

this week." So I definitely don't talk to her as much if I'm struggling with it."

This is an interesting contradiction because, as reported earlier, many participants also reported

minimizing their own symptoms and not feeling "sick enough." However, it appears that at least

a small part of these participants could grasp the seriousness of what they were going through,

and wanted their support people to understand it too. A few participants also reported that their

emotional support person(s) would normalize body dissatisfaction as a "normal female

experience," thus minimizing the severity and struggle of the participant. Participants also spoke

about the lack of understanding from their support person and how this created a barrier to being

open about their symptoms. Participants described this lack of understanding as developing

through support people not knowing enough about eating disorders in general, not knowing the

best ways to help, or not having lived it themselves.

Importance of both emotional and tangible support (n = 9). The next theme, which

was identified as a potential facilitator to seeking treatment, was participants' need for both

tangible and emotional support in their relationships. On the demographic survey, participants

listed individuals who provided emotional support (i.e., empathy, love, trust and care) and

instrumental support (i.e., tangible help with finances or day to day tasks). Several participants

preferred a combination of both emotional and tangible support, and that advice about what to do

is not taken seriously if the participant is not first heard and validated regarding their struggles.

Participants described tangible help to include humor, distractions, or advice. One participant

described the usefulness of humor that does not minimize the eating disorder struggle, but allows

the participant to have some compassion for herself:

"She just constantly reminds me that I'm human. Like, it's ok. I think I texted her one

time and I was like "Well, I just ate my entire cabinet so, that's great." And she

responded, "Good you need the extra food for your exam on Wednesday!""

Many participants reported that listening and validation were helpful when struggling with the

eating disorder symptoms. These participants reported that going right into "fix it" mode is not

always helpful. For example:

"And so it's things like that when I'm really feeling down, I'm like no, (fiancé name)

loves you the way you are, God loves you the way you are. It's fine, breathe through it

and then figure out a solution. Versus before my immediate thought would be to fix it,

and fix it wasn't healthy."

Support people may struggle with how to balance emotional support and tangible solutions, and

findings suggest that both types of support are useful, but the balance will be different for

everyone. Rather than jumping right into "solution mode" and suggesting treatment, perhaps

support people can utilize a combination of both emotional and tangible to increase openness to

treatment.

Discussion & Implications

Subclinical eating disorders are more common than clinical eating disorders but

significantly less understood (Wei-wei, et. al., 2015). The present findings were drawn from a

larger study, which examined feminist-informed protective factors in the lives of females who

live with subclinical eating disorders. Feminist-informed research suggests that relationships and

empowerment may serve as protective mechanisms for the gender-based oppression that

contributes to eating disorders. Using a combination of socio-political and socio-relational

factors, the present study utilized the feminist- relational model (Jordan, 1997; Maine & Bunnell,

2008; Surrey, 1991) to examine how supportive relationships can serve as both a barrier and a resource in seeking treatment for individuals with subclinical eating disorder symptoms.

Early Intervention and Screening

Within the findings, there were many dangerous assumptions regarding subclinical symptoms, which prevented individuals from seeking help. The fact that participants in the present study did not feel "sick enough" to seek treatment supports previous research (Becker, et al., 2004) and points to the need for increased awareness and understanding of subclinical eating disorders. The assumption that one must "look" a certain way to struggle with an eating disorder is dangerous for sufferers, their loved ones and professionals. Support people and clinicians may not act quickly enough, which prevents early intervention and a better overall response to treatment. Early intervention and screening reduces the risk of needing inpatient or residential treatment, an outcome that should appeal to insurance companies (Lask & Bryant-Waugh, 1999).

Previous research indicates intervening as close to the onset of symptoms as possible, regardless of physical severity, can increase the chances of long term recovery (Lask & Bryant-Waugh, 1999). Increased education around subclinical and clinical eating disorders should be provided for anyone who works with adolescents and young adults, such as guidance counselors, gym or health teachers, and sports coaches. During a yearly physical, it is now common practice for hospitals to screen for depression, anxiety and substance use. Implementing a brief screening for eating disorders as a part of the standard diagnostic assessment in private and group practice provides a way for clinicians to put clients on their "radar" who may have levels of body image disturbances that go beyond normative discontent. This would involve increased education for clinicians on how to screen for eating disorders, as well as understanding the difference between normative discontent, subclinical symptoms, and clinical eating disorders.

Normative Discontent

The present study mirrors previous studies which found that a lack of understanding related to eating disorders serves as a barrier to treatment (Regan et al., 2017). "Normative discontent" theory posits that due to high levels of body dissatisfaction for females in society, dissatisfaction with the body is the norm rather than the exception (Rodin, Silberstein, & Streigel-Moore, 1984). Participants within the present study would admit they were struggling, but would hide it under the guise of "typical body dissatisfaction" that exists within society. This attempt to normalize symptoms seemed partially due to the pervasiveness of body dissatisfaction in female culture, and because participants were still able to function well enough in their daily lives. Although participants were "functioning," subclinical and clinical eating disorders represent a level of preoccupation with the body that goes beyond normative discontent. When participants and their support people categorized their struggles as "typical body dissatisfaction," their symptoms were minimized, which served as a potential barrier for seeking appropriate treatment.

Increasing Clinical Competency

Previous research has suggested that health care providers should be educated regarding the false or inaccurate beliefs regarding eating disorders (Regan et al., 2017). Many individuals who are struggling with subclinical eating disorders may seek therapy even if the presenting concern is not related to food. Increased education and screening for eating disorders could increase confidence for clinicians who are not specialized in treating eating disorders, as many will immediately refer a client to a specialist. Creating an environment where only specialists can treat eating disorders reduces the likelihood that clinicians in the larger community will receive the education and experience needed to appropriately screen and treat these conditions.

This is particularly important if individuals are unwilling to seek specialized eating disorder treatment. Clinicians should refer clients to a medical doctor to test for eating disorder-related medical complications. However, if a client is medically stable, clinicians can continue to work with those with subclinical eating disorder symptoms in an outpatient non-specialized setting. In many ways, the eating disorder is a metaphor for a deeper internalized wound, and the eating behaviors are simply a way to communicate this pain. Regardless of their theoretical background or training, most clinicians know how to address the internal pain that underlies destructive behaviors. The intimidation that clinicians may feel when it comes to treating eating disorders, furthers the stigma surrounding the condition, and decreases their own clinical competency. If more clinicians feel comfortable discussing and treating eating disorders, symptoms may be detected earlier, reducing the likelihood that those with subclinical symptoms will go on to develop clinical eating disorders.

Utilizing Supportive Relationships

The present findings introduced ways to incorporate supportive relationships as a facilitator for seeking treatment. It appears that having a support person with a shared experience of a mental health struggle, particularly one related to eating disorders, helped participants reach out for support when needed. This may relate to the concepts of vulnerability and shame (Brown, 2006). An individual is more likely to disclose something they find shameful, if they know that it will be met with openness and nonjudgement, two concepts that participants consistently reported to be helpful from their support system. This is consistent with previous literature which identified shame, embarrassment and fear of judgement as significant barriers to seeking treatment for those struggling with eating disorder symptoms (Akey et al., 2013; Pettersen et al., 2008). Therefore, support people who disclose their shared history of a mental health struggle,

may help decrease shame that individuals feel regarding their symptoms, increasing the chance that individuals might disclose symptom use and be receptive to treatment suggestions. Participants also reported that honesty about their eating disorder struggles had the potential to decrease engagement in symptoms. In part, this was due to the support person understanding the nature of the symptoms and challenging the eating-disordered behaviors. Support people should not be afraid to challenge the eating disorder and are encouraged to help their loved find alternatives to their destructive behaviors. As current feminist-informed research suggests (Haugen, 2017), safe and supportive relationships increase feelings of individual empowerment. This combination of relational support and feelings of empowerment can be utilized as fuel to challenge eating disordered behaviors.

Reducing Stigma

The theme of protecting the eating disorder symptoms was likely influenced by the stigma that surrounds mental illness and eating disorders. Participants reported concerns that admitting they were struggling equated to being "weak," a message that still permeates in society and prevents individuals from getting the care they need. Previous research shows that stigma related to mental illness detracts from quality of life and reduces the likelihood that sufferers will receive appropriate treatment (Jorm, Angermeyer & Katschnig, 2000). Additionally, feminist theory suggests that gender based oppression may further limit the ability of females to speak up regarding their experiences, limiting their sense of agency and power over their own lives (Bordo, 1993). Clearly, more needs to be done to reduce the stigma surrounding eating disorders and what it means to ask for help, particularly for females who are already vulnerable to a metaphorical "silencing" of voice. To counter this, participants in the study mentioned that support people were often the first to mention concern about their symptoms. Participants were

willing to engage in this conversation and acknowledge the symptoms as problematic if the relationship was safe and supportive. The openness and nonjudgment mentioned previously can be important tools for support people who want to help their loved one, and/or may have misperceptions or judgements about eating disorders. From a feminist perspective, it appears that the concepts of voice and connection work in tandem. That is, within the context of safe and supportive relationships, individuals can speak up regarding their eating disorder symptoms.

Limitations & Future Directions

First, the study employed a relatively homogeneous sample. Eating disorders have previously been stigmatized as a white, middle-class, female issue (Malson & Burns, 2009). While it is now acknowledged that eating disorders do not discriminate based on gender, race, socio-economic status, or any other variable, future research should seek to include more diverse samples. Second, quantitative research would be useful to compare treatment-seeking experiences of those with clinical and subclinical eating disorders to a control group. This can more clearly distinguish openness to treatment and readiness for change between subclinical and clinical populations. For example, how does openness to change, motivation for recovery, and the ability to challenge eating disorder behaviors differ at the subclinical and clinical level? Understanding these differences will inform and help clarify how loved ones and professionals facilitate treatment-seeking for individuals with subclinical eating disorders.

Additionally, participants were screened using the EAT-26, without a full diagnostic interview. It is possible that those who scored just above or below the subclinical cut off (20-45) were still struggling with subclinical symptoms but could not be included in the study. Therefore, the subclinical population may not be accurately represented, which limits the transferability of the qualitative findings. Future research should continue to study subclinical

populations using a more rigorous evaluative process to more accurately screen and assess for

eating disorders at varying stages. Brief measurement tools should also be developed to

specifically screen for subclinical symptoms without a full diagnostic interview. Additionally, to

qualify for the study, participants had to have no history of eating disorder treatment. Thus, the

lack of openness around the eating disorder may have been more exaggerated than it would be in

a subclinical sample of individuals currently in treatment or therapy.

Lastly, the results came from a larger study on feminist-informed protective factors, with

a primary focus on theoretical development. Therefore, only a few interview questions from the

original study specifically referred to treatment, and results were inferred from participant

responses. Several significant barriers and facilitators to treatment were identified. However,

more research is needed on how to address these factors so that those with subclinical eating

disorders get the help they need, and support people feel more equipped to facilitate the process

of seeking treatment. Finally, more research is needed on the ways that supportive relationships

help reduce experiences of shame and provide opportunities for openness and vulnerability.

Conclusions

Subclinical eating disorders are considered a public health concern (Franko & Omiro,

1999) due to clinically significant impairments in functioning (Stice et al., 2009). If left

untreated, subclinical symptoms have a greater likelihood of developing into clinical eating

disorders (Herzog, Hopkins & Burns, 1993). Despite this knowledge, much of the research on

treatment and prevention of eating disorders focuses on clinical level symptoms. The present

analyses were drawn from a larger study examining feminist-informed protective factors for

women with subclinical eating disorder symptoms. Several themes emerged as barriers to

seeking treatment, however, supportive relationships led to honesty around symptoms and thus

an increased openness to treatment. Supportive relationships should be harnessed as a resource

for treatment-seeking. Additionally, early intervention and screening efforts for subclinical

eating disorders could provide necessary information to clinicians, support people, and larger

communities. These preventative efforts could decrease rates of clinical eating disorders, reduce

stigma, and improve overall quality of life for the affected individuals and their relationships.

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Table 1

Barriers to Treatment

Themes	Definition	n (%)
Avoiding treatment for personal reasons	• Not wanting help • Not ready to give up symptoms • Benefit of symptoms outweighs perceived cost of getting help • Fears of weight gain • Feels she can control the symptoms on her own • Lack of resources to access treatment	15 (100)

Lack of Openness with Support System	• Not wanting others to worry or feel burdened
	• Fear of negative emotional response and that support person will:
	  o Blame self
	  o Feel bad
	  o Be angry
	  o Push treatment
		10 (66)

Participants' misperceptions of subclinical eating disorders	• Not extreme enough to need treatment • Would get help if symptoms "seriously impacted my life" • Eating disorders are only Anorexia or Bulimia • Participant doesn't feel "sick enough" or "look like" she has an eating disorder • Normalizing symptoms • Not admitting symptoms are problematic (denial)	10 (66)
Stigma	• Shame or embarrassment around the eating disorder symptoms • Concerns about being judged or labeled • Struggling feels like weakness • Stigma related to general mental health disorders • Desire to portray the image that 'I have my life together'	9 (60)

Table 2

Facilitators for Treatment

Themes	Definition	n (%)
Relational Empowerment	• Participant values relationship with support person • Support person notices the symptoms • Honesty about symptoms creates openness • Support person challenges the eating disorder behaviors (ie., restaurant food)	15 (100)
Utilize shared experiences and self-disclosure	• Shared experience of mental health struggles are helpful: Result in openness about symptoms, nonjudgement, decreased feelings of shame	13 (86)
Understand the seriousness of the issue at hand	• Frustrated that emotional support person(s) does not understand the seriousness of the eating disorder symptoms • Frustrated that emotional support person normalizes body dissatisfaction	13 (86)
Importance of both emotional and tangible support	• Appreciates a combination of emotional and tangible support • Prefers support person does not go right into "fix it" mode • Tangible support includes humor, solutions, and distractions • Emotional support includes empathy, love, trust and care	9 (60)

Chapter 5

Implications & Conclusions: Dissertation Article 3

My third and final article, *Application of the Feminist-Relational Model for the Treatment of Subclinical Eating Disorders*, serves as Chapter five of my dissertation. This article ties everything together, by highlighting my use of theory as it pertains to both the clinical and empirical aspects of the project. This article will be submitted to the *Journal of Feminist Family Therapy and* represents the integrative conclusion to my dissertation (See Appendix Z for the submission guidelines).

Application of the Feminist-Relational Model for the Treatment of Subclinical Eating Disorders

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Abstract

Subclinical eating disorders are more common than eating disorders, but far less understood. Despite knowledge that the larger socio-cultural context contributes to the maintenance of eating disorders, little is known regarding how feminist-informed factors can serve as protective mechanisms for women with subclinical eating disorders. This article utilized the feminist-relational model to provide a conceptualization of the symbiotic relationship between feminist-informed protective factors, suggesting through supportive relationships, individuals experience increased empowerment and agency to cope with their subclinical symptoms. Implications for family therapists are discussed, including therapeutic tasks and questions informed by narrative therapy and the feminist-relational model.

Keywords: subclinical eating disorders, protective factors, feminist-relational model, clinical implications

Application of the Feminist-Relational Model for Treatment of Subclinical Eating Disorders

In comparison to promoting protective factors, the field of eating disorders focuses mainly on reducing risk factors, such as body dissatisfaction and internalization of the thin ideal, (Stice, 1998). Understanding protective factors for eating disorders provides a more comprehensive understanding of both the problem, and how to potentially mitigate symptom development. This represents a theoretical shift from deficit-oriented to strengths-based (Masten, 2001; Walsh, 2003). Additionally, subclinical eating disorders represent a variation of clinical eating disorders that are far less understood. Compared to clinical eating disorders, subclinical symptoms are less frequent and severe in behavioral nature, but are still associated with severe impairment in psychological functioning (Flament et al., 2015). Currently, the field of eating disorder treatment is lacking strength-based models that address protective factors for subclinical eating disorder symptoms.

Therefore, the purpose of the present article was to propose a theoretical conceptualization of subclinical eating disorders, which highlights potential feminist-informed protective factors, and how those factors can be applied in a clinical context. Aspects of the feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991) including connection, social support, voice, empowerment and feminist identity are explored as potential protective factors for women with subclinical eating disorders. The present article advances the use of the feminist-relational model by showing how many of the constructs intersect symbiotically in a protective way. This conceptualization provides a framework for family therapists, suggesting safe and supportive relationships are important in helping individuals with subclinical eating disorders experience an increased sense of empowerment, agency and voice. Additionally, this paper draws primarily on narrative therapy (White & Epston, 1990) to

implement therapeutic questions and interventions that are feminist-informed and non-pathologizing. This narrative and feminist-informed approach provides a strategy for family therapists to implement the theoretical concepts in the present paper.

Subclinical Eating Disorders

Approximately 18 million individuals in the United States currently live with clinical eating disorders, a condition which has the highest mortality rate of any mental illness (Forbush & Hunt, 2014). Alarmingly, subclinical eating disorders are more common than clinical eating disorders, but significantly less understood (Franko & Omiro, 1999; Wei-wei, et al., 2015). Subclinical eating disorders are considered a variation of clinical eating disorders, and represent eating-disordered behaviors that are less severe and frequent than those classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM). While an estimated 1% to 4% of female college students meet the clinical criteria for Anorexia-Nervosa (AN) and Bulimia Nervosa (BN), subclinical symptoms impact an upwards of 35% to 70% of female college students (Heatherton, Nichols, Mahamedi, & Keel, 1995). The continuity hypothesis places disordered eating on a spectrum, with subclinical level symptoms on one end and clinical level symptoms on the other (Franko & Omiro, 1999). Thus, the only difference between clinical and subclinical levels of AN and BN are the severity and duration of behavioral and physical symptoms. Subclinical eating disorders are considered a public health issue due to their correlation with depression, anxiety, anger, suicidal ideation and low self-confidence (Flament et al., 2015).

Though emphasis has been placed on the negative outcomes associated with clinical eating disorders, there is little difference in severity of psychological symptoms for those with subclinical and clinical eating disorders (Franko & Omiro, 1999). Thus, in a sense, because the

physical symptoms have not escalated to the point of hospitalization or other forms of intensive treatment, those with subclinical symptoms are frequently rendered invisible, even though they may be suffering from significant emotional and psychological distress (Franko & Omiro, 1999). As a result, those with subclinical symptoms may not get the treatment they need, making it far more likely that if left untreated, their symptoms would escalate into a clinical eating disorder. For example, in a longitudinal study of 33 women requesting treatment for their subclinical eating disorder symptoms, half of the women were found to develop a clinical eating disorder at a later time (Herzog, Hopkins & Burns, 1993). Thus, intervening and treating subclinical symptoms as early as possible during the development of an eating disorder is imperative.

Risk Factors

A wealth of research has examined the development of clinical eating disorders by exploring various individual, familial, and societal risk factors. Conceptually, risk factors for eating disorders are considered "health-compromising" behaviors which increase the risk of developing an eating disorder (Croll, Neumark-Sztainer, Story, & Ireland, 2002, p. 167). This section will explore individual, familial and societal risk factors most relevant to subclinical eating disorders.

Individual Factors

An argument has been made that distinct personality traits may exist in those with eating disorders. Specific personality traits associated with AN include a temperamental disposition toward emotional and behavioral restraint and decreased sociability and dominance (Casper, 1990). Besides personality traits, there are numerous individual health characteristics associated with an increased risk of disordered eating. Being overweight is thought to increase the risk for binge eating, unhealthy weight control behaviors, and bulimic behaviors in adolescents

(Neumark-Sztainer & Hannan 2000). In adolescence, disordered eating is also associated with a higher likelihood of having an emotional disorder, including but not limited to, depression and anxiety (Wade, Bergin, Martin, Gillespie, & Fairburn, 2006). Finally, substance use and other high risk behaviors have also been correlated with disordered eating. For example, in several studies of both male and female adolescents, smoking was associated with weight concerns and weight loss behaviors, both antecedents to eating disorders (Croll et al., 2002).

Familial Risk Factors

In early studies of families and eating disorders, the family was considered a metaphor in conceptualizing problem development (Minuchin, Rosman & Baker, 1978). An eating disorder on behalf of one family member was thought to be symbolic of larger relational issues within the family. However, more recently, researchers have taken a strong stance that family factors are not causative (Le Grange, Lock, Loeb, & Nicholls, 2010). Instead, the complexity of disordered eating is created through families and individuals who may already be vulnerable to eating disorders due to biological or psychological factors, combined with environmental factors that promote disordered eating behaviors (Robin, Bedway, Siegel & Gilroy, 1996). In fact, the Academy for Eating Disorders (AED) recently took a position against an etiological model of eating disorders, suggesting families and other social relationships could be influential, but not the primary cause of the disorder (Le Grange et al., 2010). Therefore, critically examining the larger culture in which these individual and family risk factors exist, allows for a more comprehensive understanding of eating disorders from an etiological, treatment, and prevention perspective.

Societal Risk Factors

Societal risk factors include aspects of the social and cultural environment that might promote disordered eating. The next section highlights these socio-cultural risk factors for subclinical eating disorders, including gender, the thin ideal, social comparisons, and traditional gender roles.

Gender. The single greatest risk factor for developing an eating disorder is being female. Researchers have found rates of eating disorders to be twice as common among females, with moderate increases with age (Merikangas et al., 2010). Epidemiological studies of adults have shown significantly higher rates of clinical AN and BN among women (2.1%) compared to men (.03%) (Hudson, Hiripi, Pope & Kessler, 2006). While both clinical and subclinical eating disorders are more prevalent in females compared to males, the gender discrepancy is not well understood. One hypothesis is that males and females may struggle at similar levels, but rates for males may be under-reported due to the stigma that eating disorders are a "female problem" (Franco, Tamburino, Carroll & Bernal, 1988). In one outdated argument, researchers hypothesized that, due to the rarity of eating disorders in men and boys, the nature of the illness must be atypical for those with biologically male sex characteristics (Cobb, 1950). However, in studies comparing men and women with clinical eating disorders, their symptom presentation and response to treatment are very similar (Woodside & Kaplan, 1994), which lends support to the idea that eating disorders are not biologically a female disorder. Instead, societal constructions of beauty and the extra pressure on women to conform to the thin ideal are more plausible explanations for the gender discrepancy (Bordo, 1993; Orbach, 1986).

The thin ideal. The thin ideal is the concept of promoting values which suggest being "thin" is a marker of being a more valuable and worthwhile individual (Stice, 1998). Informed by socialization theory (Kandel, 1980), socio-cultural pressures to be thin are often used to

describe aspects of the social environment that reinforce messages regarding thinness and beauty, especially for females. Specifically, current societal standards can perpetuate disordered eating by objectifying girls and placing undue emphasis on the size and shape of female bodies, and encouraging females to reach unattainable standards of beauty and thinness (Bordo, 1993). Females may be particularly vulnerable to these messages, as patriarchal notions often enforce the idea that self-worth is determined by physical appearance (Orbach, 1986). For example, women's access to power and privilege is often tied to their accommodation of mainstream beauty ideals and their ability to ascribe to feminine gender roles (Hurtado, 1990). One effect of trying to reach these unattainable societal standards is development of disordered eating behavior, including subclinical levels of such behavior.

Social comparisons. Social comparison theory suggests that there is an innate drive for humans to compare themselves to others on psychologically important attributes (Rieves & Cash, 1996). How people "measure up" on these attributes compared to others then influences evaluation of self-worth. Due to the emphasis on thinness and physical appearance in Western cultures, as noted above in the discussion of the thin ideal, it has been suggested that comparison of appearance is a significant way to measure self-worth and more common among females (Rieves & Cash, 1996). Social comparisons and body image dissatisfaction appear to be closely related, in that regular comparison of oneself to another person increases the risk of body image dissatisfaction and disordered eating, which often accompany one another (Tsiantas & King, 2001).

Traditional gender roles. An additional socio-cultural risk factor relates to traditional gender roles. A traditional gender role encompasses looking feminine, conforming to personal and societal standards of beauty and expressing traditional gender role values (Cash & Ancis,

1997). There has been repeated empirical support for the association between aspects of feminine gender roles and disturbed body image. For example, adherence to a traditional female gender role is correlated with a higher risk for disordered eating (Martz, Handley & Eisler, 1995). Researchers examined 122 female undergraduate students and found that women who endorsed more traditional gender roles in male–female social relations tended to have greater levels of internalization of societal standards and tended to be more focused on their physical appearance (Cash & Ancis, 1997). One theory suggests that rigid adherence to the female gender roles, manifesting in a focus on physical attractiveness and the need for approval by others, can create significant psychological distress, which explains the disproportionate rates of eating disorders among women (Martz et al., 1995).

Feminist Critique of Eating Disorders

Historically, etiological models of eating disorders sought to define and explain their development as a means of pinpointing primary causes. As discussed previously, early research on primary causes of eating disorders focused on individual personality characteristics, such as perfectionism and rigidity (Casper, 1990), and dysfunctional family systems that were avoidant or enmeshed (Minuchin, et al., 1978). However, when considering the etiological development of eating disorders, no single correlative factor can be understood in isolation (Robin, et al., 1996). While specific factors such as body dissatisfaction, internalization of the thin ideal and dieting behaviors are strongly correlated with eating disorders (Stice, 1998), they do not fully explain problem development.

Additionally, factors such as personality characteristics, behaviors and relationships, can only be examined as risk factors for eating disorders if the context in which they exist is also understood (Weaver, Wuest, & Ciliska, 2005). The "context" of eating disorders involves the

social, relational, and political environments of those at risk for eating disorder development. In particular, feminist theorists encourage researchers to examine eating disorders from a critical-socio-cultural perspective, especially in regard to dominant discourses and power distributions as they relate to gender and oppression (Bordo, 1993). From a feminist perspective, oppression results from relations between social categories, which involve discrimination, exploitation, and domination of one group over another, or one person over another (Pharr, 1997). Feminism has long been misperceived as wanting to elevate women to a higher social status then men. However, the preferred definition of feminism for this paper is, "The struggle to end sexist oppression... It does not privilege women over men. It has the power to transform in a meaningful way all our lives" (hooks, 2000, p. 28).

Feminist-Informed Protective Factors

Understanding feminist-informed protective factors for eating disorders does indeed have the potential to alleviate suffering on behalf of women. In general, protective factors alter responses to adverse events so that potential negative outcomes can be avoided (Masten, 2001). Emerging research suggests that feminist-informed prevention programs may be helpful for those at risk for eating disorders (Peterson, Grippo, & Tantleff-Dunn, 2008; Piran, Levine, & Irving, 2000). These programs seek to teach women about societal objectification of their bodies and develop feelings of empowerment by increasing personal competence and critical consciousness to stand against societal pressures from the dominant culture (Piran, et al., 2000). Major components of these intervention programs related to empowerment include media literacy regarding the negative impact of the thin ideal, and development of life skills to build positive body image, manage stress, and increase healthy peer relations (Piran et al. 2000). In terms of efficacy, these programs led to increases in weight-related esteem, decreases in dieting,

increased awareness of the media on eating disorders, and changes in choice of leisure magazines (Neumark-Sztainer, Sherwood, Coller, & Hannan, 2000). These results were maintained at a three month follow up, however, there were no overall changes in dieting. Given the important but limited information on feminist-informed protective factors, more research is needed regarding which feminist-informed protective factors are useful for treating subclinical eating disorders, and which factors may reduce dieting and body dissatisfaction.

Other prevention programs for eating disorders have focused on individual-level risk factors, didactic approaches, and individual-level change. In contrast, feminist prevention approaches take a systemic perspective, emphasizing critical analysis of the dominant culture and participatory action (Piran et al., 2000), which makes conceptual sense given that feminists consider eating disorders as rooted in larger systemic issues and gender-based oppression. Therefore, these programs aim to counter the impact of social oppression and increase feelings of empowerment (Piran et al., 2000). The hope is that this increase in empowerment leads to an experience of active engagement within the community to help transform social institutions.

Collectively, feminist-informed prevention programs represent an important start in conceptualizing protective factors for women at risk for eating disorders. However, more research is needed on the effectiveness of these programs, and which specific factors serve as protective mechanisms for eating disorders. For example, in one study, feminism promoted an intellectual understanding of the toxicity of culture and how gender-based oppression contributes to eating disorders (Rubin, Nemeroff & Russo, 2004). However, this intellectual knowledge did not appear to change participants' personal feelings about the importance of beauty and their appearance. Thus, knowledge from a feminist perspective of the role society plays in female objectification and body dissatisfaction was helpful, but did not translate into behavior changes

(Rubin et al. 2004). Therefore, more research is needed regarding ways to transfer an understanding of gender-based oppression into participatory action, as well as how clinicians can implement these approaches within a clinical context to help women who are at risk for eating disorders.

The Feminist-Relational Model

Feminist approaches to treating eating disorders tend to promote relationships and the importance of connection, but do not always make this explicit. The feminist-relational model developed through an understanding of the relational self (Miller, 1984) and the idea that self can exist only in relation to other selves. Miller (1984), along with other feminist theorists, were critical of models of human development that did not seem to adequately explain the experience of women, or appreciate the relational nature of the female sense of self. Pioneering feminist theorists explicitly and implicitly called for relational and contextual paradigms to understand human experience (Miller, 1984). The feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991) involves two overlapping spheres involving the relational and political contexts within the social world. First, the socio-relational context involves relationships, support and connection to facilitate healthy psychological development and growth (Jordan, 1997). The socio-political context involves the Western capitalist consumer culture in which females experience gender-based oppression and social inequity (Orbach, 1986). Together, these two overlapping contexts imply that individuals are shaped by both their social and political environments. While feminists have always sought to de-pathologize connection (Jordan, 1997), the feminist-relational model makes this explicit, while still emphasizing the importance of the socio-political sphere. Additionally, the combination of both spheres, serves to transform the intellectual understanding of female oppression (i.e., socio-political sphere) into

tangible ways to decrease this oppression via relationships and experience (i.e., socio-relational sphere). Several foundational constructs from the feminist-relational model are important to understand, as they apply to subclinical eating disorders. These constructs include: connection, social support, voice, empowerment, and feminist identity. In the present paper, a model emerged from these constructs, by linking the socio-relational and socio-political aspects of the feminist-relational model together (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991), suggesting that through safe and supportive relationships, individuals with subclinical eating disorders can experience an increased sense of empowerment and utilization of voice. See Figure 1 for a visual depiction of this model and the various constructs linked together.

Connection and Social Support

What is it that liberates women from the dissatisfaction they feel with their bodies? Why do some women struggle with subclinical symptoms but do not go on to develop full-blown clinical eating disorders? The feminist-relational framework would suggest that connection, relationships, and support are the answer (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991). The process of eating disorder development inherently disconnects individuals from their support systems. It has been theorized that both emotional and instrumental support are needed to stop this disconnection from occurring. Additionally, feminist theory seeks to de-pathologize connection (Jordan, 1997), suggesting healthy relationships, both with loved ones and with food, and are key in protecting women from disordered eating. The limited research on social support as a protective factor has highlighted the importance of relationships in the recovery process from clinical eating disorders (Weaver et al., 2005). Therefore, it makes conceptual sense that connection and supportive relationships may serve as important protective factors for women experiencing subclinical eating disorders, as subclinical and clinical symptoms represent

variations of the same condition. Conceivably, it is through these relationships that participants

can speak about their symptoms and develop an understanding of their experience. Gaining a

perspective other than their own may also help them understand the destructive nature of

symptoms that may feel normative. Through this relational process, seeking treatment and

actions needed to decrease eating disordered behaviors can be explored.

Voice

Voice can be defined as an aspect of psychological empowerment, which occurs through

the relational collaborative process of expressing oneself in relation to others (Belenky, Clinchy,

Goldberger, & Tarule, 1986). During the adolescent developmental task of shifting from a

relational life to an autonomous one, research has theorized that females who develop eating

disorders often metaphorically lose their voice (Olson, 1995). As females navigate the struggles

of life while also in a subordinate societal position, the eating disorder becomes a metaphor to

articulate their grief and pain to others. Feminist theorists consider the varied meanings of food

refusal and encourage individuals and their loves ones to listen closely to what the eating

disorder is trying to "say" (Bordo, 2003). From a socio-political standpoint, the eating disorder is

often considered a "protest" against the effects of gender-based oppression. This loss of voice is

experienced both within the self and between others, as these young women become

disconnected from their own experience and from their relationships (Olson, 1995). As women

lose their "genuine voice" they simultaneously develop an "eating disorder voice." This involves

beliefs and thoughts associated with the eating disorder that become self-destructive behaviors.

Gender based oppression may further limit the ability of females to speak up regarding their

experiences of injustice, limiting their sense of agency and power over their own lives (Bordo,

1993). Thus, women learn to express their emotional pain through their bodies, rather than using their voice (Maine & Bunnell, 2008).

Narrative therapy is a contemporary postmodern approach informed by social construction and interpretive frameworks (White & Epson, 1990). Consistent with feminist-theory, narrative therapists believe that individuals come to story themselves through their experiences and the larger socio-political world context (Scott, Hanstock, & Patterson-Kane, 2013) and eating disorders becomes a way for individuals to "speak" when they are oppressed or marginalized. The practice of narrative therapy allows the individual to locate the problem outside of themselves, by exploring the dominant culture and destructive internalized narratives that allowed for the construction of the problem (White & Epson, 1990). Theoretically, the less strength a problem has, the easier it is to distinguish one's own beliefs and values from those of the problem. Those at both the clinical and subclinical level can create this separation between the genuine self and the eating disorder. Perhaps those with subclinical symptoms have an easier time separating their own voice, values and beliefs from those of the eating disorder, because there is more metaphorical "space" between their genuine self and the eating disorder. Narrative therapy is considered an emancipatory and empowering approach that does not rely heavily of pathology or DSM-V labels (Scott et al., 2013).

Empowerment

From a feminist perspective, empowerment is a verb. It involves the process of "gaining control over one's life and influencing the organizational and societal structure in which one lives" (Rogers, Chamberlin, Ellison, & Crean, 1997, p. 1042). Additionally, the dominant discourse regulating power and how men and women attain power within society is currently organized in such a way that thin women are given more freedom than larger women to develop

culturally favorable identities, which simultaneously provides thin women with more power

(Bordo, 1993; Orbach, 1986), albeit a false sense of power in that it colludes with patriarchal

notions. From a feminist perspective, gender, age and body size are intrinsically connected to

trying to obtain power. Researchers have theorized that those who feel powerless in regard to

their bodies may passively internalize societal standards of beauty more so than others, resulting

in a disturbed body image (Peterson et al., 2008). Specifically, it has been suggested that more

studies should focus on enhancing and empirically testing girls' feeling of power over their own

lives, whether that be body image, education, employment or relationships (Peterson et al.,

2008). These researchers theorize that feeling empowered across various domains of life may

reduce risk factors for disordered eating, namely self-objectification and body image disturbance.

Empowerment in the context of the feminist-relational model (Jordan, 1997; Maine &

Bunnell, 2008; Surrey, 1991) also prioritizes collaboration over authority, with the goal of

sharing "power-with" others rather than having "power-over" others. Feelings of empowerment

are fostered through a collaborative experience of shared power within supportive relationships.

This "shared power" involves collaborative control, discussions, decision making, and the ability

to assert important ideas, values and beliefs within a safe relationship. In previous research,

lower rates of empowerment and higher feeling of powerlessness were both correlated with

higher levels of body image disturbance (Peterson et al., 2008). According to feminist theory,

equitable distribution of power between the genders should result in an increased sense of

agency, utilization of voice and feelings of empowerment for women (Bordo, 1993). As women

are disproportionately affected by subclinical eating disorders, equitable distribution of power

may serve as a protective factor for the development of a full blown clinical disorder.

Of additional importance is experience over intellect in inoculating females against eating disorders (Peterson et al., 2008). In previous research, body image acceptance was more likely to occur in those who felt empowered in their day-to-day lives (Peterson et al., 2008). Women can intellectually know that their appearance and weight status are not what make them worthy of love, but they need experiences of empowerment for these messages to solidify. Protective factors such as empowerment and voice are not simply things to hand over to girls in a pep talk and expect them to use. This would represent a top-down hierarchy, rather than a collaborative approach. From a feminist perspective, these constructs are experienced and must be cultivated in relation to others. Therefore, it is within safe and supportive relationships where vocalization of injustice and critical reflexivity to challenge dominant discourses can occur (Currie & Kelly, 2006), and this process can be facilitated by family therapists. In the lives of women with subclinical eating disorders, these supportive relationships can include connection with friends, family, the larger community and a trusted therapist.

Feminist Identity

"Feminist attitude" is the term used to describe women who subscribe to nontraditional or feminist views regarding women's roles (Tiggeman & Stevens, 1999, p. 104). These views include equality between the sexes, subjective identification with the women's movement, and engagement in activism for gender-based oppression. Therefore, feminist identity is defined here as valuing equality between the sexes and/or engaging in activities that seek to decrease gender-based oppression. Women who identify as having feminist attitudes are less likely to evaluate themselves on physical appearance alone (Martz et al. 1995; Tiggemann & Stevens 1999). Evaluating self-worth based on physical appearance is a common precursor to disordered eating. Additionally, in a study of women ranging from 18 to 59, women 40 and above were more likely

to possess a feminist identity and less likely to express concerns about their weight (Tiggemann & Stevens, 1999). With adolescent and young adult women being at increased risk for disordered eating, increasing feminist-informed protective factors in their lives would mean no longer having to wait until mid-life to be comfortable in their bodies.

It has been suggested that the importance of appearance becomes so engrained in young women during adolescence and emerging adulthood, that it may become a part of their core belief system (Cash & Ancis, 1997; Tiggemann & Stevens, 1999). Thus, young women are sent the message that the only way to maintain power, is to remain attractive. What is it about a feminist identity that might inoculate young women from the perils of disordered eating? Previous research shows that a feminist identity allows women to challenge sexism within Western capitalist culture and, by standing against the emphasis placed on physical appearance as a determinant of value or worth (Brown & Jasper, 1993), they reduce their risk for eating disorders.

Critical consciousness of female oppression can be considered an important aspect of feminist identity. Females need space to name their experiences of gender inequality and the possibilities they have for standing against it. Providing young women this space to "critically interrogate" their experiences of gender oppression moves them from object to subject in a world that has historically objectified their embodied experience (Currie & Kelly, 2006, p. 434). Feminist consciousness can also create heighted awareness of the relationship between female body objectification and disordered eating, conceptualizing objectification as a form of social control which prevents women from achieving in other areas of their lives (McKinley & Wojszwilo, 1999).

Using the feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey,

1991), feminist consciousness happens relationally, by sharing knowledge of female oppression

and the dominant discourse with others. In this way, the two spheres of the feminist-relational

model come together, as relationships lead to knowledge and empowerment, with the outcome

being a desire to stand against the dominant discourse. Because feminist-informed intervention

programs have sought to clarify potential protective factors for eating disorders, this has

enhanced the understanding of the role they may play in symptom development and mitigation

(Peterson et al., 2008). Using this information regarding feminist-informed protective factors, in

combination with the feminist-relational model, it can then be applicable within a clinical context

to help professionals who are working with women at risk for disorder eating.

Implications for Family Therapists

In the present paper, the socio-relational and socio-political aspects of the feminist-

relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991) were combined to

provide clinicians with a theoretical model they can use in treatment for women at risk for

disordered eating. See Table 1 for a list of therapeutic tasks and questions informed by the

feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991) and narrative

therapy (White & Epston, 1990), which can be utilized in a clinical context to decrease the

harmful effects of subclinical disordered eating on individuals and their relationships.

Build Support Networks

Due to the importance of connection within the feminist-relational model (Jordan, 1997;

Maine & Bunnell, 2008; Surrey, 1991), and previous research which shows supportive

relationships as being protective for subclinical and clinical eating disorders (Haugen, 2017;

Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991), one of the first therapeutic tasks is to help

clients build their support networks. Family therapists can help clients identify the most

emotionally and instrumentally supportive people in their lives and help clients find ways to

increase the amount and quality of time with them. Therapists can also encourage involvement of

support people in therapy. This can begin by exploring who in the client's life knows about the

eating disorder symptoms and what these people have done to help. Therapists can also help

clients identify how they experience themselves within their support network (i.e., comfortable,

open) and how this may relate their ability to discuss their eating disorder symptoms with

supportive others. However, clients may have difficulty being open about their symptoms with

others, and therapists can then discuss fears around disclosing the eating disorder symptoms. If

clients have a limited support network, therapists can work to connect clients with eating

disorder support groups, or other resources. These kinds of support groups may initially feel

intimidating, so clients can begin with increased community involvement through volunteering

or student groups not related to eating disorders.

Additionally, through the combination of the socio-political and socio-relational spheres

of the feminist-relational model, strong support networks may result in an increased sense of

empowerment. As current research suggests (Haugen, 2017), the mechanism that helps move

from connection with others to a sense of empowerment is the support, vulnerability and safety

felt within the relationship. This sense of empowerment results in taking various actions against

the eating disorder, such as being involved in the community and finding aspects of self-worth

that are not associated with weight status or appearance.

Develop Discrepancy Between Client and her "Eating Disorder Voice"

The use of externalization questions from narrative therapy (White & Epston, 1990) can

be used as a tool to help implement the feminist-relational model within therapy for individuals

experiencing subclinical eating disorder symptoms. Narrative therapy was developed through

family therapy work related to eating disorder (Scott et al., 2013; White & Epston, 1990).

Externalization helps clients separate from their eating disorder voice and explore the

contradictions between what they believe and value, and what the eating disorder wants.

Therapists can also help clients explore what their eating disorder is metaphorically trying to

"tell" others through these actions.

This can be accomplished by identifying the current purpose of the eating disorder.

Examples may include being in a time of transition, coping with stress, numbing difficult

emotions, lack of voice or agency, or a variety of other reasons. It is important that the therapist

stays curious. Even though eating disorders, on any level of the spectrum, may stem from similar

experiences of gender-oppression, no two individuals will have the same experience with their

symptoms. Until the unique function of the eating disorder is explored, in an externalized way, it

is difficult to build and develop a counter-voice. Clients will also have a hard time standing

against the eating disorder, if the intentions, thoughts and values of both the participant and the

eating disorder are not well understood. The ability to externalize the eating disorder made

narrative therapy a useful approach with families, as they could "stand against" the eating

disorder and unite to decrease its influence (White & Epston, 1990). From a feminist-informed

narrative perspective, this "stand against" the eating disorder represents the use of voice and

taking action within the context of supportive relationships.

Explore Self-Worth Outside of Appearance and Weight Status

As current research suggests (Haugen, 2017), the mechanism that helps move from

connection with others to a sense of empowerment is the support, vulnerability and safety felt

within the relationship. This sense of empowerment results in taking various actions against the

eating disorder voice, such as being involved in the community and finding aspects of self-worth that are not associated with weight status or appearance. Therapists can help clients identify and challenge messages that reinforce a core belief system that equates thinness and appearance with self-worth. Therapists and clients can discuss the difference between external and internal markers of self-worth, and identify which internal markers of self-worth they want to be more present in their lives. This can begin with an exploration of how appearance and weight status affect how clients view themselves. In more concrete terms, clients can quantify what percentage of their self-worth is made up of external markers (i.e., beauty and weight status) compared to internal markers (i.e., compassion, care for others). From a feminist-perspective, external markers of self-worth often develop from societal expectations regarding body objectification and the role of females in society (McKinley & Wojszwilo, 1999). Therefore, it may be useful for therapists to help clients clarify where the importance of external markers of worth developed and whether or not the client agrees with this. Sometimes it is helpful for clients to draw this in a visual or pie chart to show the discrepancy, how much value the eating disorder places on external markers of self-worth, and from what sources these messages developed.

This may also be a time to explore what feminism means to clients and whether aspects of a feminist identity can be made more present in their lives. Research suggests that aspects of feminist identity may help participants find meaning and value in their lives outside of the eating disorder and include community involvement, values related to helping others, and understanding the history of female oppression (Haugen, 2017). It is important to note that clients do not have to identify as feminists, nor must therapists use the word "feminism" in therapy in order to apply principles of the feminist-relational model. For example, by examining higher rates of eating disorders in females and how this has come to be, clients can explore larger

societal messages which stem from a patriarchal culture that oppresses women and perpetuates disordered eating, without ever using the word "patriarchy." However, if participants have negative connotations associated with concepts related to feminism, this would be worth exploring in therapy.

Develop Critical Consciousness

Therapists can provide a safe space for participants to explore the society in which they exist and the toxic messages to which they have been exposed. During this task, it will be important to identify which societal messages or experiences of gender oppression may fuel the eating disorder. Without a critical look at the way society perpetuates disordered eating, clients are unable to challenge the dominant discourse and their own experiences of oppression. Once this oppression is understood, clients can then work to stand against it by identifying people in their lives who have reduced these toxic messages, or ways these support people take action against gender-based oppression.

In previous research on women with subclinical eating disorders (Haugen, 2017), many participants reported that they found it an empowering time to be a female because they understood the history of oppression that came before them. Participants were compelled to work and go to school because these were historically difficult things for women to do in prior generations. This shows how an intellectual understanding of oppression can compel women towards action against the dominant discourse. This is where moving from intellect to action comes into play. Therapists can help facilitate this process by helping clients understand the history of female oppression, in what ways this has affected them, and then participatory ways that clients can challenge gender-based oppression. In this way, it may be helpful for therapists to help clients identity what they find exciting or empowering about being a female in society

today and what potential feminist-informed values the client is already living out (i.e., advocacy,

community involvement). Components of feminist-informed prevention programs can also be

incorporated into sessions, or therapists can consider running their own prevention group. Major

components of these programs include media literacy regarding the negative impact of the thin

ideal, and development of life skills to build positive body image, manage stress and increase

healthy peer relations (Piran et al. 2000).

Taking Action

The combination of both spheres of the feminist-relational model (Jordan, 1997; Maine &

Bunnell, 2008; Surrey, 1991), serves to transform the intellectual understanding of female

oppression into actions which decrease this oppression via relationships and experience. In this

way, both spheres of the feminist-relational model are necessary to produce meaningful and

lasting outcomes. In this context, lasting outcomes would be improved body image, a sense of

self-worth outside of weight status and critical consciousness of the dominant discourse which

promotes these ideal. To move beyond an intellectual understanding of this oppression towards

action, clients should be encouraged to explore actions they have already taken to overcome

oppression and how their relationships have helped this process. Therapists can help clients

identify people in their lives who encourage the use of voice and critical consciousness. As

mentioned in the feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey,

1991), therapists can introduce the concept of "power with" compared to "power over" by

identifying relationships that feel equitable and collaborative. In these empowering relationships,

clients may have a greater capacity to make informed decisions, assert themselves, and speak

their minds (Haugen, 2017). Therapists and clients should consider how eating disorder-related

activism can be incorporated as a part of their healing process to reduce further symptom

development. This can start with a discussion of what community involvement means to clients and how they may already be involved. If appropriate, therapists can introduce the idea of eating disorder-related activism such as volunteering with the National Eating Disorder Association (NEDA) or being involved in "Eating Disorder Awareness Month" through this organization. Exploring any hesitations around this type of activism is also useful.

Conclusion

This paper sought to identify constructs from the feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991), and illuminate how these constructs could serve as protective mechanisms in the lives of women with subclinical eating disorder symptoms. This discussion helped advance the feminist-relational model (Jordan, 1997; Maine & Bunnell, 2008; Surrey, 1991) and is in line with current research which links the socio-relational and socio-political aspects of the model together, suggesting that through safe and supportive relationships, individuals with subclinical eating disorders can experience an increased sense of empowerment and utilization of voice (Haugen, 2017). These safe relationships include those with the self, the therapist, support people, and the larger community. This empowerment helps individuals use their voice without relying on the eating disorder to "speak" for them, and increases the ability to be actively involved in a life outside of the eating disorder. Therapists are encouraged to consider how they can help clients move beyond an intellectual understanding of their experience of female oppression as it relates to eating disorders. Challenging dominant discourses, encouraging involvement in the community, and promoting eating disorder related-activism are a few of the many ways therapists can help participants move from critical consciousness to action. It is this empowered action within safe relationships that allows participants to reduce the negative effects produced by the eating disorder.

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Figure 1

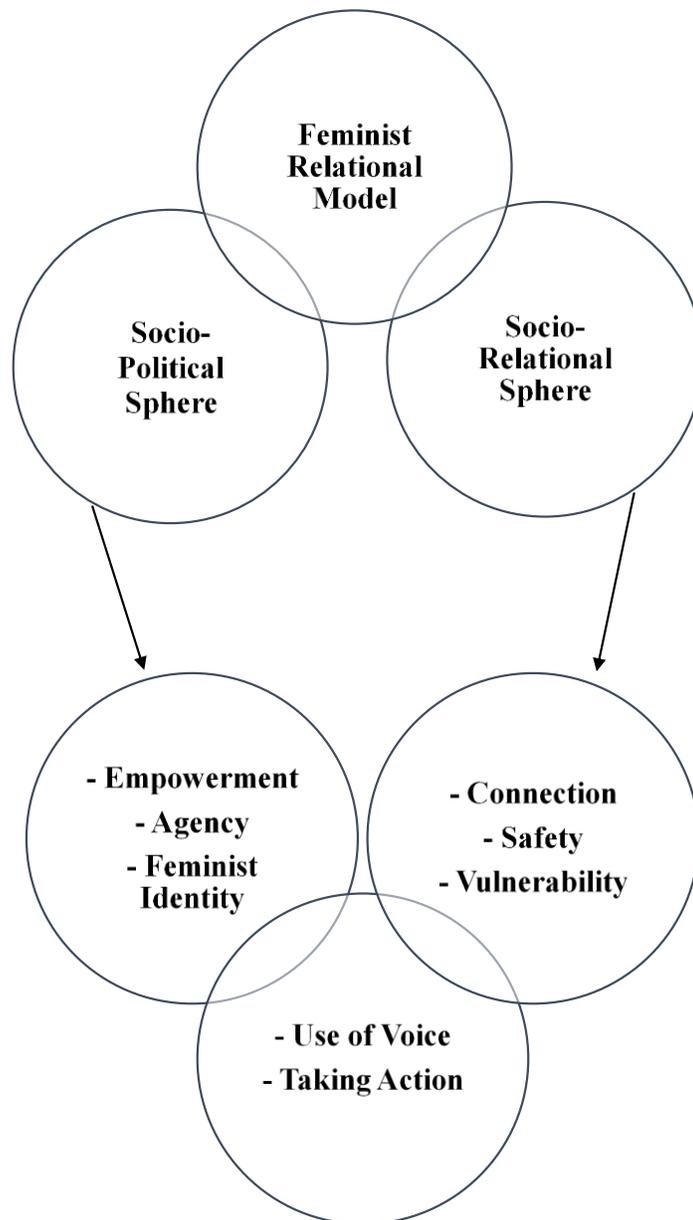*Feminist-Relational Model: Empowerment through Supportive Relationships*

Table 1

The Feminist-Relational Model: Therapeutic Tasks and Questions

Therapeutic Task	Questions for Therapists
Build Support Networks	• When you need help or support, how do you ask for it? • How have you been able to open up to others about your symptoms? • How can you build in meaningful time with these people?
Develop Discrepancy Between Client and her "eating disorder voice"	• What is the eating disorder metaphorically trying to "tell" others? • What does the eating disorder voice believe and value? • What do you believe and value? • How do your beliefs and values differ from those of the eating disorder?
Explore Self-Worth Outside of Appearance and Weight Status	• How (if at all) do your appearance and weight status affect how you view yourself as a person? What percentage of your self-worth is defined by these external markers? • What makes you worthy of love from others? • What do you value and believe in that is not associated with the physical body? Why do you value these things? • What does feminism mean to you? How can aspects of feminist identity become more present in day to day life?
Develop Critical Consciousness	• What does being "critical" of society mean to you? • Which societal messages fuel your eating disorder symptoms? • In what ways have you experienced gender oppression? • How might these experiences of oppression relate to the development of your eating disorder symptoms? • Is there anything you find exciting or empowering about being a female in society today?
Taking Action	• Who in your life encourages the use of voice and critical consciousness? • What does community activism or involvement mean to you and how involved have you been in it? Why or why not? Do you know others who are involved in these activities? • Have you ever considered eating disorder-related activism? Why or why not?

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Appendix A

Recruitment Poster

DO YOU STRUGGLE WITH BODY IMAGE OR YOUR RELATIONSHIP WITH FOOD?

- **Who:** Young women ages 18-25
- **What:** A research study involving a one-on-one interview to talk about their experiences with eating disorder symptoms
- **Why:** Explore the *relational* and *societal* factors that might have helped them avoid a clinical disorder or hospitalization.

We are especially interested in talking with women with no history of eating disorder treatment

If you are interested, please email
edcontextresearch@gmail.com
651-317-9724

You will receive a $20 Target Gift Card
for your participation. All information
will remain confidential.

Department of Human Development
Virginia Tech

Eating Disorders in Context Email: edcontextresearch@gmail.com Call: 651-317-9724	Eating Disorders in Context Email: edcontextresearch@gmail.com Call: 651-317-9724	Eating Disorders in Context Email: edcontextresearch@gmail.com Call: 651-317-9724	Eating Disorders in Context Email: edcontextresearch@gmail.com Call: 651-317-9724	Eating Disorders in Context Email: edcontextresearch@gmail.com Call: 651-317-9724	Eating Disorders in Context Email: edcontextresearch@gmail.com Call: 651-317-9724	Eating Disorders in Context Email: edcontextresearch@gmail.com Call: 651-317-9724	Eating Disorders in Context Email: edcontextresearch@gmail.com Call: 651-317-9724	Eating Disorders in Context Email: edcontextresearch@gmail.com Call: 651-317-9724	Eating Disorders in Context Email: edcontextresearch@gmail.com Call: 651-317-9724	Eating Disorders in Context Email: edcontextresearch@gmail.com Call: 651-317-9724

Appendix B

Recruitment Letter - Professionals

This is a way of recruiting participants by connecting with professionals. I will cut and paste this into an email or letter, or use this as a script if I talk with the person on the phone or in person. I will personalize this information if it is someone I know or have a connection to.

Dear _____,

Hello, my name is Emily Haugen. I'm a doctoral student in the marriage and family therapy program at Virginia Tech. I am contacting you because you have been identified by [name of referral person, psychology today, etc.] as someone who works with women ages 18-25 who might be at risk for disordered eating.

I would like to tell you about my dissertation research and ask for your help. I am studying the experiences of young women with subclinical eating disorder symptoms. Specifically, I am interested in understanding the feminist-informed protective factors that might mitigate symptoms before they develop into clinical disorders. To learn more about this, I will be interviewing women between the ages of 18-25 regarding their experiences with eating disorder symptoms in order to develop a theory of the process of symptom mitigation. My long term goal is to use these results to help inform treatment and prevention efforts for eating disorders.

If you are willing, would you consider putting up a poster for my study in your private practice or agency? Additionally, if you have colleagues who work with this population or clients who might be eligible for the study, would you be willing to provide them with my contact information, or give them a copy of the flier for the study?

This study has been approved by the Virginia Tech Institutional Review Board. If you have any questions about this study, please contact me through email at hauge307@vt.edu or by phone at (715) 377-5192. You may also contact my research advisor and co-investigator, Dr. Dolbin-MacNab by email at mdolbinm@vt.edu or by phone at (540) 231-6807. In addition, I have attached a copy of the flier for the study and give you full permission to share it with friends, colleagues and clients.

I appreciate your time and thank you in advance for your help

Sincerely,

Emily Haugen, MS, LMFT, Doctoral Candidate
Department of Human Development, Virginia Tech
The Emily Program, St. Paul, MN
715-377-5192
hauge307@vt.edu

Appendix C

Online Recruitment Script – Participants
(e.g. Organization Websites, Facebook, Twitter, Tumblr or other online message boards/chat rooms)

Young Women Invited to Participate in a Research Project

We are recruiting individuals in the Minneapolis-St. Paul area to take part in a research study. Participants should be women ages 18-25 who are currently experiencing eating disorder symptoms but have no history of a clinical diagnosis or treatment. This study involves a brief questionnaire and in-depth interview which will take approximately 2 hours. Participants will receive a $20 Target gift card for their participation. The goal of this research is to develop a theory related to protective factors that might delay or stop eating disorder symptoms.

Participation is voluntary and all information associated with this study will remain confidential. This project has been approved by Virginia Tech's Institutional Review Board for the Protection of Human Subjects (16-049).   If you have questions or would like to discuss eligibility, please contact the researcher by email at hauge307@vt.edu.

Appendix D

Eligibility Checklist & Tracking Form
Participant Version

PARTICIPANT NAME: _____

ADDRESS: _____

_____

_____

PHONE: _____

EMAIL: _____

PREFERRED METHOD OF CONTACT: _____

****

HOW DID THE PARTICIPANT LEARN ABOUT THE STUDY?

INCLUSION CRITERIA
(Fill out the following information after the participant has completed the EAT-26)

1. Age 18-25: Yes/No

   a. Age: _____

2. Female: Yes/No

3. Able to speak and read English: Yes/No

4. Eating Attitudes Test score 20 or above: Yes/No

   a. Score: _____

5. Eating Attitudes Test below 45: Yes/No

6. Past or current treatment for eating disorder symptoms: Yes/No

7. History of clinical eating disorder diagnosis: Yes/No

8. Agrees to participate in an in depth interview lasting approximately 2 hours: Yes/No

Participants are ineligible for the study if:

❑ The answer to any of the questions 1-5 or 8 are no (check this box if that is the case)

❑ The answer to either question 6-7 are yes (check this box if that is the case)

HOW DID THE PARTICIPANT LEARN ABOUT THE STUDY?

INCLUSION CRITERIA
(Fill out the following information after the participant has completed the EAT-26)

9. Age 18-25: Yes/No

    b. Age: _____

10. Female: Yes/No

11. Able to speak and read English: Yes/No

12. Eating Attitudes Test score 20 or above: Yes/No

    b. Score: _____

13. BMI considered underweight: Yes/No

    a. Score: _____

14. Have they lost more than 20 pounds in the last 6 months: Yes/No

15. According to the behavioral measures, have they engaged in bingeing and purging at least once a week for the past three months: Yes/No

16. Currently in treatment or therapy for eating disorder symptoms: Yes/No

17. History of clinical eating disorder diagnosis: Yes/No

18. Agrees to participate in an in depth interview lasting approximately 1-2 hours: Yes/No

a. Contact Information: _____

b. Preferred method of contact (email, phone, etc.) _____

Participants are ineligible for the study if:

❑ The answer to questions 4-6 and 8-9 are all yes (indicates clinical diagnosis of anorexia)

❑ The answer to questions 4 and 7-9 are all yes (indicates clinical diagnosis of bulimia)

❑ The answers to questions 8-9 are both yes

<u>VERIFY THE INCLUSION CRITERIA:</u>
(Check the box to indicate that you have verified this information with the participant)

❑ Age 18-25

❑ Female

❑ Able to speak and read English

❑ Not currently in treatment with the primary focus being eating disorder symptoms

❑ No history of a clinical eating disorder diagnosis

❑ EAT-26 Score above 20

❑ Agrees to participate in an interview lasting 1-2 hours

❑ The participant has given you their preferred method of contact

PLEASE RECORD *EVERY* CONTACT WITH THE PARTICIPANT:

DATE	NATURE OF CONTACT & ACTION TAKEN/NEEDED	INITIALS

Appendix E

Eating Attitudes Test (Garner, Olmsted, Bohr, & Garfinkel, 1982)

Please circle the answer that best fits how often you have had these feelings or engaged in the following behaviors in the past month (4 weeks):

How often….	Never	Rarely	Sometimes	Often	Usually	Always
1. I am terrified about being overweight.	0	1	2	3	4	5
2. I avoid eating when I am hungry.	0	1	2	3	4	5
3. I find myself preoccupied with food.	0	1	2	3	4	5
4. I have gone on eating binges where I feel that I may not be able to stop.	0	1	2	3	4	5
5. I cut my food into small pieces.	0	1	2	3	4	5
6. I am aware of the calorie content of foods that I eat	0	1	2	3	4	5
7. I particularly avoid food with high carbohydrates content (e.g., breads, potatoes, rice)	0	1	2	3	4	5
8. I feel that others would prefer I ate more.	0	1	2	3	4	5
9. I vomit after I have eaten	0	1	2	3	4	5
10. I feel extremely guilty after eating.	0	1	2	3	4	5
11. I am preoccupied with a desire to be thinner?	0	1	2	3	4	5
12. I think about burning up energy (calories) when I	0	1	2	3	4	5

exercise.

13. Other people think I am too thin.	0	1	2	3	4	5
14. I am preoccupied with the thought of having fat on my body.	0	1	2	3	4	5
15. I take longer than others to eat my meals.	0	1	2	3	4	5
16. I avoid foods with sugar in them	0	1	2	3	4	5
17. I eat diet foods.	0	1	2	3	4	5
18. I feel that food controls my life.	0	1	2	3	4	5
19. *I display self-control around food.	0	1	2	3	4	5
20. I feel that others pressure me to eat	0	1	2	3	4	5
21. I give too much time and thought to food	0	1	2	3	4	5
22. I feel uncomfortable after eating sweets	0	1	2	3	4	5
23. I engage in dieting behavior	0	1	2	3	4	5
24. I like my stomach to be empty	0	1	2	3	4	5
25. *I enjoy trying new rich foods	0	1	2	3	4	5
26. I have the impulse to vomit after eating	0	1	2	3	4	5

BMI Chart

Height: _____ Feet _____ In
Weight: _____ Pounds
BMI Score: _____

BMI	Normal						Overweight					Obese										Extreme Obesity		
	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
Height	Weight (Pounds)																							
Feet / Inches																								
4 / 10	91	96	100	105	110	115	120	124	129	134	139	144	148	153	158	163	167	172	177	182	187	191	196	201
4 / 11	94	99	104	109	114	119	124	129	134	139	144	149	154	158	163	168	173	178	183	188	193	198	203	208
5 / 0	97	102	108	113	118	123	128	133	138	143	149	154	159	164	169	174	179	184	189	195	200	205	210	215
5 / 1	101	106	111	116	122	127	132	138	143	148	153	159	164	169	175	180	185	191	196	201	206	212	217	222
5 / 2	104	109	115	120	126	131	137	142	148	153	159	164	170	175	180	186	191	197	202	208	213	219	224	230
5 / 3	107	113	119	124	130	135	141	147	152	158	164	169	175	181	186	192	198	203	209	215	220	226	231	237
5 / 4	111	117	122	128	134	140	146	151	157	163	169	175	181	186	192	198	204	210	216	221	227	233	239	245
5 / 5	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252
5 / 6	118	124	130	136	143	149	155	161	167	173	180	186	192	198	204	211	217	223	229	235	242	248	254	260
5 / 7	121	128	134	140	147	153	160	166	172	179	185	192	198	204	211	217	223	230	236	243	249	255	262	268
5 / 8	125	132	138	145	151	158	164	171	178	184	191	197	204	210	217	224	230	237	243	250	257	263	270	276
5 / 9	129	135	142	149	156	163	169	176	183	190	196	203	210	217	223	230	237	244	251	257	264	271	278	284
5 / 10	132	139	146	153	160	167	174	181	188	195	202	209	216	223	230	237	244	251	258	265	272	279	286	293
5 / 11	136	143	151	158	165	172	179	186	194	201	208	215	222	229	237	244	251	258	265	272	280	287	294	301
6 / 0	140	147	155	162	170	177	184	192	199	206	214	221	229	236	243	251	258	265	273	280	288	295	302	310
6 / 1	144	152	159	167	174	182	190	197	205	212	220	227	235	243	250	258	265	273	280	288	296	303	311	318
6 / 2	148	156	164	171	179	187	195	203	210	218	226	234	241	249	257	265	273	280	288	296	304	312	319	327
6 / 3	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	280	288	296	304	312	320	328	336
6 / 4	156	164	173	181	189	197	205	214	222	230	238	246	255	263	271	279	288	296	304	312	320	329	337	345

Behavioral Questions

In the past 6 months have you:	Never	Once a month or less	2-3 times a month	Once a week	2-6 times a week	Once a day or more
Gone on eating binges where you feel that you may not be able to stop?						
Ever made yourself sick (vomited) to control your weight or shape?						
Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?						
Exercised more than 60 minutes a day to lose or to control your weight?						
Lost 20 pounds or more in the past 6 months		Yes		No		

Eating Attitudes Test (Garner, Olmsted, Bohr, & Garfinkel, 1982) Scoring Tool

1) Your Eating Attitudes Test (EAT-26) is: _____

	Scoring System for the EAT-26					
	Always	Usually	Often	Sometimes	Rarely	Never
Score for questions 1-25	3	2	1	0	0	0
Score for question #26	0	0	0	1	2	3

2) Your Body Mass Index (BMI) is: _____

If your BMI meets the criterion for "underweight" it is an important risk factor for a serious eating disorder

Table: BMI Considered "Underweight" for Females at Different Ages According to Norms												
Age	9	10	11	12	13	14	15	16	17	18	19	20	21+
BMI	14.0	14.5	14.5	15.0	15.5	16.0	16.5	17.0	17.5	18.0	18.5	18.5	19.0

3) Behavioral Questions: If you scored in the checked boxes you should seek an evaluation from a trained mental health professional

In the past 3 months have you:	Never	Once a month or less	2-3 times a month	Once a week	2-6 times a week	Once a day or more
Gone on eating binges where you feel that you may not be able to stop?				✓	✓	✓
Ever made yourself sick (vomited) to control your weight or shape?				✓	✓	✓
Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?				✓	✓	✓
Exercised more than 60 minutes a day to lose or to control your weight?						
Lost 20 pounds or more in the past 6 months	✓ Yes		No			

Appendix F

EAT 26 Permission Letter

VirginiaTech
Invent the Future

Emily Haugen <hauge307@vt.edu>

EAT-26

---

eat26_reproduce_permission@eat-26.com <eat26_reproduce_permission@eat-26.com>
To: hauge307@vt.edu

Thu, Jan 21, 2016 at 1:07 PM

Thank you for your permission request to reproduce and use the EAT-26. The EAT-26 is protected under copyright; however, all fees and royalties have been waived because it has been our wish for others to have free access to the test.

Please consider this e-mail as granting you permission to reproduce the test for the purpose suggested in your request as long as the EAT-26 is cited properly. The correct citation is: "The EAT-26 has been reproduced with permission. Garner et al. (1982). The Eating Attitudes Test: Psychometric features and clinical correlates. Psychological Medicine, 12, 871-878."

You can download a copy of the scoring instructions and the test on the homepage of the EAT-26 website. If you use the written version of the test, it is recommended that you provide respondents with the link to the EAT-26 website (www.eat-26.com) so that they can learn more about the test.

Again, thank you for requesting permission to reproduce and use the EAT-26. If you intend on publishing your work, please send me your results so that they can be included in a research database being developed on the EAT-26 website (www.eat-26.com).

Best wishes,

David M. Garner, Ph.D.
Administrative Director
River Centre Clinic
5465 Main Street
Sylvania, OH 43560
dm.garner@gmail.com

Appendix G

Participant Phone Screening and Interview Scheduling Scripts

Participant name: _____ Phone number: _____

Introduction & purpose: "My name is Emily Haugen. I'm a doctoral student at Virginia Tech and I'm conducting a research study for my dissertation. I'm interested in understanding protective factors for women at risk for disordered eating. My hope is that this study will improve treatment and prevention efforts for women at risk for disordered eating."

"I would like to tell you more about participating in this study, confidentiality, and ask you some eligibility questions. Would that be OK?"

- ❑ Yes
- ❑ No

If no, "Thank you for your time. I hope you have a nice day." [end phone conversation]
This process can take up to a half hour, do you have that time right now?
- ❑ Yes
- ❑ No

If no, "What would be a more convenient time for me to call you back?" *(Write down preferred contact method using Appendix D to follow up at an agreed upon time).*

Confidentiality: "I want you to know that your participation in this study is completely voluntary. Also, the information you provide me will be kept confidential. There are a couple of exceptions to this. If you tell me about any abuse, such as abuse of a child, or that you plan to harm yourself or someone else, I would need to tell the police about these things. After this study is over, I plan to share the results in my dissertation paper, articles, trainings, and conference presentations. There will be no information that would identify you, in any written documentation or presentation. All your information will be de-identified during the process of transcription. The only person who will have access to the study data are myself and undergraduate researchers who are helping with transcription"

"Do you have any questions about confidentiality?"

- ❑ Yes
- ❑ No

Questions/Answers:

Eligibility: If yes, "Would it be OK for me to ask you a few questions to help me determine your eligibility to participate in this study?"

- ❑ Yes
- ❑ No

If no, "I can understand that. Thank you for letting me talk with you about this. I hope you have a nice day." [end phone conversation]

If yes: How old are you? _____

If between 18-25 continue to the next question. If under 18 or over 25: "I appreciate your interest in this study but unfortunately this study is looking at the experiences of women ages 18-25. I really appreciate you taking the time to talk with me and learn more about what I am doing. I wish you the best and am happy to provide you with resources if you are interested in seeking information or help for your eating disorder symptoms." [end phone conversation]

"Have you experienced any of following symptoms in the past month?"

- ❏ Bingeing
- ❏ Purging via exercise
- ❏ Purging via vomiting
- ❏ Purging via laxatives
- ❏ Restricting food intake
- ❏ Guilt after eating
- ❏ Shame or embarrassment after bingeing/purging
- ❏ Excessive exercise
- ❏ Preoccupation with food or dieting
- ❏ Recent weight loss
- ❏ Recent weight gain
- ❏ Perfectionism
- ❏ Feelings of inadequacy
- ❏ Fear of gaining weight
- ❏ Isolation
- ❏ Anxiety
- ❏ Social anxiety
- ❏ Depression
- ❏ Body dissatisfaction
- ❏ Difficulty expressing emotions
- ❏ Impulsivity
- ❏ Obsessive behaviors

"To your knowledge, have you ever been treated for an eating disorder in the past?"

- ❏ Yes
- ❏ No

If participant answers yes, they are *ineligible* to participate: "I appreciate your interest in this study but unfortunately I am recruiting women with no history of eating disorder treatment. I really appreciate you taking the time to talk with me and learn more about what I am doing. I wish you the best and am happy to provide you with resources if you are interested in seeking treatment for your eating disorder symptoms."

"To your knowledge, have you ever been diagnosed with a clinical eating disorder?"

- ❏ Yes

❑ No

If participant answers yes, they are *ineligible* to participate: "I appreciate your interest in this study but unfortunately I am recruiting women with no history of a clinical eating disorder diagnosis. I really appreciate you taking the time to talk with me and learn more about what I am doing. I wish you the best and am happy to provide you with resources if you are interested in seeking treatment for your eating disorder symptoms."

If the participant answers no, "For the next part, we will be using the Eating Attitudes Test to determine your level of symptomology." *Refer to Appendix F for the EAT-26 screening and scoring. The researcher will fill in the participant's answers as she responds.*

After completion of the survey:

Score between 20-45: "Based on your score, you are eligible to participate. Before we schedule a time for an interview, is it ok if I verify some information with you?" *(Refer to Appendix D, fill in the necessary participant information and verify the inclusion criteria. Then move to the scheduling script.)*

Score below 20: Unfortunately, you are <u>not eligible</u> to participate in the study because your score indicates a low risk of eating disorder symptoms. I really appreciate you taking the time to talk with me and learn more about what I am doing. I wish you the best and am happy to provide you with resources if you are interested in learning more about eating disorders." *(Write down preferred contact method using Appendix D to follow up with resources).*

Score above 45: Unfortunately, you are <u>not eligible</u> to participate in the study because your score indicates a high risk of a clinical eating disorder. Based on this, it is highly recommended that you seek a clinical evaluation for your symptoms from both a mental health professional and a medical doctor. Can I provide you this information? *(Write down preferred contact method using Appendix D to follow up with resources).* I really appreciate you taking the time to talk with me and learn more about what I am doing. I wish you the best and again, I highly encourage you to seek further evaluation."

If yes, Participation: "Your participation would mean that you would first complete a demographic survey and then I would interview you face-to-face. The whole process takes about 2 hours. During the interviews, I will first ask some general questions about your eating disorder symptoms for example, when did you first notice them and why you think they developed. Then I will ask a series of questions about your social support, personal feelings of empowerment, as well as how gender and culture might influence your experience with eating disorder symptoms. I will audio-record and transcribe the interviews to make sure I get them right. You do not need to answer any questions that you do not want to and you can end the interview at any time."

"Do you have any questions so far about this study or your participation?"

❑ Yes
❑ No
Questions/Answers:

Compensation: "As a thank you for participating in this interview, you will receive a $20 Target gift card. If you start the interviews and chose not to finish them, you will still receive the gift card."

Verbal Consent to Participate: "Your consent is completely voluntary. You are not required to participate.

"Would you like to participate in this study?"

❑ Yes
❑ No

If no, "I can understand that. Thank you for letting me talk with you about this. I hope you have a nice day." [end phone conversation]

Scheduling Script

When would be a good day and time for you to come in for the demographic survey and interview? Keep in mind this process will take about 2 hours."

Date: _____ Time: _____

"I would prefer to meet with you at my office, which is located at 2230 Como Ave. St. Paul, MN 55108. This is the location that I can best offer you confidentiality. However, we could also meet at a public Library and reserve a room. If we meet there, you may run into people you know. Additionally, I can interview you at your home. Where would you like to meet?"

Location: _____

"Thank you. I will send you a confirmation email with all the necessary information for the interview. This will include the date and time of the interview as well as what to expect during the process." (*Confirm email using Appendix D*)

"In addition, I'll call you a few days before your appointment to confirm (*Confirm preferred contact method using Appendix D)*. I'm looking forward to talking with you more about your experiences with your eating disorder symptoms and factors that have helped you avoid a clinical diagnosis. Please feel free to call or email me with any questions prior to your scheduled interview. Take care."

Appendix H

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Consent for Participants
in Research Projects Involving Human Subjects

Title of Project: Eating Disorders in Context - The Social, Relational and Political Aspects of Disordered Eating

Co-Investigator: Emily Haugen, MS, LMFT, Doctoral Candidate
Principal Investigator and Dissertation Chair: Megan Dolbin-MacNab, PhD, LMFT

Overview:
- You are being asked to be in a research study. Studies are done to find better ways to treat people or to understand things.
- This form will tell you about the study to help you decide whether or not you want to participate.
- You should ask any questions you have before making up your mind to participate. You can think about it and discuss it with your family or friends before you decide.
- It is okay to say "No" if you do not want to be in the study. If you say, "Yes," you can change your mind and stop participating in the study at any time without getting in trouble.

Please consider the information carefully. Feel free to ask questions before making your decision whether or not to participate. If you decide to participate, you will be asked to sign this form and will receive a copy of the form.

I. Purpose of this Research Project

Little is known regarding subclinical eating disorder symptoms in terms of why some people overcome these symptoms, while others stay the same or move into clinical symptomology. This study seeks to examine aspects of the social, relational and political contexts of our lives as potential protective factors for those with subclinical eating disorder symptoms. Your participation will focus on describing your own experience with eating disorder symptoms and answering open-ended questions related to social support, voice, agency, culture and other constructs. I will interview approximately 20 women, between the ages of 18 and 24. Results will be used for my dissertation project, publication, professional presentations, and to inform other research and prevention efforts.

II. Procedures

If you agree to participate, you will be asked to fill out a pre-interview demographic questionnaire and take part in an individual interview. The questionnaire is expected to take approximately 10-15 minutes to complete. The interview will be recorded with a digital audio recorder, and will take approximately 60 to 120 minutes. It is estimated that the consent process, pre-interview questionnaire, and in-depth interview will take approximately 2 to 2.5 hours. You

can decide to stop participating in the study at any time. There is no penalty for stopping your participation.

III. Risks

Risk of breach of confidentiality. Project staff that have information about participants include the research investigators and the undergraduate research assistants working on transcription. Each of these people have been trained and instructed not to share confidential information about participants with anyone else. If a project staff member knows you, they will not be allowed to have access to the information you share with us.

Risk of emotional discomfort or distress. The questionnaires and interview in this study ask you reveal personal information about yourself and your experiences. You can choose to not answer any questions. Discussing your experiences may be upsetting, particularly if you discuss difficult experiences. At the end of the interview, I will ask you a few questions to debrief in case the process was emotional for you. I will also provide you with a list of mental health resources and eating disorder specific treatment centers.

IV. Benefits

Benefit to participants: Your participation in this project may help you feel better about your experience with eating disorder symptoms, by exploring what has helped you avoid a clinical diagnosis or hospitalization. Additionally, sometimes just talking about things can make you feel better. For some, talking about their experiences and improving communication skills may reduce emotional discomfort, increase relationship closeness, and improve access to social support.

No promise or guarantee of benefits has been made to encourage you to participate.

V. Extent of Anonymity and Confidentiality

After the interview, the audio will be transcribed and any identifying information will be removed. Every effort will be made to keep your study-related information confidential. the audio recording of your interview will be separated from the forms (papers) that have your name on them. When this happens, your interview will be assigned a code number and it will not be possible to match your name to your answers to the interview questions.

All information from this study will be stored in a locked file cabinet and/or password-protected computer in a locked office. Any computer files with your identifying information will be encrypted. Only members of the research project will be able to open the office and file cabinet and use the computer. When the study is over, the audio recording of your interview will be destroyed. We will keep your answers to the interview questions that we type out. Only the research investigators will be able to use this information.

Your participation in this study is confidential. This means that no one, except the researchers, will see or hear your answers to the interview questions. However, there may be circumstances

where this information must be released. Personal information regarding your participation in this study may be disclosed if you indicate an immediate threat to harm yourself or someone specific, or there is physical or sexual abuse of a minor or elder. The appropriate authorities (e.g. local police or emergency department, children's services, adult services) will be contacted by the researchers.

Your records may be reviewed by the following groups (as applicable to the research): Office for Human Research Protections or other federal, state, or international regulatory agencies; The Virginia Tech Institutional Review Board or Office of Responsible Research Practices. The Virginia Tech (VT) Institutional Review Board (IRB) may view the study's data for auditing purposes. The IRB is responsible for the oversight of the protection of human subjects involved in research.

VI. Compensation

Participants will be given a $20 Target gift card.

VII. Freedom to Withdraw

You are free to leave this study at any time without penalty or loss of incentive. You do not have answer any questions that you do not want. If you withdraw or stop participating, you will still receive the compensation described above.

There may be situations where the investigator may determine that a participant should not continue with the project. In those circumstances, you will still receive the compensation described above.

VIII. Subject's Responsibilities

To summarize, we are asking you to spend about two hours completing a pre-interview survey and answering interview questions about your experience with eating disorder symptoms. You will let the researcher know if you have any questions related to being in this study.

IX. Questions or Concerns

Should you have any questions about this study, you may contact one of the research investigators via the contact information below:

Emily Haugen, Co-Investigator   Phone: 715-377-5192
Doctoral Candidate Department of Human Development   Email: hauge307@vt.edu
Virginia Polytechnic Institute and State University
2230 Como Ave
St. Paul, MN 55108

Megan Dolbin-MacNab, Principal Investigator   Phone: 540-231-6807
Associate Professor, Department of Human Development   Email: mdolbinm@vt.edu

Virginia Polytechnic Institute & State University
Blacksburg, VA 24061

Should you have any questions or concerns about the study's conduct or your rights as a research subject, or need to report a research-related injury or event, you may contact the VT IRB Chair, Dr. David M. Moore at moored@vt.edu or (540) 231-4991.

X. Subject's Consent

I have read (or someone has read to me) this form. I have had a chance to ask questions before making up my mind. I want to be in this research study.

Participant

_____   _____

Printed name of participant   **Signature of participant**

                                            _____

                                            Date

I am willing to be contacted at a later date to review the results of the study and provide my opinion (NOTE: This is optional and will not impact your participation in the study)

Participant

_____   _____

Printed name of participant   **Signature of participant**

                                            _____

                                            Date

Research Investigator

I have explained the research to the participant before requesting the signature above. There are no blanks in this document. A copy of this form has been given to the participant or his/her representative.

_____   _____

Printed name of research investigator   **Signature of research investigator**

                                            _____

                                            Date

Appendix I

Demographic Survey - Participants

Participant ID #_____

Background information about yourself: please fill in the blanks below.

Age _____

Height _____(feet and inches)

Weight _____(pounds)

Highest educational status achieved (please check one):

_____ Grade school   _____ Some high school   _____ High school graduate

_____ Some college   _____ Associates Degree   _____ College graduate

_____ Master's Degree   _____ Advanced degree (doctorate, medical, law degree, etc.)

Gender: please check one of the following.

_____ Male   _____ Female   _____ Transgender   _____ Prefer not to Disclose

Sexual Orientation: please check one of the following.

_____ Lesbian   _____ Gay   _____ Bisexual   _____ Queer   _____ Straight

_____ Other   _____ Prefer Not to Disclose

Which of the following best describes your ethnic background?

    a. Hispanic or Latino (includes persons of Cuban, Mexican, Puerto Rican, South American,

       Central American, or Spanish culture)

    b. Not Hispanic or Latino

Which of the following best describes your race? (circle all that apply)

    a. White/Caucasian

    b. Black or African American

    c. Native Hawaiian or other Pacific Islander

    d. American Indian or Alaska Native

    e. Asian

    f. Other (specify)_____

How would you identify your current relationship status?

    a. _____ Single

    b. _____ Dating

    c. _____ Domestic partnership

    d. _____ Engaged

    e. _____ Married

    f. _____ Divorced

    g. _____ Widowed

    h. _____ Other (specify)

If partnered, specify length of time together: _____

Household: please indicate who lives with you now (if you split your time between two households, please check all that apply):

_____ Mother   _____ Father   _____ Stepmother   _____ Stepfather

_____ Siblings (brothers or sisters)   _____ Other family members (e.g., aunt, grandfather)

_____ Significant Other (e.g., partner or spouse) _____ Other (e.g., friends, your own children)

Social Support

Who do you identify as the most *emotionally* supportive people in your life? (Those who provide empathy, love, trust and care). List as many individuals as you would like and include their relationship to you (e.g., mother, partner, friend etc.)

_____

_____

Who do you identify as the most *instrumentally* supportive people in your life? (Those who provide tangible aid such as help with finances). List as many individuals as you would like and include their relationship to you (e.g., mother, partner, friend etc.)

_____

_____

<u>Please mark any of the behavioral eating disorder symptoms you are *currently* experiencing:</u>

- ❑ Bingeing
- ❑ Purging via exercise
- ❑ Purging via vomiting
- ❑ Purging via laxatives
- ❑ Restricting food intake
- ❑ Guilt after eating
- ❑ Shame or embarrassment after bingeing/purging
- ❑ Excessive exercise
- ❑ Preoccupation with food or dieting
- ❑ Recent weight loss
- ❑ Other (please describe): _____

<u>Please mark any of the behavioral eating disorder symptoms you have had in the past but are *not* currently experiencing:</u>

- ❑ Bingeing
- ❑ Purging via exercise
- ❑ Purging via vomiting
- ❑ Purging via laxatives
- ❑ Restricting food intake
- ❑ Guilt after eating
- ❑ Shame or embarrassment after bingeing/purging
- ❑ Excessive exercise
- ❑ Preoccupation with food or dieting

❑ Recent weight loss
❑ Other (please describe): _____

Please mark any psychological symptoms you are *currently* experiencing

❑ Perfectionism
❑ Feelings of inadequacy
❑ Fear of gaining weight
❑ Isolation
❑ Anxiety
❑ Social anxiety
❑ Depression
❑ Body dissatisfaction
❑ Difficulty expressing emotions
❑ Impulsivity
❑ Obsessive behaviors
❑ Other (please describe):
_____

Please mark any psychological symptoms you have had in the past but are *not* currently

experiencing: Perfectionism

❑ Feelings of inadequacy
❑ Fear of gaining weight
❑ Isolation
❑ Anxiety
❑ Social anxiety
❑ Depression
❑ Body dissatisfaction
❑ Difficulty expressing emotions
❑ Impulsivity
❑ Obsessive behaviors
❑ Other (please describe):
_____

Please indicate approximately how old you were when you first began engaging in eating

disordered behavior: _____

Appendix J

Interview Script

The purpose of this interview is to allow you to begin to reflect on your experience of living with

subclinical eating disorder symptoms and to begin to think about what, if anything, has helped

your current symptoms from getting worse. Remember there are no right or wrong answers

Overview

1. To start, can you tell me a little about the history of your eating disorder symptoms? When did you first notice them?

2. Do you have any ideas as to why these eating disorder symptoms developed for you? What was going on at that time in your life?

3. If you could use a metaphor to describe your experience of living with these symptoms, what would it be?

4. Eating disorders have a tendency to quietly get worse and worse. What do you think has helped you to avoid more serious measures when it comes to your eating disorder (hospitalization, a clinical diagnosis, etc.)?

5. How would you describe your current experience living with these eating disorder symptoms?

6. How big of an impact do your eating disorder symptoms have on your day to day life?

Connection and Social Support

1. Thinking back on the demographic survey you filled out, who do you identify as the most supportive people in your life and why?

2. In thinking about your relationship with that person, how would you describe your relationship overall? (Repeat as necessary depending on how many supportive people are identified)

3. How well do you and that person communicate?

4. If the eating disorder could tell us about the role it plays in your relationship, what if anything, do you think it would say?

5. What (if anything) are the eating disorder symptoms trying to tell this important person in your life?

6. In what ways (if any) is your relationship *helpful* as you deal with your eating disorder symptoms?

7. In what ways (if any) is your relationship(s) *unhelpful* as you deal with your eating disorder symptoms on a daily basis?

   * (Repeat questions 2-7 as necessary, depending on how many supportive people are identified)

8. How comfortable do you feel in going to others for support when you are struggling with the eating disorder symptoms?

Voice and Empowerment

1. Do you feel like you can speak up to people? What is it like for you?

2. How would you describe your ability to make decisions?

3. Which people in your life (particularly those identified in the demographic survey) do you find most helpful when you need to make important decisions? Least helpful?

4. When you are having a hard time with your eating disorder symptoms, how comfortable are you talking about it to others?

5. How much control do you feel you have over your life and the things you do on a daily basis?

6. How much control do you feel your eating disorder symptoms have over you (and vice versa)?

7. Think ahead a few years. What would your future self tell you regarding which voice to listen to, your own voice or your eating disorder's voice? Why do you think that is?

8. How involved have you been in seeking professional help or treatment for your eating disorder symptoms? Why or why not?

9. How important is community activism to you?

10. Currently or in the past, how involved have you been in activities that heighten awareness of the societal role in eating disorders? (I.e., Love your Body Day, Eating Disorder Awareness Month, feminist blogs)

Gender and Power Dynamics

1. Why do you think there are higher rates of females with eating disorders in our society compared to males?

2. How (if at all) do you think your gender influences how you feel about your body?

3. How (if at all) do you think your gender has influenced your development of eating disorder symptoms?

4. What difficulties (if any) have you have experienced in life as a result of being female?

5. What (if anything) do you enjoy most about identifying with the female gender?

6. What (if anything) do you find difficult about identifying with the female gender?

7. How would you define what makes up your own sense of worth?

8. How (if at all) do your appearance and weight status affect how you view yourself as a person?

9. How do you define your sense of worth outside of your physical appearance and weight status? What makes you worthy of love from others?

Appendix K

Data Collection and Compensation Forms

<u>DATA COLLECTION SESSION:</u>

Date: _____

Time: _____

With: _____

Start Time: _____   Finish Time: _____   TOTAL TIME: _____

<u>COMPENSATION:</u>

Participant:
     Date Sent: _____ Return Receipt Received: _____

<u>NOTES:</u>

Appendix L

Debriefing & Resource List

Thank you for taking the time to meet with me today. Sometimes, sharing and talking about your experience with your eating disorder symptoms may be difficult. It is normal to experience mixed emotions after talking about these things. We will be providing you with a resource list that you may find useful. If you are considering seeking an assessment for your symptoms, reputable treatment centers in the area are located under "Local Eating Disorder Resources." Even if you are on the fence about getting help or think your symptoms are not that bad, it's never too early to look into getting support.

Additionally, if you have any questions or would like to more information related to your participation in this project, please contact the co-investigator, Emily Haugen at hauge307@vt.edu or at 715.377.5192. If you have any questions regarding human subjects or the IRB at Virginia Tech, their contact information is on the copy of your consent form.

Thank you again for coming in and sharing your story with me. It was great meeting you.

EATING DISORDERS IN CONTEXT:
The Social, Relational and Political Context of Disordered Eating
RESOURCE LIST

Name	Description	Contact Info
Co-Investigator	Emily Haugen, MS, LMFT	hauge307@vt.edu 715-377-5192
Local Mental Health Resources		
Crisis Connection	Free 24-hour counseling hotline. Services are free and confidential	612-379-6363 866-379-6363 Crisis.org
COPE	Hennepin County mobile crisis team. Mental health emergencies, both hotline and home visits	612-596-1223 715-377-5192
Lutheran Social Services	In-home mental health services, job placement, emergency shelters, accepts insurance	Locations across the metro area 888-881-8261 www.lssmn.org
Walk-In Counseling Center	Mental health counseling, no appointments necessary	2421 Chicago Avenue S 612-870-0565 www.walkin.org
Local Eating Disorder Resources		
The Emily Program	"Real help for eating disorders." Offers outpatient, intensive outpatient, day treatment and residential care.	888-364-5977 Locations in Duluth, Minneapolis, St. Louis Park, St. Paul and Woodbury www.emilyprogram.com
Melrose Center	"Melrose heals eating disorders." Offers outpatient, intensive outpatient, partial hospitalization, residential and specialty care.	952-993-6200 Locations in Maple Grove, St. Louis Park and St. Paul http://www.parknicollet.com/SpecialtyCenters/Melrose-Center
COR Retreat Inc	COR Retreat: A food recovery program, 12 step program, spiritual healing, offers intensive outpatient care and week/end long retreats	612-669-6110 1221 Wayzata Blvd. East Wayzata, Minnesota 55391 http://cormn.org/
Water's Edge Counseling and Healing Center (WECHC)	"A team of multidisciplinary professionals committed to walking with individuals on a journey of healing." Offers outpatient, intensive outpatient, nutrition based counseling and Christian based therapy	952-898-5020 1755 Southcross Drive West Burnsville, MN 55306 www.watersedgechc.com Info@watersedgechc.com
National Eating Disorder Resources		
National Eating Disorder Association (NEDA)	The leading 501 (c)(3) non-profit organization in the United States advocating on behalf of and supporting individuals and families affected by eating disorders.	Helpline: 800-931-2237 New York, NY http://www.nationaleatingdisorders.org/

	The most comprehensive list of national and international resources for eating disorder is located on their website: www.nationaleatingdisorders.org/resource-links	info@myneda.org
The Academy for Eating Disorders	A global professional association committed to leadership in eating disorders research, education, treatment, and prevention.	847-498-4274 Deerfield, IL www.aedweb.org info@aedweb.org
Multi-service Eating Disorders Association Inc. (MEDA)	A nonprofit organization that provides early detection, education, and recovery assistance to prevent and treat eating disorders	866.343-MEDA 617-558-1881 Newtonville, MA www.medainc.org info@medainc.org
Eating Disorders Coalition	Working to increase awareness, educate policymakers, and promote understanding about the disabling and life-threatening effects of eating disorders. Our mission is to advance the federal recognition of eating disorders as a public health priority	202-543-9570 Washington, DC www.eatingdisorderscoalition.org
The Marginalized Voices Project	A collaboration between the National Eating Disorders Association and feminist activist and editor of Everyday Feminism, Melissa A. Fabello. Calling for stories that focus on underrepresented experiences and communities in order to create a platform for people to share what it means to suffer (and recover) from an eating disorder	https://www.nationaleatingdisorders.org/marginalized-voices

Appendix M

Recruitment Letter - Focus Group

(Contact script for Potential Therapist Participants)

I will cut and paste this into an email or letter or use this as a script if I talk with the person on the phone or in person. I will personalize this information if it is someone I know or have a connection to.

Dear _____,

Hello, my name is Emily Haugen. I'm a doctoral student at Virginia Tech in the Marriage & Family Therapy Ph.D. program. I would like to tell you about my dissertation research study and ask for your help. I am looking at the experiences of young women with subclinical eating disorder symptoms. So far, I have interviewed [#] women between the ages of 18-25. I have analyzed their interviews and developed a model of feminist-informed protective factors for women at risk for disordered eating and what might mitigate the process of developing a clinical eating disorder. The next step in my study is to conduct a focus group. That is, I plan to do a group interview with a sample of therapists who specialize in working with young women who are at risk for disordered eating. The primary purpose of this focus group is to allow you to share your expertise in working with women at risk for eating disorders as it pertains to the findings of my study. Your input on my emerging model will help me understand if my results are consistent with the population it is intended to apply.

I am contacting you because you have been identified by [name] as someone who might be eligible to participate. To participate in the focus group, you must:

1. Hold a license recognized by the Minnesota Board of Marriage and Family Therapy, Licensed Professional Counseling, Psychology or Social Work.
2. Have at least 3 years of experience treating women ages 18-24 who are at risk for disordered eating
3. Your professional work with this population should have been conducted at an eating disorder specific treatment center.

If you meet these criteria, would you consider participating in this focus group? The focus group will be approximately 2 hours long and include 6-8 mental health professionals. The group will be held in person at The Emily Program adolescent facility, 2230 Como Ave. St. Paul MN, 55108. Once all participants are identified, we will schedule a date and time that is most convenient for everyone. During the focus group, you will have an opportunity to share your perspective on aspects of feminist theory might serve as protective mechanisms for women at risk for disordered eating. In addition, I would like to hear your response to my findings. Additionally, I would like your input on how my findings might be relevant to your work with this population. You will also be entered into a drawing to win one of three $25 Target gift cards.

Please respond to this email to let me know whether or not you are interested in participating in this focus group. I'll call you in the next few days to follow up on this email [or other kind of contact].

This study has been approved by the Virginia Tech Institutional Review Board. If you have any questions about this study, please contact me through email at hauge307@vt.edu or by phone at (715) 377-5192. You may also contact my research advisor and co-investigator, Dr. Dolbin-MacNab by email at mdolbinm@vt.edu or by phone at (540) 231-6807. In addition, I have attached a copy of the Virginia Tech Institutional Review Board approval letter for your review.

Thank you for your consideration and I look forward to hearing back from you.

Sincerely,

Emily Haugen, MS, LMFT
Doctoral Candidate, Department of Human Development
Virginia Tech
715-377-5192
Hauge307@vt.edu

Appendix N

Eligibility Checklist & Tracking Form
Focus Group

PARTICIPANT NAME: _____

ADDRESS: _____

               _____

               _____

PHONE: _____

EMAIL: _____

PREFERRED METHOD OF CONTACT: _____

****

HOW DID THE PARTICIPANT LEARN ABOUT THE STUDY?

INCLUSION CRITERIA

   19. Do you hold a professional license in the state of Minnesota? Yes/No

   20. Is your license affiliated with one or more of the following boards? Circle all that apply

        c. Minnesota board of Marriage and Family Therapy

        d. Minnesota Board of Behavioral Health (Licensed Professional Clinical

            Counselor)

        e. Minnesota Board of Social Work

        f. Minnesota Board of Psychology

   21. Number of years doing therapy with women ages 18-24 who are at risk for eating

        disorders: _____

22. To ensure your specialization, does the therapy you conduct with these young women

 take place in an eating disorder specific treatment center?

    a. Yes

        i. If so, which center? _____

    b. No

23. Agrees to participate in a focus group lasting approximately 2 hours: Yes/No

<u>VERIFY THE INCLUSION CRITERIA:</u>
(Check the box to indicate that you have verified this information with the participant)

❑ Licensed as an LMFT, LPCC, LP or LICSW in the State of Minnesota

❑ Three or more years working with women at risk for eating disorders

❑ At least 3 years of professional work has taken place in an eating disorder specific treatment center

❑ Agrees to participate in a focus group lasting 2 hours

❑ The participant has given you their preferred method of contact

<u>PLEASE RECORD *EVERY* CONTACT WITH THE PARTICIPANT:</u>

DATE	NATURE OF CONTACT & ACTION TAKEN/NEEDED	INITIALS

Appendix O

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Consent for Participants
in Research Projects Involving Human Subjects

Title of Project: Eating Disorders in Context - The Social, Relational and Political Aspects of Disordered Eating

Co-Investigator: Emily Haugen, MS, LAMFT, Doctoral Candidate
Principal Investigator and Dissertation Chair: Megan Dolbin-MacNab, PhD, LMFT

Please consider the information carefully. Feel free to ask questions before making your decision whether or not to participate. If you decide to participate, you will be asked to sign this form and will receive a copy of the form.

I. Purpose of this Research Project

Little is known regarding subclinical eating disorder symptoms in terms of why some people overcome these, while others stay the same or move into clinical symptomology. This study seeks to develop this understanding using feminist theory to examine aspects of the social, relational and political contexts of our lives as potential protective factors for those with subclinical eating disorder symptoms. During the initial stages of the project the co-investigator interviewed 20 women ages 18-24 regarding social support, voice, agency, culture and other constructs. The purpose of this focus group is for mental health professionals who work with young women at risk for clinical eating disorders to review and discuss the findings of this study. Approximately 6-8 mental health professionals will participate. Results will be used for a dissertation project, publication, professional presentations, and to inform other research and prevention efforts.

II. Procedures

If you agree to participate, we will schedule a focus group with approximately 6 to 8 professionals who specialize in working with women at risk for eating disorders and those with clinical diagnoses. Upon arrival to the focus group, you will complete a brief demographic survey. The focus group discussion will involve participants' feedback on the results of my study, and the emerging theoretical model of protective factors for eating disorders. The focus group will be recorded with a digital audio recorder, and will take approximately 2 hours. After the focus group, the audio will be transcribed and identifying information will be removed.

III. Risks

Your participation in this research carries no unanticipated risks or benefits beyond what can be expected from normal daily conversation about your professional role as someone who treats those who live with eating disorders. Your participation is strictly voluntary. You may choose not to answer any question(s) and you may terminate participation at any time.

IV. Benefits

No promise or guarantee of benefits has been made to encourage you to participate. However, you may find yourself experiencing positive feelings from having the opportunity to share your thoughts and experiences regarding potential protective factors for women at risk for disordered eating. Your input on my emerging theoretical model will help me understand if my results are consistent with the population it is intended to apply. These results can then be utilized in treatment and prevention efforts for eating disorders. You may feel positive knowing that you have contributed to the common good by advancing research.

V. Extent of Anonymity and Confidentiality

The focus group will be audio-recorded and then transcribed. These recordings and all information collected during this study will be stored on a secure computer or in a locked file cabinet in a locked office. Only members of the research team will be able to open the file cabinet. These audio-recordings will be destroyed after they have been transcribed. The researcher may hire someone to help with the transcription. This person will sign a confidentiality agreement and will not have access to any of your personal information. When the study is over, the demographic surveys and other forms will be destroyed. A database containing only your answers and the transcripts will be kept for future use. Only the research investigators and undergraduate research assistants can use this database.

The research investigator may include quotes from the focus group in the results of the study. If needed, the researcher will change these quotes enough so that no one can identify you by reading the quote. What you say will never be linked to your identity.

Every effort will be made to keep your study-related information confidential. However, there may be circumstances where this information must be released. Personal information regarding your participation in this study may be disclosed if you indicate an immediate threat to harm yourself or someone specific, or there is physical or sexual abuse of a minor. The appropriate authorities (e.g. local police or emergency department, children's services) will be contacted by the researchers.

Your records may be reviewed by the following groups (as applicable to the research): Office for Human Research Protections or other federal, state, or international regulatory agencies; The Virginia Tech Institutional Review Board or Office of Responsible Research Practices. The Virginia Tech (VT) Institutional Review Board (IRB) may view the study's data for auditing purposes. The IRB is responsible for the oversight of the protection of human subjects involved in research.

VI. Compensation

Participants will be entered in a drawing to win one of three $25 Target gift cards. The odds of winning are approximately 40%

VII. Freedom to Withdraw

You are free to leave this study at any time without penalty or loss of incentive. You do not have answer any questions that you do not want. If you withdraw or stop participating, you will still receive the compensation described above. There may be situations where the investigator may determine that a participant should not continue with the project. In those circumstances, you will still receive the compensation described above.

VIII. Subject's Responsibilities

I voluntarily agree to participate in this study. I have the following responsibilities:
1. Attend a 2-hour focus group and fill out a short demographic survey.
2. Answer questions if I feel comfortable.
3. Respectfully listen when other participants are speaking.
4. Keep everything discussed during the focus group confidential.
5. Keep the identities of the participants in the focus group confidential.
6. Let the researcher know if I have any questions related to participating in this study

IX. Questions or Concerns

Should you have any questions about this study, you may contact one of the research investigators via the contact information below:

Emily Haugen, Co-Investigator   Phone: 715-377-5192
Doctoral Candidate Department of Human Development   Email: hauge307@vt.edu
Virginia Polytechnic Institute and State University
2230 Como Ave
St. Paul, MN 55108

Megan Dolbin-MacNab, Principal Investigator   Phone: 540-231-6807
Associate Professor, Department of Human Development   Email: mdolbinm@vt.edu
Virginia Polytechnic Institute & State University
Blacksburg, VA 24061

Should you have any questions or concerns about the study's conduct or your rights as a research subject, or need to report a research-related injury or event, you may contact the VT IRB Chair, Dr. David M. Moore at moored@vt.edu or (540) 231-4991.

X. Subject's Consent

I have read (or someone has read to me) this form. I have had a chance to ask questions before making up my mind. I want to be in this research study.

 Participant

_____   _____

Printed name of participant   **Signature of participant**

_____
Date

Research Investigator

I have explained the research to the participant before requesting the signature above. There are no blanks in this document. A copy of this form has been given to the participant or his/her representative.

_____   _____
Printed name of research investigator   **Signature of research investigator**

_____
Date

Appendix P

Focus Group Guide

<u>Welcome</u>

1. Introduce myself and the topic
2. Explain why the participants were selected
3. Explain how the results will be utilized
4. Pass out the results of the study including the themes and theoretical model that emerged

"Thank you for agreeing to participate in this focus group. My name is Emily Haugen and I am a doctoral candidate at Virginia Tech, as well as a therapist at the Emily Program in St. Paul, specializing in working with adolescents with eating disorders. My dissertation research focuses on aspects of feminism that might protect young women from developing clinically significant eating disorders. I have already interviewed (xx) number of young women with subclinical eating disorders to develop a feminist-informed theoretical framework to explain protective factors for eating disorders. You were selected for this focus group because you hold a mental health license in the state of Minnesota, and have at least three years of specialized experience working with individuals with eating disorders. The primary purpose of this focus group is to allow you to share your expertise in working with women at risk for eating disorders as it pertains to the findings of my study. Your input on my emerging model will help me understand if my results are consistent with the population it is intended to apply."

<u>Guidelines</u>

1. Review Confidentiality
2. No right or wrong answers, only differing points of view
3. Reminder that the facilitator will keep the discussion moving
4. Talk to one another
5. We are on a first name basis

"Anything discussed in the focus group today should remain confidential. Additionally, the interviews which informed this model have been de-identified, but as a reminder, please keep the stories shared by participants confidential. There are no right or wrong answers, and I encourage everyone to share their point of view. Please talk to one another, and as the facilitator I will ensure that the discussion keeps moving so we get through all the questions in a timely manner. Please let me know if you have questions at any time."

<u>Beginning the Discussion:</u>

"Please take a few moments to read over the results of this study. After you finish, I will facilitate a discussion about your reaction to these results."

1. What are your thoughts and feelings about the themes that emerged from the study?

    a. Which themes do you agree with? Why?

    b. Which themes do you disagree with? Why?

      c.   Which themes (if any) were surprising? Why?

2. What are your thoughts and feelings about the theoretical model that emerged from the study?

      a.   What is not in the findings that you thought would be?

      b.   Were there aspects of the model you found confusing or unclear?

3. How do my findings fit with what you see in your treatment of young women who are at risk for disordered eating but may not yet have a clinical diagnosis?

      a.   What aspects of the model resonated with your own clinical experience? Why?

      b.   What aspects of the model did not resonate with your clinical experience? Why?

      c.   Is there anything you would change or add to the model based on your own clinical experience?

      d.   How (if at all) would you see yourself utilizing the results of this model in your own clinical work?

4. Is there anything else you would like me to know or consider as I finalize the results of this study?

"Thank you for your participation in the focus group today. I appreciate you taking the time to add your input and expertise to this project. Your feedback will be invaluable. We will wrap things up with the drawing for the Target gift cards."

Appendix Q

Focus Group Analysis

After completion of the interviews and formulation of the grounded theory model, a focus group was held to discuss the results with clinicians. The group consisted of six therapists with specialized training in eating disorders. The clinicians had, on average, 7.75 years of experience working with individuals with eating disorders. The clinicians provided insights into the applicability of the model and their own experiences working with women at risk for eating disorders. The following information was taken from the transcript of the focus group and separated into themes based on the discussion.

Group Discussion and Themes

Separation of Self from the ED

- Egosyntonic vs. ego dystonic experience: syntonic – no separation from ED, no sense of it/maybe never have versus dystonic – the verbiage that I can separate myself from the ED. How does this play out in relationships? E.g. someone who may be experiencing symptoms and in denial then hears someone else speak of their struggle and relates
- The power of Jenny Schafer's book *Life without ED*, powerful because it was a way to explain the differentiation between sense of self versus the eating disorder self
- What role does having a more solid sense of identity play? The ED gives them that sense. I wonder how those things connect when it comes to people not acting in accordance with values and beliefs when they are holding onto the idea that the ED gives me a voice or allows me to feel confident, etc.

Subclinical Eating Disorders

- The hierarchy is interesting. Many clinical clients don't think they are "sick enough" and in the study, subclinical thought "mine isn't that bad" or "as bad as someone else".
- What about differentiation, sense of self and how the eating disorder does that for you. With subclinical people, maybe there is still that aspect of "the ED makes me feel different" but isn't quite as severe.
- We know about the clinical population, we know about normative discontent; but you are showing the spectrum of voices in turmoil and what that sounds like. Everyone needs to understand this better
- It is always interesting to talk to young women who have a parent (female, often mom) with an ED who might fall into subclinical category. For the subclinical group, how many of them have family members with an ED?

Implications for Clinicians

- Whatever these themes are, they will apply to not only subclinical but even people who are clinically diagnosed.
- More education around subclinical eating disorders gives a non-ED therapist the confidence to work with a subclinical person.
- Remind clinician's that eating disorders aren't about food; this is the stuff we're trained to work with, what's underneath the behavior? We see so many new clinicians coming in who "don't know how to do this" – but they do, it's therapy.
- The more our work looks medical/specialized, the more we feel incompetent as generalists; if the insurance companies are driving this, this could be good information for them to save money, to work with the subclinical.

Early Intervention Work

- Early onset work in the primary healthcare centers, this kind of information would be helpful for screening and prevention in the primary healthcare places, as that is one place that people do come.
- This is the type of thing that is helpful in health classes, med schools, gym teachers, coaches, guidance counselors to have an understanding for the things for red-flags.
- Group thought: our society, we operate in 2 ways, reactive and extreme. This could be a good way for anyone in the health field to move, to be proactive, to not have to think in extremes e.g. well because I dropped X amount of weight or now I'm X and overweight and medically compromised, we don't need to wait that long
- Non-profit outreach prevention organizations to provide early screenings for other mental health professionals and those who treat adolescents adolescent (coaches, doctors counselors).
- Early intervention projects happening currently - how do you change family cultures and school cultures starting as early as preschool and kindergarten.
- Is this that different than subclinical depression, anxiety, etc.? Will help to destigmatize mental health, the earlier we see it, the earlier we treat it.

Cultural Considerations

- Curiosity about sample, homogeneous in terms of race – include this in results.
- Consider the cultural impact. In which cultures is the community more important than the individual? How does this filter into the conversation about being accepting of or open to the idea of separating yourself from the ED or is that not culturally something you would do?
- Consider how externalization plays out in other cultures. One therapist mentioned a client from another culture, when parents heard the language of "ED voice" parents took client to get an exorcism.

- Handful of Hispanic clients whose parents are from Mexico and children are raised in USA; the translation for parents to understand the concept of "externalizing" the ED from the self was difficult. Not only a language barrier but a cultural difference too.

Appendix R

Sample Voice Memo

I: This is a voice memo for participant 13, I did the interview on September 24th. This was a good interview; she was very bright so it was just nice to talk with her about some of these big theoretical things around eating disorders, society and gender and all of that. It was hard because she does still seem very sick in a way. And I don't mean that in a pathologizing way, just that her eating disorder symptoms seem very strong and so it was hard sometimes not to go into you know, into therapy mode and that. So, I want to be mindful of that as I'm coding.

Um, themes that are becoming prevalent, hearing that there are more important things...like when I ask them why they have not slipped into a clinical eating disorder. I've heard as a theme that there are more important things in life than the eating disorder. And if they were to continue restricting, they wouldn't have the cognitive capacity to keep up with the demands of life.

And also, the impact on friendships and going out with friends is social, you go to restaurants, you go and eat food. And so, this participant and others are saying, you know, "I'm choosing those friendships over the eating disorder."

Um, definitely was the theme again, which I think I found in many of the interviews, is protecting their symptoms. But with the most emotionally supportive person they can be 100% open about the eating disorder and then it goes down from there. And then with most other people in her life, just not open about the subject at all.

Um, some resistance to getting treatment. And I'm not sure what that was about, but she said she "doesn't even want to go there" with that subject. Whereas other participants have considered it, she won't even wrap her mind around it, which is consistent potentially with her eating disorder symptoms being very strong, preventing her from considering help.

I wonder if there was anything else? This participant did say that, as the one before, that it was...when I asked about what makes her worthy of love, she said "Being a person." And that felt really powerful. She said in the interview, just when we're in a society that we need to do things, we need to earn things...earn respect and earn love and earn money and we forget that just being human is what makes us worthy of love. We don't need to earn it. And so, that was really nice and refreshing to hear.

And she also said that she was moved from just kind of existing and being in her eating disorder to actively participating in her life. And that was an interesting way to frame that and I want to kind of think about that as I'm coding these interviews of these women as...because many of them have had a period of time where their eating disorder was so strong and then they moved out of it, which is consistent with this person. Her symptoms seem strong but not as strong as before, which makes sense given her subclinical status. And so, thinking about it as now, while they are all still struggling, they are being intentional to actively engage in life. So, alright that's it for that one.

Appendix S

Eating Disorders in Context
TRANSCRIPTION PROTOCOL

Before Transcribing

1. Formatting: *(open an existing transcript and **Save As** for easy formatting…or see below)*
   a. Use Arial font and 12 point font size.
   b. In the **Header**, type in:

ED CONTEXT   Interview   4/2/2016
                              Page #

2. After the preceding information has been typed, type the following information with the date and appropriate initials: (I) = Interviewer's initials and date;
                              (T) = Transcriber's initials and date completed;
                              (C) = Checker's initials and date completed;
                              (N) = NVivo ready and date. For example:

(I) – April 2, 2016 (ECH)
(T) – April 6, 2010 (XX)
(C) – April 7, 2010 (XX)
(N) – April 10, 2010 (XX)

3. Insert the participant number before typing the transcript:

   P01

While Transcribing

1. To indicate who is speaking, type "**I**" for the interviewer and "**P**" for the interviewee. Tab after the speaker's "initial."

2. When interviewees reference other people's names, type in __(name)__. When interviewees reference places that may identify them, type in __(city)__ or __(county)__.

3. Use two spaces at the end of each sentence (adjust settings in Word so it will automatically do this).

4. Single-space each person's response. Do not indent or use tabs, unless the person talking has switched.

5. Separate each person or "turn take" with two hard returns (creating one full space between speakers).

6. Codes: Use a comma   **,**   for a short pause or short non-verbal hesitancy
          Use three dots **…** for a longer and more pronounced pause

Use parenthesis for non-verbals, like laughter, crying, etc.: (laughs)
Use brackets   [ ]   for modified words and phrases to protect confidentiality
Use less- & greater-than-signs for incomprehensible words or phrases: <inc>
Use dashes for interruptions. For example:

P: I don't know that she really had a reaction. She was more -

I: No reaction at all?

P: - worried about me than she was about herself. Yeah, she didn't cry or anything. That was kinda good. I needed her to be strong.

7. Separate each section of the interview with bolded headers. It should be obvious based on the interviewer's question when the interview is moving into a new section:

   1. Overview
   2. Connection & Social Support
   3. Voice & Empowerment
   4. Gender & Power Dynamics

Saving and Filing

1. Save your transcribed data on the research flashdrive under the folder "Data." Name your files using **Participant Number** (e.g. P01) and indicate if the transcript is incomplete. For example, **P01 incomplete**. Once the transcript is completed, change the name to **P01**.

2. After you have completed the entire transcription:

   - Be sure that all identifying information has been de-identified (e.g. cities, specific places, unique names, etc) correctly using [modified].
   - On the first page of the transcription, note the date of completion and your initials, as already described earlier. For example: (T) – November 3, 2010 (RSC)
   - Check to make sure the file name has been changed to indicate it is complete.
   - On the participant folder, mark the date that the interview was transcribed once completed and include your initials.

3. After the transcription has been listened to by a third party and the Check is complete:

   - Be sure that all identifying information has been de-identified (e.g. cities, specific places, unique names, etc) correctly using either underlined or [modified].
   - On the first page of the transcription, note the date of double-check and your initials. For example: (C) – December 7, 2010 (MM)
   - On the participant envelope cover, mark the date that the interview was checked once completed and include your initials.

4. After the transcription is finished and checked, it is ready to be made NVivo prepared:

- On the first page of the transcription, note the date of NVivo preparation and your initials. For example: (N) – December 7, 2010 (TLM)

Appendix T

Reflexivity Statement

Throughout the interview process, it is understood that I will be co-constructing the participants' stories through the questions I ask. During this reciprocal process, I bring in my own biases and personal experiences (Charmaz, 2008). Reflexivity involves the researcher's scrutiny of his or her experience, decisions and interpretations in ways that bring the researcher into the process and allow the reader to assess how and to what extent the researcher's interests, positions and assumptions influenced the inquiry. By definition, "a reflexive stance informs how the researcher conducts his or her research, relates to the research participants, and represents them in written reports" (Charmaz, 2006, p. 188-189). Prior to beginning my data collection, I wrote a reflexivity statement, as I am researching a topic that is important to me from both a personal and professional perspective. The reflexivity statement allowed me to identify potential biases that I had. To address these biases, this statement was also used to inform my memo writing throughout the data analysis process (Charmaz, 2006). These approaches enhanced credibility, as I was able to keep my experiences separate from those of the participants. Thus, the data was more accurately drawn from my sample.

Personal Narrative

In staying consistent with my approach to academic writing, and the importance of reflexivity in feminist methodology, I will take this opportunity to acknowledge my social location. My worldview is shaped by my social location as a Caucasian, heterosexual, female, middle-class graduate student who is non-disabled but has a history of mental health issues. For the purposes of this project specifically, it is important to acknowledge that I emphasize

philosophies rooted in feminism, social justice, and symbolic interactionism in my work. I also identify as a feminist scholar with a history of an eating disorder.

In addition to my social location, this narrative involves both personal and professional experience with eating disorders. When I look back on my childhood, I remember a quirky but confident child who was okay with being different. My father nicknamed me "Sparkle" as a toddler because my eyes would shine when I was happy or when I was up to mischief. As I transitioned into adolescence, my sparkle seemed to dull. Somewhere between the ages of 11 and 15, I became insecure, unsure, withdrawn and frightened. I was terrified of what others thought of me and I had no faith in my abilities as a student, friend, and daughter. I was at war with myself, or as I see it now, my eating disorder had a tight grasp on my personhood. I found comfort in exercising and purging to fill the void that I was convinced was created by my imperfections. I spent most of high school in and out of treatment for my eating disorder. There were various doctors, nutritionists and therapists who helped me during this time, but the most significant experience was family therapy.

I have now spent years pulling apart the layers of my life to understand why I might have gravitated towards an eating disorder and how I was able to recover. The history of my experience is shaped by a genetic predisposition to anxiety, particular family dynamics, and societal standards of beauty, which equate thinness with control and success. My experience now shapes my identity as a family therapist and researcher, working to uncover the ways that families may contribute to mental illness but, more importantly, how they help sustain recovery. This experience has helped me understand my own family of origin, and brought me closer to the family members who believed I could recover during the times that I did not. My experience now shapes my identity as a feminist activist, raising consciousness about the ways that societal

expectations of women reinforce internalization of the thin ideal and other limiting ideals. My experience now shapes my identity as an aunt to five beautiful nieces, pouring my efforts into research and activism to create a world where my nieces can continue to be the quirky and confident young girls that they are. My hope is that society never dulls the sparkle that I see in them.

This curiosity to understand how I overcame an eating disorder, as well as the importance of my own family in my recovery, led me to a master's in marriage and family therapy. I chose a master's program rooted in feminist and social justice principles because of the liberal values within my family, as well as my college involvement in LGBTQ+ activism and the student democrats club. During graduate school, I immersed myself in feminist theory and read as many feminist interpretations of eating disorders as I could. I was enthralled with the explanations of the role of society and the use of the protest metaphor, describing starving women as a product of gender oppression. As a family therapist, I gravitated towards these explanations because it helped me understand how some of the destructive behaviors (e.g., violence, substance abuse) expressed by my clients were an unhealthy vocalization of the injustice they had experienced in life. Additionally, I now had a better framework for my own experience. I realized that, during the times I struggled the most with my eating disorder, I was in relationships and environments in which I literally and metaphorically felt that I could not use my voice. It is also important to acknowledge that I have graduate training in narrative therapy. While I incorporate other theoretical perspectives and interventions, narrative therapy is the primary lens in which I conceptualize clinical issues.

Reflection on Biases

By writing this narrative, I identified several biases that I have related to the importance of family support systems, feminist theory, and the connection between voice and eating disorders. First, due to my experience in family therapy, the importance of my own family in my recovery, and my training as a family therapist, I have an obvious bias regarding the importance of family support and connection to overcome an eating disorder. I currently work in a treatment center for adolescents and families with eating disorders. This work reinforces the importance of the family system in overcoming an eating disorder, an assumption that I share. This has likely informed the theoretical conceptualization of my study by examining support and connection as protective factors for those at risk for disordered eating. Additionally, I was fortunate enough to have a family who understood my struggles and worked to help me through treatment. Although my analytical framework is strengths-based, it will be important to remember that not everyone who struggles with eating disorder symptoms has the positive support that I received. It is possible that individuals with very limited social support might mitigate symptom development using other factors. I will need to ensure that I am spending the same amount of time discussing and analyzing factors related to voice, empowerment and activism as I am exploring social support. Additionally, I will want to keep an open mind for social support that is not simply defined by biological family.

Second, my training in a feminist and social justice-informed master's program, which emphasized narrative therapy, uniquely shapes my stance on the importance of feminist methodology. It is important to acknowledge the feminist values which guide my work and my conceptualization of this project. These include reciprocity, equality, engagement, empathy, and activism (Huisman, 2008). In writing my narrative, it became apparent that feminist theory was an important way for me to understand what I had been through, and paved the way for my

conceptualization of the etiology of "problematic behavior" that brings clients to therapy. It is possible that the emphasis I place on understanding the role of society could blind me to other explanations of how individuals have managed to not develop a clinical eating disorder. Before I wrote this narrative, I had not realized just how important feminism and activism were as I reached the final stages of eating disorder recovery. It will be important to remember that these participants are not in recovery from a clinical disorder, and there are many paths to overcoming eating disorder symptoms. My "lifeboat" was feminism, but that might not be the case for my participants. I will want to stay open to the idea that other factors beyond voice, empowerment and activism may help individuals mitigate eating disorder development. Additionally, due to my extensive training in narrative therapy and emphasis on this approach in my clinical work, it is possible that this lens could shape and basis some of the interview questions and themes. I will want to be particularly mindful of this as I analyze the findings.

I also have a clear bias regarding the importance of regaining one's voice during eating disorder recovery. It is possible that the metaphor of "loss of voice" may probe me to ask questions that assume my participants are unable to vocalize their needs or feel a lot of injustice related to their current circumstances. I will need to stay mindful that this study is focused on protective factors, and therefore, my interview questions tap into the participant's experience of using their voice and feeling empowered. As I collect and analyze my data, I will return to this reflexivity statement as I write memos to ensure that my findings pertain to the lives of the participants, and are not simply an extension of my own biases and experiences.

Appendix U

Example of Open Coding

Open Coding Basics

- Breaking the data up into their component parts or properties
- Defining the actions on which they rest
- Looking for tacit assumptions
- Explicating implicit actions and meanings
- Crystallizing the significance of the points
- Comparing data with data
- Identifying gaps in the data

Questions to consider with open coding

- What process(es) is at issue here? How can I define it?
- How does this process develop?
- How does the research participant act while involved in this process?
- What does the research participant profess to think and feel while involved in this process? What might his or her observed behavior indicate?
- When why and how does the process change?
- What are the consequences of the process?

Theoretical sampling – Questions were incorporated into the interviews after finding these themes in the initial data

- Protecting symptoms
- Percentage of self-worth that is you versus the ED
- ED as a distinct voice
- Calorie counting as a way that ED symptoms start
- Restaurants and social activities that challenge the ED
- Thinness as a marker of self-worth

The open codes in the table below were taken from the following interview questions based on the sensitizing concepts of gender and power:

- Why are there higher rates of EDs in women compared to men?
- Gender and your own ED development
- Difficulties experienced due to being female
- What do you enjoy most about identifying as female?
- What do you dislike about identifying as female?

Open Code + Page # + Participant	Sensitizing Concept	Quote
- Participant has received the message from society says men should be tough and women should be thin P1 P#41 P2 P#69 P8 P#45 P7 P#53 P4 P#73 P6 P#37	Gender & Power Dynamics – *Higher rates of EDs in women:* Message from society says men should be tough and women should be thin	P. 41 - …For guys I think it's much harder cause like you're supposed to have a tough body, and I think for girls it's just like you're supposed to be thinner, so like that's where it comes from I: So the main message that women get is related to their thinness?
- Internalizing messages from society as a part of ED development for females P10 P#33 P8 P#44 P7 P#54 P4 P#73 P6 P#40	Gender & Power Dynamics – *Gender and ED development:* Internalizing messages from society as a part of ED development for females	P. 44 - P: Yeah, I think that part of it is just like we talk about it more, which I kind of said before, something that's just so common in conversation. But I think hearing other people complain about other aspects of their body makes me like judge my own a little bit more. I feel like we just do internalize it like throughout a conversation that's negative, you're like thinking about all the negative things about yourself while someone else is talking, too, and I feel like it's just—I don't know.
- Women are looked down on for being more emotional P10 P#55 P8 P#45-46 P6 P#38	Gender & Power Dynamics – *Difficulties experienced due to being female:* Women are looked down on for being more emotional	P. 45-46 – P: I feel like I've been less likely to go to people with an issue because they think of me as emotional because I'm a girl. And so I think that that's hard because there's this stigma that women are weak and emotional and not put together and so I think part of the reason I don't want to go to somebody is that I want to show them that I'm put together and II can handle it on my own.
- Enjoys feeling accomplished as a woman because getting an education and working were historically difficult for women (exciting time to be a woman) P1 P#47-48	Gender & Power Dynamics – *Enjoy about identifying as female:* Feeling accomplished as a woman because getting an education and working were historically difficult for women	P. 47-48 – P: Um, and I also just think that like, it's nice to be like, "I am, like I am a woman and I'm making a difference, and I'm getting a job" like I feel more accomplished I would say I: Empowering? P: Yeah and I think that guys don't necessarily get the empowerment that women do. So I think that's cool. Yeah, like no matter what your

P8 P#47 P7 P#58		choices are, if you like doing it, they're like, "Good for you." I'm like, "Thank you."
- Feeling pressure to always look nice (wear makeup, not look sloppy, etc.) P2 P#74 P6 P#41 P9 P#46	Gender & Power Dynamics – *Dislike about identifying as female:* Feeling pressure to always look nice (wear makeup, not look sloppy, etc.)	P. 74 - P: Yeah, I guess like kind of on the flip side of expressing femininity on like days where I don't really feel like I -- like I don't feel like I want to put on makeup or, you know, look nice, I feel that pressure of like, oh, I'm gonna look sloppy if I don't put on makeup -- or if I'm not wearing like "real clothes" or, um -- and -- yeah, I don't know, I think that is kind of a like masculine/feminine thing.

Note. Only one quote is included with each open code. In the original document, multiple quotes were included for each open code. Additionally, for the purposes of this example, only one open code and sensitizing concept are provided for each question.

Appendix V

Example Focused Coding

Peer Debriefing:

- Agree with symptom development codes based on her clinical experience
- Feels they will always struggle with this: Feels more like ED – clinical level way of thinking. How is it impacting their daily life. LOOK AT QUOTES to see their framework
- ED as a way to seek validation and be noticed, someone pay attention here – true to her clinical experience
- Participant states firm approach was helpful in hindsight: Doesn't happen as much in clinical ED – that firmness is helpful – not the norm
- Consider as a whole: It's not the characteristics of the person but what happens between the participant and emotional support person that makes a difference (relational)

Focused Coding: As you raise a code to a category, you want to (Charmaz, 2000):

- Define the category
- Explicate the properties of the category
- Specify the conditions under which the category arises, is maintained and changes
- Describes its consequences
- Show how this category relates to other categories

Linking of categories to form a theory thus far: ED symptoms → ED as separate from the participant → ED symptoms impact relationships → Relational or feminist protective factors decrease the ED → Participant moves towards preferred self

The codes in the table below show the collapsing of open codes into more specific focused codes, which eventually became themes

Gender as a Protective factor (Eventual Theme)

Focused Code	Open codes collapsed together	Participant, Page #, Subtheme
Enjoys being female because there is flexibility	- Enjoys being female because there is flexibility in how you present yourself (dress, act, etc.) - Enjoys being female because there is flexibility in roles – can engage in "nontraditional" feminine activities (being loud, non-submissive) and feminine activities (care giving) - More acceptable to be a tomboy female in society than to be a girly male	**In how you present yourself** 5 **In your roles** 3

Participant enjoys expressing her femininity in the clothes and makeup she wears	**-** Expressing her femininity in the clothes and makeup she wears	6
Enjoys deep and meaningful relationships, more acceptable as a woman	- Ability to form deep and meaningful relationships - Enjoys female relationships and friendships	3
Exciting time to be a woman	- Enjoys feeling accomplished as a woman because getting an education and working were historically difficult for women (exciting time to be a woman)	**Feels accomplished because school and working were historical struggles for women, something they fought for** 6 **Empowering time to be a female** 4
Sense of self-worth outside of appearance	- Participant finds self-worth outsider her appearance and ED through activism and community involvement - Participant finds self-worth outside of her appearance and weight status through her relationships (relationship with God too) - Being a good person: generous, caring and willing to be there for others as a part of self-worth - Being a hard worker (ie., getting good grades, external accomplishments) as a part of self-worth - Participant finds self-worth by leaving an impact on the world and making a difference for others - Participant finds self-worth in getting an education - Participant finds self-worth in being knowledgeable - Participant finds self-worth outsider her appearance and ED by being well spoken	**Activism and community involvement** 3 **Through her relationships** 10 **Being a good person to others** 7 **Being a hard worker** 5 **Having hobbies and interests outside the ED** 6 **Knowledge/Education** 5 **Caring for others** 2

	- Participant finds self-worth outside of her appearance and weight status through being a Mom - Participant finds self-worth outside of her appearance and weight status through her knowledge - Being someone others want to be around - Feeling useful and being good at things - Having endurance to run long distances as a part of self-worth - Community involvement in church as a part of self-worth2	
Aspects outside of weight and appearance that make participant worthy of love	-Being able to connect with others and help them during difficult times - Who participant is in her relationships (actions she takes) is what makes her worthy of love - Just existing makes her worthy of love, it doesn't need to be earned - Being a positive force in the world	**Connecting with others during difficult times** 3 **Being compassionate and positive** 4 **Who participant is in her relationships** 2 **Just existing, being a person** 3 **Does not yet feel worthy of love** 4
Percentage of self-worth based on appearance	- Percentage wise, weight and appearance make up about 25% of participant's sense of self worth - Percentage wise, weight and appearance make up about 50% of participant's sense of self worth - Percentage wise, weight and appearance make up about 80% of participant's sense of self worth - Percentage-wise, other aspects of self-worth are currently higher than weight and appearance	**Weight and appearance make up about 25% of self-worth** 5 **Weight and appearance make up about 50% of self-worth** 4 **Weight and appearance make up about 80% of self-worth** 1

		Weight and appearance used to have a greater impact on self-worth than they do now 4

Appendix W

Example Axial Coding

Axial Coding: While focused coding involved identifying themes and subthemes from the codes developed during open coding, axial coding involves examining the relationships between the different themes, for the purposes of developing larger categories (Charmaz, 2006). Axial coding helps write a "story-line" which connects the conceptual categories and begins the process of piecing the data back together (Charmaz, 2006)**.** Thus, the focused codes identified in the previous step are grouped into themes (gender as a protective factor, gender as a risk factor) which then became larger categories. A simple way I did this was moving the focused code categories into a separate document and grouping them with other categories that fit together logically and conceptually as a theme.

Gender as a Protective Factor (Category)

Enjoys being female because there is flexibility
Participant enjoys expressing her femininity in the clothes and makeup she wears
Enjoys deep and meaningful relationships, more acceptable as a woman
Exciting time to be a woman
Sense of self-worth outside of appearance
Aspects outside of weight and appearance that make participant worthy of love
Percentage of self-worth based on appearance

Appendix X

Theoretical Coding

All categories, themes and subthemes for the finalized grounded theory model

Category: Participant as separate from the ED

Theme	Subthemes + Number of Participants
Eating disorder as separate from participant (13)	➢ Participant can distinguish ED as a separate voice from her own (first introduced by participant) (6) ➢ Participant can distinguish ED as a separate voice from her own (first introduced by interviewer using theoretical sampling) (4) ➢ Participant refers to ED as a part of her and not necessarily a separate voice (because it's been there so long) (3) ➢ Great difficulty separating herself from the ED (2) ➢ Described ED voice as regulatory (1)
Developing a framework or metaphor to understand the ED (8)	➢ Developing a larger framework to understand ED experience (3) ➢ Two separate voices/people (3) ➢ Powerful song/quote (3) ➢ Analogy (1) ➢ Quotes/Bible verses for ED recovery (1) ➢ Positive-oriented analogy for ED recovery (3)

Category: Contradictory thoughts and feelings

Theme	Subthemes + Number of Participants
Trying to control the ED (12)	➢ To control the ED and not have it spiral, participant must give it power (a false sense of control) (10) ➢ Participant feels both in and out of control with her relationship with food (8) ➢ ED makes participant engage in behaviors that are contradictory to what she really wants (8) ➢ Likes running and counting calories, but also feels that she's giving into the ED (3) ➢ Part of me wants to give up my symptoms, but part of me doesn't trust what will happen if I do (1) ➢ ED controls her decisions (1)
Conflict regarding self-worth (9)	➢ Knows self-worth shouldn't be about appearance and weight-status but still believes it (6) ➢ Does not feel that appearance and weight are what makes her worthy of love, though they are a significant part of self-worth (4) ➢ Other people are still beautiful if they gain weight, but not me (4) ➢ Other people are deserving of love and help, but not me (3) ➢ Will speak up for others (not always herself) (2)

	➢ I can struggle with an ED but other people shouldn't have to (1)
Relational contradictions (7)	➢ ➢ Wants to be open about her ED but also doesn't, worries about judgement (5) ➢ Knows emotionally supportive people don't care about looks/weight but still feels they do (3)

Category: Risk Factors

Theme	Subthemes + Number of Participants
Lack of Support or Understanding from Emotional Support Person(s) (15)	Unintentionally encourages ED behaviors (13) ➢ Unintentionally encourages ED behaviors (11) ➢ Shared struggles with body dissatisfaction/ED results in comparisons (8) ➢ Struggles with own food or body image issues (5)
	Diminishes the severity of the situation (12) ➢ Doesn't understand seriousness of extent of the ED (7) ➢ Normalizes body dissatisfaction as a typical female experience (4) ➢ Doesn't take action (3) ➢ Hard to take ES's advice if still struggling with food/body image (3)
	Lack of understanding regarding EDs and how to help (10) ➢ Lack of understanding regarding EDs (6) ➢ Monitors/analyzes participant's behaviors (5) ➢ Punitive or shaming approach (5)
Experiences of Gender Oppression (15)	Sexualization and Objectification (9) ➢ Even when aware of female objectivity, you can't escape it because you are living in it (5) ➢ Safety concerns (4) ➢ Sexualization of women as a contributing factor to EDs (3) ➢ Tends to be harassed/objectified the thinner she gets (counterintuitive – trying to gain power in society, but you become less powerful) (1)
	Body hatred as part of the female experience (9) ➢ Hatred of the body as a part of the female experience and discourse (6) ➢ Participant feels gender has influenced some of her ED behaviors (5)
	Power Imbalances (8) ➢ Competition between females (4) ➢ Not being taken seriously as a woman (4) ➢ Intersection of age and gender results in less power (3) ➢ Lack of power in the workplace (3) ➢ Femininity is devalued (3) ➢ Looked down on for being emotional (3)
	Pressure to "do it all" (7) ➢ Constant double binds (3) ➢ Not being the "right" kind of female (3)

	➢ Women always haveto find the perfect (and unrealistic) balance of where and what to be (3) ➢ Tension between choosing a career or marriage (3)
Messages from Media and Society Equating Thinness and Appearance with Self-worth (15)	Internalizing societal messages contributes to ED (14) ➢ Internalizing messages from society as a part of ED development (10) ➢ Media contributes to higher rates of females with EDs (7) ➢ Pre-determined type of person that girls "should be" (7)
	Pressure from media and society to be thin (11) ➢ Women should be thin, men should be tough (9) ➢ Weight as a marker of self-worth for women (9) ➢ More pressure from the media and society on women (7) ➢ Rules and pressure to look a certain way (5) ➢ Feeling pressure to always look nice (4)

Category: Protective Factors

Theme	Subthemes + Number of Participants
Support Person Provides Emotional and Tangible Support (14)	Shared experience of mental health struggles result in openness and non-judgement (13) ➢ Shared experience of ED struggles (8) ➢ Shared experience of mental health issues (6) ➢ Shared experience of body dissatisfaction (5) ➢ ES is open about her own struggles (5) ➢ Support person struggles with own mental health issues so participant is more open to going to this person for help (3) ➢ ES is nonjudgmental because struggles with ED too (2)
	Combination of emotional and tangible support (9) ➢ ES provides a combination of logic (fix it) and emotion (validation) (7) ➢ Humor (3) ➢ Tangible ideas (3) ➢ Distractions (3) ➢ Participant wishes support person would provide both emotional and instrumental support (3)
	Love, empathy and validation (12) ➢ ES provides listening and validation (5) ➢ ES provides validation instead of trying to "fix it" (5) ➢ Unconditional love regardless of weight (4) ➢ Empathy regarding the ED struggles (4) ➢ Others cared for her even when participant didn't care for herself (4)
Support Person Challenges the ED (15)	Emotional support person models and encourages a balanced relationship with food and exercise (15) ➢ ES and participant are "super healthy" together (5) ➢ ES models eating a variety of foods ("good" and "bad" foods) (8) ➢ Eating meals with support person helps participant get in a variety of foods and not feel guilty (7)

	➢ ES models to participant that it's possible to lose weight in a healthy way (4) ➢ ES person has a balanced relationship with food (5) ➢ Encourages participant to eat but allows for autonomy (5) ➢ ES person has a balanced relationship with exercise (3)

	Support person provides accountability to decrease symptom use (13)
	➢ Support person(s) notices the ED (7)
	➢ Holds participant accountable to not use symptoms (6)
	➢ Discourages ED behaviors (6)
	➢ Important relationships help participant realize behaviors are problematic (6)
	    ○ College friends (2)
	    ○ Family members (2)
	    ○ Personal trainer (1)
	    ○ Perspectives outside of family (1)
	➢ Friends notice and intervene (5)
	➢ Siblings and parents notice and intervene (admits firm stance was helpful in hindsight) (4)
	➢ Honesty made the ED have less power (3)

	Participant values relationships with others more than the ED (12) ➢ Participant values relationship (10) ➢ Desire to spend time with others instead of the ED (6) ➢ Improved relationship with self (5) ➢ Relationship with God, Religion and/or spirituality (4) ➢ Experiencing a sense of community (4) ➢ Wanting to be a role model for kids and/or younger siblings (3) ➢ Enjoys deep and meaningful relationships, more acceptable as a woman (3) ➢ Community of others who struggle (1)
Personal Sense of Agency (15)	Support person helps with decision making and fosters agency (15) ➢ Most emotionally supportive person as the biggest help with making decisions (13) ➢ Participant goes to others for help with decisions (11) ➢ Doesn't make decisions for the participant (6) ➢ ES provides a different perspective (5) ➢ Emotional support person fosters a sense of agency for participant (4) ➢ Goes beyond weighing pros/cons, deep trust in emotional support person's opinion (3) ➢ Participant will speak up to emotional support person(s) (3) ➢ Feeling empowered in her relationships (2)
	Vocalizes her opinions (13) ➢ Vocalizes her opinions (10) ○ Something she cares about emotionally (5)

	o Depends on the situation (5) o In class (4) o With friends (3) o Will speak up for others (not always herself) (2) ➢ Direct and assertive (9) ➢ Participant is more comfortable speaking up now that she's older, understands not everyone will agree (3) ➢ Easier to disagree in work situations (3) ➢ Participant is more comfortable speaking up now that she's older, college helped (2) ➢ Has learned to pick her battles (2)
	Empowering time to be female (13) ➢ Feels accomplished because school and working were historical struggles for women, something they fought for (6) ➢ Participant enjoys expressing her femininity in the clothes and makeup she wears (6) ➢ Flexibility in how you present yourself (5) ➢ Empowering time to be a female (4) ➢ Flexibility in your roles (3)
	Experiences control over her life without resorting to the ED (12) ➢ Feels a sense of agency or control over her life (12) o Schoolwork and grades (7) o Most things in life (6) o Daily tasks (4) o Work/Job (4) o Relationships (6) ➢ Takes time to consider big life decisions (5) ➢ Personal sense of agency (4) ➢ Good at making decisions (4)
Community Involvement and Activism (13)	Participant values community, connection, and helping others (12) ➢ Community activism is important (8) ➢ Identification of values related to supporting people and giving back (8) ➢ Major in the helping field (4) ➢ Connecting with people with similar values (3) ➢ Definition of community activism is positive and active (3) ➢ Less likely to isolate when in community (2) ➢ Making the world a little better/brighter (2) ➢ Systemic nature of issues (2) ➢ We are relational beings (1)
	There are many ways to be an activist (11) ➢ Is involved in community activism (11) o Traditional activism (3) o Nontraditional activism (3) o Group sports (4)

	o Nonprofit (5) o Church (6) o Student groups (3) o Volunteer activities (5) o Social Media (3)

	Activism that supports women's issues and eating disorders (7)
	➢ Participant is involved in activism that supports women's issues (3)
	    o Feminist student groups (2)
	    o Positive group for HS girls (1)
	    o Violence prevention educator (2)
	    o Domestic violence shelter (1)
	➢ No involvement in ED-related activism (15)
	➢ Would consider ED-related activism (10)
	➢ Non-traditional ED Activism (5)
	    o Speaking up against negative ED talk (2)
	    o Talk one-on-one about her own ED experience (2)
	    o Body positivity group for High School girls (1)

Category: Acting in contradiction to preferred values and beliefs (15)

Theme	Subthemes + Number of Participants
Putting up walls - participant is protecting the ED (15)	➢ ES person doesn't know much about the ED struggle (6) ➢ Lying to others about symptoms (5) ➢ Unable to accept love and advice from others (5) ➢ ES person is unaware of the ED (5) ➢ Would only reach out if ED was seriously impacting her life (5) ➢ Would reach out if extremely low weighted or excessively exercising/restricting (5) ➢ Shares some with ES but not the extent of the ED (4) ➢ ED creates conflict or tension in relationships (4) ➢ Keeping ED symptoms completely secret (3) Not open about symptoms: ➢ Doesn't want others to worry (9) ➢ Not wanting help yet/wants to fix it herself (9) ➢ Doesn't want help regarding the ED and/or not ready to give up symptoms (7) ➢ Wants to portray the image that she has her life together (5) ➢ Concerns about being judged (5) ➢ Embarrassment around the ED (5) ➢ Participant doesn't feel "sick enough" (4) ➢ ES will get angry (4) ➢ Struggling feels like a sign of weakness (3) ➢ Doesn't want to burden others (3) ➢ Tends to keep most things to herself (3) ➢ Support person will feel like it was her fault (3)

	➢ Support people will feel bad (3) ➢ ES will want her to get treatment (2) ➢ Defends food choices (1)
Thinness and appearance as markers of self-worth (13)	➢ Appearance and weight status have a significant impact on sense of self-worth on a daily basis (11) ➢ Weight as a marker of self-worth for women (9) ➢ Weight status as a marker of self-worth (6) ➢ Losing weight has a big impact on self-worth (4) ➢ Overweight equates to being ugly (2)
Struggles trusting self and using own voice (12)	➢ Inability to trust herself (8) ➢ Participant labels herself as indecisive (6) ➢ Participant knows instinctually what she wants, will then second guess and check with others, then go back to gut decision (4) Unable to use own voice without the ED (12) General Communication ➢ Seeking validation and praise – "Notice me!" (6) ➢ "I'm struggling, someone pay attention to me" (4) ➢ "I need more structure" (2) ➢ I'm not taking care of myself the way I should (1) ➢ "I feel out of control" (1) ➢ I need more help than I'm getting from you (1) ➢ I'm terrified of starting puberty (1) ➢ "I don't believe you, I don't trust you, stop telling me what to do with my symptoms" (1) ➢ "I'm messed up and not deserving of your love" (1) ➢ "I don't know how to deal with my emotions" (1) Body image distress ➢ Seeking validation from others that body is ok the way it is (5) ➢ "Dieting and/or exercising is how I connect with you" (3) ➢ "I want my body to look better for you" (Significant other) (3) ➢ "You are really fit and I wish I looked like you" (1) ➢ "I'm dissatisfied with my body" (1) ➢ "I'm afraid you'll leave me if I don't lose weight (or you lose weight and I don't)" (1) ➢ "I'm afraid of looking like you because you're overweight" (1) ➢ I want to be proud of what I look like and look like an athlete (1)
Isolation and distress during social activities (11)	➢ Anxiety when eating at restaurants with friends (5) ➢ Participant feels guilt when eating at restaurants with friends (4) ➢ Avoids social events to avoid fear foods (4) ➢ Less time spent with others due to time spent on ED (4) ➢ Increased isolation (3) ➢ Moodiness (3) ➢ Fatigue (2)

Category: Acting in line with preferred values and beliefs (15)

Theme	Subthemes + Number of Participants
Finding worth outside of appearance and weight status (15)	➢ Having hobbies and interests outside the ED (6) ➢ Knowledge/Education (5) ➢ Being a hard worker (5) ➢ Just existing, being a person (3) ➢ Activism and community involvement (3) ➢ Weight and appearance used to have a greater impact on self-worth than they do now (4) ➢ Does not yet feel worthy of love (4) ➢ Weight and appearance make up about 25% of self-worth (5) ➢ Weight and appearance make up about 50% of self-worth (4) ➢ Weight and appearance make up about 80% of self-worth (1)
Is open about ED symptoms (14)	➢ Participant will open up about ED struggles because she feels emotionally supported (9) ➢ ED is not trying to tell ES person much of anything because relationship is positive (7) ➢ More likely to share if support person goes to her first (5) ➢ Will disclose symptoms to friends when struggling (4) ➢ No longer has to use self-destructive mechanisms to get her message across (4) ➢ Will open up due to longevity of relationship (4) ➢ Participant will open up about ED because the relationship feels safe and vulnerable (3)
Listening to her own voice (14)	➢ Desire to not listen to the ED voice (11) ➢ Desire to have a balanced relationship with exercise, not avoiding it but not doing it excessively (6) ➢ Avoiding scales (5) ➢ Develop a healthier relationship with food, exercise, body image (4) ➢ Focusing on healthy food (macronutrients) instead of calories (3) ➢ Losing weight but not having a "goal weight" to get to (3) ➢ Working to control her relationship with food in a healthy and positive way (Redefining control) (2) ➢ Choose positivity over self hate (2) ➢ Live in the moment, invest in relationships (2) ➢ Self-acceptance (2) ➢ Look at the big picture, weight doesn't matter (2) ➢ Start being open about the ED (1) ➢ It's ok to make mistakes (1) ➢ Participant wants to combat the stereotypes about women that have contributed to her ED (1) ➢ Working out for strength instead of calories (1)

	➢ Running as empowerment instead of self-destruction or punishment (1)
Is actively involved in life (10)	➢ Goes to social events with friends (9) ➢ Eating meals with support person helps participant get in a variety of foods and not feel guilty (7) ➢ Having more important things to do besides the ED (7) ➢ Being busy (7) ➢ Stability and balance in life (6) ➢ Going to restaurants with friends (6) ➢ Being a college student (6) ➢ ED has prevented her from doing things in her life previously (4) ➢ Needing to nourish her body to accomplish what she wants in life (3) ➢ Actively participating in my life (1)

Appendix Y

Participant Member Checking Script

Dear _____,

I hope you are doing well! I interviewed you back in _____ for my dissertation study and really appreciated your participation in the interview. I learned so much from everyone who participated, and gathered some incredibly rich data that I believe will help others who live with subclinical eating disorder symptoms. I have analyzed the results and come up with a larger model to explain the findings.

In a nutshell, I found that participants could separate themselves from the eating disorder and talked about it almost as a separate person or voice. I then categorized the findings into risk and protective factors that were either relational or feminist (gender/activism/empowerment). Essentially, the risk factors reinforce the ED voice and move a participant to act in contradiction with values and beliefs, while protective factors reinforce their "genuine voice" and help them to move towards preferred values and beliefs. For example, "transparency and vulnerability" (depicted under the larger protective category "emotional support person") emerged as a theme where participants said that if a support person was transparent about their own struggles, the participant could then open up to them. Therefore "open about symptoms" is categorized "under act in accordance with values and beliefs."

 You had indicated that you would be open to me contacting you to share the findings. If you are open to it, I was wondering if you would look at my model (attached to this email) and provide your thoughts and feedback. You can keep your comments more general, or you can use the questions below to guide your feedback. You can send your thoughts in an email, or we can discuss your ideas over the phone if that is easier for you. You can also add feedback directly to the model using comments and track changes, and then send that back to me in a document. You can keep your thoughts as brief or as detailed as you want. Whatever works best for you.

1.   What are your thoughts and feelings about the themes and larger theoretical model that emerged from the study?

> a.   Which themes do you agree with? Why?
> b.   Which themes do you disagree with? Why?
> c.   Which themes (if any) were surprising? Why?
> d.   Were there aspects of the larger model that you found confusing or unclear?

2.   How do my findings fit with your own experience?

> a.   What aspects of the model resonated with your own experience?
> b.   What aspects of the model did not resonate with your experience? Why?
> c.   Is there anything you would change or add to the model based on your own experience?

3.   Is there anything else you would like me to know or consider as I finalize the results of this study?

Please let me know if you have questions on the model or need further clarification. Also, if you would like to see which particular themes and categories you endorsed, let me know and I can send that to you. I am writing my results right now and hoping to complete a draft by mid-January, so if you are interested in providing feedback I would need your thoughts by Sunday, January 8th.

I know this is a very busy time of year so I <u>completely understand</u> if this is something you cannot commit to at this time. I appreciate your time and consideration.

Happy holidays and good luck wrapping up your semester!

Best,

Emily

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Appendix Z

Journal Requirements

Article #1: Journal of Eating Disorders

https://jeatdisord.biomedcentral.com/submission-guidelines/preparing-your-manuscript/research-article

"Criteria. Journal of Eating Disorders strongly encourages that all datasets on which the conclusions of the paper rely should be available to readers. We encourage authors to ensure that their datasets are either deposited in publicly available repositories (where available and appropriate) or presented in the main manuscript or additional supporting files whenever possible. Please see Springer Nature's information on recommended repositories.

Plain English summary. All articles in Journal of Eating Disorders require a Plain English summary of between 100 and 200 words, in addition to the Abstract. This should be a summary of the article written in language suitable for people with lived experience of illness and the wider public to easily understand. It should not contain technical terminology or complicated statistics. It should convey the key messages of your paper. Please include this within the main body of your manuscript file. Please do not include the plain English summary as part of the official scientific abstract that is requested separately by the journal submission system. The plain English summary should be inserted immediately after the official scientific abstract within the manuscript file under the heading "Plain English summary". By adding a plain English summary, we hope to broaden the reach of the article and bring it to the attention of a more general audience. Researchers are trained to be highly focused, specific, and conservative with extrapolation and speculation. These attributes are useful for scientific publications, but not for wider public understanding. Many non-scientists have difficulty understanding technical terms and jargon, and the public requires more context-setting by way of introduction and more help drawing a conclusion. The following resources provide further information: INVOLVE Plain English summaries resource; The Plain English Campaign guide on medical writing; Cochrane Library.

Preparing your manuscript. The information below details the section headings that you should include in your manuscript and what information should be within each section. Please note that your manuscript must include a 'Declarations' section including all of the subheadings (please see below for more information).

Title page. The title page should:
- present a title that includes, if appropriate, the study design e.g.:
  - "A versus B in the treatment of C: a randomized controlled trial", "X is a risk factor for Y: a case control study", "What is the impact of factor X on subject Y: A systematic review"
  - or for non-clinical or non-research studies a description of what the article reports
- list the full names, institutional addresses and email addresses for all authors

         ○   if a collaboration group should be listed as an author, please list the Group name as an author. If you would like the names of the individual members of the Group to be searchable through their individual PubMed records, please include this information in the "Acknowledgements" section in accordance with the instructions below
- indicate the corresponding author

Abstract. The Abstract should not exceed 350 words. Please minimize the use of abbreviations and do not cite references in the abstract. Reports of randomized controlled trials should follow the CONSORT extension for abstracts. The abstract must include the following separate sections:
- Background: the context and purpose of the study
- Methods: how the study was performed and statistical tests used
- Results: the main findings
- Conclusions: brief summary and potential implications
- Trial registration: If your article reports the results of a health care intervention on human participants, it must be registered in an appropriate registry and the registration number and date of registration should be in stated in this section. If it was not registered prospectively (before enrollment of the first participant), you should include the words 'retrospectively registered'. See our editorial policies for more information on trial registration

Keywords. Three to ten keywords representing the main content of the article.

Background. The Background section should explain the background to the study, its aims, a summary of the existing literature and why this study was necessary or its contribution to the field.

Methods. The methods section should include:
- the aim, design and setting of the study
- the characteristics of participants or description of materials
- a clear description of all processes, interventions and comparisons. Generic drug names should generally be used. When proprietary brands are used in research, include the brand names in parentheses
- the type of statistical analysis used, including a power calculation if appropriate

Results. This should include the findings of the study including, if appropriate, results of statistical analysis which must be included either in the text or as tables and figures.

Discussion. This section should discuss the implications of the findings in context of existing research and highlight limitations of the study.

Conclusions. This should state clearly the main conclusions and provide an explanation of the importance and relevance of the study reported.

List of abbreviations. If abbreviations are used in the text they should be defined in the text at first use, and a list of abbreviations should be provided.

Declarations. All manuscripts must contain the following sections under the heading 'Declarations':
- Ethics approval and consent to participate
- Consent for publication
- Availability of data and material
- Competing interests
- Funding
- Authors' contributions
- Acknowledgements
- Authors' information (optional)

Please see below for details on the information to be included in these sections. If any of the sections are not relevant to your manuscript, please include the heading and write 'Not applicable' for that section.

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- include a statement on ethics approval and consent (even where the need for approval was waived)
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Consent for publication. If your manuscript contains any individual person's data in any form (including individual details, images or videos), consent for publication must be obtained from that person, or in the case of children, their parent or legal guardian. All presentations of case reports must have consent for publication. You can use your institutional consent form or our consent form if you prefer. You should not send the form to us on submission, but we may request to see a copy at any stage (including after publication). See our editorial policies for more information on consent for publication. If your manuscript does not contain data from any individual person, please state "Not applicable" in this section.

Availability of data and materials. All manuscripts must include an 'Availability of data and materials' statement. Data availability statements should include information on where data supporting the results reported in the article can be found including, where applicable, hyperlinks to publicly archived datasets analysed or generated during the study. By data we mean the minimal dataset that would be necessary to interpret, replicate and build upon the findings reported in the article. We recognise it is not always possible to share research data publicly, for instance when individual privacy could be compromised, and in such instances data availability should still be stated in the manuscript along with any conditions for access.
Data availability statements can take one of the following forms (or a combination of more than one if required for multiple datasets):

- The datasets generated and/or analysed during the current study are available in the [NAME] repository, [PERSISTENT WEB LINK TO DATASETS]
- The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.
- All data generated or analysed during this study are included in this published article [and its supplementary information files].
- The datasets generated and/or analysed during the current study are not publicly available due [REASON WHY DATA ARE NOT PUBLIC] but are available from the corresponding author on reasonable request.
- Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.
- The data that support the findings of this study are available from [third party name] but restrictions apply to the availability of these data, which were used under license for the current study, and so are not publicly available. Data are however available from the authors upon reasonable request and with permission of [third party name].
- Not applicable. If your manuscript does not contain any data, please state 'Not applicable' in this section.

More examples of template data availability statements, which include examples of openly available and restricted access datasets, are available here. BioMed Central also requires that authors cite any publicly available data on which the conclusions of the paper rely in the manuscript. Data citations should include a persistent identifier (such as a DOI) and should ideally be included in the reference list. Citations of datasets, when they appear in the reference list, should include the minimum information recommended by DataCite and follow journal style. Dataset identifiers including DOIs should be expressed as full URLs. For example: Hao Z, AghaKouchak A, Nakhjiri N, Farahmand A. Global integrated drought monitoring and prediction system (GIDMaPS) data sets. figshare.
2014. http://dx.doi.org/10.6084/m9.figshare.853801. With the corresponding text in the Availability of data and materials statement: The datasets generated during and/or analysed during the current study are available in the [NAME] repository, [PERSISTENT WEB LINK TO DATASETS].[Reference number]

Competing interests. All financial and non-financial competing interests must be declared in this section. See our editorial policies for a full explanation of competing interests. If you are unsure whether you or any of your co-authors have a competing interest please contact the editorial office. Please use the authors initials to refer to each author's competing interests in this section. If you do not have any competing interests, please state "The authors declare that they have no competing interests" in this section.

Funding
All sources of funding for the research reported should be declared. The role of the funding body in the design of the study and collection, analysis, and interpretation of data and in writing the manuscript should be declared.

Authors' contributions. The individual contributions of authors to the manuscript should be specified in this section. Guidance and criteria for authorship can be found in our editorial

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Table 1

Trustworthiness and Rigor

Qualitative Concept	Purpose	Strategy Employed

Credibility	Degree to which findings are accurately drawn from the data	o Peer Debriefing
		  • Academic Mentor who provided guidance on grounded theory
		  • Mentor with eating disorder expertise provided guidance on concepts from emerging model
		  • Focus group to provide feedback on clinical implications of model
		o Self-Reflexivity
		  • Reflexivity statement
		  • Journaling
		  • Memoing

Confirmability	Extent to which participants read the description of the findings and find it accurate and valid based on their experience and not the research agenda	o Member checking
		  • Participants provide feedback on emerging model in final stages of analysis
		o Focus Group
		  • Clinicians confirmed applicability of model and offered suggestions for disseminating findings

Dependability	Ensures data collection happens in a coherent and logical fashion and could be replicated if necessary	o Audit trail
		  • Tracking methodological decision making
		  • Study could be replicated if necessary

Transferability	Fit and applicability – the extent to which findings apply to the population of study. Ensures findings fit into contexts outside the study situation	o Appropriate sampling
		  • Stringent inclusion criteria
		o Member checking
		  • Participants provide feedback on applicability of the findings

Table 2

Demographic Summary of Focus Group Participants

Characteristic	Participants ($n = 6$)
Age	$\bar{x} = 41.8$; SD = 7.1; Range = 32 – 52
Gender	Female ($n = 6$)
Highest Degree Obtained	Masters ($n = 3$), PhD ($n = 2$), PsyD ($n = 1$)
Licensure	Licensed Psychologist ($n = 2$), Licensed Marriage and Family Therapist ($n = 2$), Licensed Independent Clinical Social Worker ($n = 1$) Licensed Professional Clinical Counselor ($n = 1$)
Years specializing in eating disorders	$\bar{x} = 7.75$; SD = 3.89; Range = 2 - 12
Special training with eating disorders	FBT ($n = 2$), professional trainings and workshops related to eating disorders ($n = 2$), working intensively with day treatment and residential clients with eating disorders ($n = 2$) Specialized training endorsed only once: CBT-E; unified protocol, AAMFT Approved supervisor; motivational interviewing; yoga and body image; Postdoctoral work in an eating disorder facility; helped implement an eating disorder treatment program at a large university
Theoretical orientation	FBT ($n = 3$), CBT ($n = 3$), CBT-E ($n = 2$), DBT ($n = 2$), narrative ($n = 2$), IPT ($n = 2$). Orientations endorsed only once: Unified protocol; solution focused; client centered; exposure therapy; feminist approaches; social constructivist; biopsychosocial model; psychodynamic; psycho-educational; behavioral; getting to the core issue and not getting stuck in the presenting problem; challenging obstacles for success; knowing that change is difficult; own experience of an eating disorder.
Most important protective factors for women with eating disorders	Supportive family and friends ($n = 4$); early on identification and acceptance of the issue ($n = 3$); strong sense of self and identity ($n = 2$). Protective factors endorsed only once: vulnerability; flexible thinking with appropriate boundaries; education; relationship with parents (especially Mom); accountability; emotional awareness; alternative voices than theirs that help them identify a sense of self-worth not solely connected to shape, weight and appearance; a sense of hope/goals that are motivating; ability to work through conflict while maintaining sense of self; lack of genetic predisposition; utilization of support system; how families talk about the body; recognizing latent or demonstrated depression or anxiety early on

Figure 1

Grounded Theory Model of Feminist-Informed Factors for Subclinical Eating Disorders