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Understanding Women's Experiences of Defending Against Eating Disorder Symptoms: An Interpretive Phenomenological Analysis

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Body dissatisfaction predicts eating disorder symptomatology for some women but not for others. To better understand this disparity, the authors interviewed 7 college women who reported body dissatisfaction and no engagement in eating disorder symptoms. The authors identified 4 factors that may protect body-dissatisfied women from engaging in eating disorder symptoms.

Keywords: body dissatisfaction, eating disorders, protective

Body dissatisfaction has been identified as a longitudinal predictor of eating disorder symptoms (Stice, 2002). Yet, as Tylka (2004) discussed, despite the well-supported relationship between body dissatisfaction and the onset and maintenance of eating disorder symptoms, many women who experience body displeasure do not engage in concerning eating patterns. Tylka noted that rates of body dissatisfaction are markedly higher than rates of eating disorder symptoms among women. Thus, certain women are able to avoid a progression from feelings of body dissatisfaction to behaviors such as binging, purging, or extreme dieting. This avoidance has spurred researchers to examine variables that intervene in the association between body dissatisfaction and eating disorder symptoms (Brannan & Petrie, 2008; Buser & Gibson, 2014; Forney & Ward, 2013; Juarascio, Perone, & Timko, 2011; Twamley & Davis, 1999; Tylka, 2004). These studies have examined moderating variables that attenuate or intensify the link between body dissatisfaction and eating disorder symptoms (Frazier, Tix, & Barron, 2004).

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This is an important line of inquiry, because the identification of moderating variables may be able to prevent body-dissatisfied women from developing or persisting in eating disorder symptoms. Additional study of moderators is warranted (Brannan & Petrie, 2008), specifically in two areas. A dearth of research exists on protective factors that buffer women from the negative effects of body dissatisfaction and protect them from eating disorder symptoms (Brannan & Petrie, 2008). There is also a paucity of qualitative research in this area. In the current investigation, we carried out a qualitative study by interviewing body-dissatisfied women and asking them to reflect on ways they eschewed eating disorder symptoms. Thus, we also specifically focused on protective factors, in that we interviewed women who experienced body dissatisfaction but who did not engage in eating disorder symptoms.

BODY DISSATISFACTION

Body dissatisfaction refers to a negative evaluation of one's physical appearance (Thompson, 2004). Fiske, Fallon, Blissmer, and Redding (2014) reported that the prevalence of body dissatisfaction among adult women ranged from 11% to 72%. Noting the expansive range of these statistics, which was likely due to divergent instrumentation and the type of body dissatisfaction assessed, Fiske et al. also reported more specific statistics. For example, 46% to 66% of adult women reported dissatisfaction with their weight.

In a research review, Stice (2002) highlighted the empirical link between body dissatisfaction and eating disorder symptoms, noting its ability to predict the onset and continuation of eating disorder symptoms. Theoretically, this association between body dissatisfaction and eating disorder symptoms is based on the sociocultural model (Stice, 1994; Tiggemann, 2011). Specifically, this model underscores that women who are a part of a society that values a specific body ideal will internalize that body ideal and will subsequently experience body dissatisfaction if they deviate from that ideal (Stice, 1994). Eating disorder symptoms will then ensue as a way to meet that body ideal or to cope with the negative emotions that result from body displeasure (Stice, 1994).

MODERATING VARIABLES

As noted previously, despite this strong empirical link between body dissatisfaction and eating disorder symptoms (Stice, 2002), many women who dislike their body size and shape do not engage in eating disorder symptoms (Tylka, 2004). In an effort to understand what makes some body-dissatisfied women more or less prone to engage in eating disorder symptoms, researchers have conducted moderation studies. These researchers have identified factors that intensify or attenuate the body dissatisfaction–eating disorder symptoms link, although more research has documented the former (Brannan & Petrie, 2008). In the

following section, we discuss these findings. We focus exclusively on studies that pointed to moderating variables. Because a relatively modest amount of research has been carried out in this area (compared with the eating disorder and body dissatisfaction research in general), it was necessary to review studies completed more recently and those completed 10 or more years ago.

Forney and Ward (2013) found that, among 223 college women, perceptions that their peers valued thinness and accepted eating disorder behaviors (e.g., laxative use) intensified the relationship between body dissatisfaction and eating disorder symptoms. In their survey of 472 college women, Juarascio et al. (2011) found that the link between body dissatisfaction and eating disorder symptoms was strongest for those who scored high on the following variables: depression, state anxiety, trait anxiety, and dieting to lose weight. Tylka (2004) reported that, among 373 college women, the following variables augmented the relationship between body dissatisfaction and eating disorder symptoms: body surveillance (i.e., body monitoring in terms of how one's body looks compared with the bodies of others), neuroticism, and having a family member or friend with an eating disorder. Using a sample of 398 college women, Brannan and Petrie (2008) supported Tylka's (2004) findings regarding the intensifying effect of body surveillance and neuroticism. Brannan and Petrie also identified ego goal orientation (i.e., a focus on being seen as competent by others and meeting standards deemed socially successful), socially prescribed perfectionism (i.e., a focus on being evaluated by high standards set by others), and self-oriented perfectionism (i.e., a focus on self-evaluation and high internal standards) as intensifiers of the association between body dissatisfaction and eating disorder symptoms.

Although less plentiful, buffering variables have also been identified. Tylka (2004) reported an unexpected finding among 304 college women, wherein poor impulse regulation weakened the body dissatisfaction–eating disorder symptoms link. In a study with 249 college women, Twamley and Davis (1999) found that self-esteem weakened the link between body dissatisfaction and eating disorder symptoms. Finally, Buser and Gibson (2014) reported that, for 733 college women, high levels of an "I" position (i.e., a secure self-identity immune to extreme influence from others) attenuated the link between body dissatisfaction and eating disorder symptoms.

Some studies have also suggested potential moderators via between-groups or qualitative designs. For example, in a qualitative study with seven female college students, Buser and Parkins (2015) noted two ways in which body-dissatisfied participants (who also endorsed a belief in God/Higher Power) discussed being protected from eating disorder symptoms. Specifically, participants focused on their health and endorsed spiritual beliefs, such as faith in God's assistance and one's body being a gift from God.

Leahey, Crowther, and Ciesla (2011) found that upward appearance comparisons (i.e., comparing oneself with someone perceived to be more attractive) affected women with high levels of body dissatisfaction and eating pathology

differently than those with high levels of body dissatisfaction and no eating pathology. Participants in the former category (n = 55) reported that emotional distress and self-loathing increased after upward appearance comparisons, whereas social confidence was reduced. These changes contrasted with the changes for the participants in the latter category (n = 45), who reported less pronounced increases and decreases in those variables. Leahey et al. suggested that participants with high levels of body dissatisfaction and eating pathology may place a higher value on appearance to determine self-esteem, which may be why the upward appearance comparisons had such a marked negative effect.

Showers and Larson (1999) identified several ways in which college women with high levels of body dissatisfaction and eating disorder symptoms (n = 34) differed from those with high levels of body dissatisfaction and no eating disorder symptoms (n = 34). For example, participants without eating disorder symptoms placed a lower importance on physical appearance. Despite experiencing body dissatisfaction, these participants were also able to maintain an overall positive view of appearance (i.e., feeling attractive) and self-concept. These participants also reported healthier coping mechanisms, such as reduced use of coping styles that emphasized avoiding a stressor (e.g., distancing) and hoping a situation would change (e.g., wishful thinking).

This summary of the moderation research highlights a disparity, wherein less is known about attenuating variables compared with intensifying variables, thus prompting appeals for additional research into buffering variables (Brannan & Petrie, 2008). Moreover, the research on moderating variables has emphasized quantitative studies. Qualitative research is an important line of inquiry, because in-depth interviews with participants may suggest additional buffering variables.

THE PRESENT STUDY

In the current investigation, we focused on attending to these gaps in the literature. Specifically, we conducted a qualitative investigation of the experiences of women who endorsed body dissatisfaction but did not engage in eating disorder symptoms. Previous authors have noted that qualitative studies may allow participants to share experiences that are complex and nuanced (Boyatzis & Quinlan, 2008). Thus, through qualitative interviews, we hoped to identify moderating variables potentially missed by quantitative research. In addition, in an effort to recognize buffering variables, we specifically recruited participants who experienced body dissatisfaction without eating disorder symptoms. In line with the aims of our qualitative methodology, wherein researchers explore how participants make meaning in a common context (Smith, Flowers, & Larkin, 2009), our main research question for this study was as follows: How do body-dissatisfied women without eating disorder symptoms make sense or meaning of their feelings about their bodies and their eating behaviors?

METHOD

Participants

Seven female college students took part in this study. Because of the small sample size, we report limited demographic information to protect participants' confidentiality. Participants self-reported a mean age of 22.14 years (SD = 3.29) and were enrolled in a private northeastern university as 1st-year, sophomore, senior, or graduate students. All reported a race/ethnicity of Caucasian/White, and no participants reported being international students. All participants reported a heterosexual sexual identity and reported economic backgrounds of lower class, working class, middle class, and upper middle class. Most participants (n = 4) self-reported a body mass index (BMI) in the normal or healthy weight range; the remaining participants (n = 3) self-reported a BMI classified as overweight or obese (Centers for Disease Control and Prevention, 2015).

Procedure

Subsequent to obtaining institutional review board approval, the first and second authors posted calls for participants on specific websites and provided a research invitation at the end of a separate quantitative survey on similar topics. We recruited all participants via the latter method. This quantitative survey instructed participants who were interested in taking part in an interview to supply their contact information for a follow-up contact. For the purposes of this study, we included participants who endorsed body dissatisfaction but no eating disorder symptoms and used data from these participants only in the present study. The first or second author met with participants in person for audiotaped interviews. Interviews lasted approximately 30 minutes to 1 hour. The first author assigned participants codes and pseudonyms for confidentiality.

The first and second authors used a semistructured interview protocol to guide the interviews. These interview questions included inquiries about body image, attitudes about food and weight, spiritual beliefs, core life values, ways that participants avoided engaging in eating disorder symptoms, and ways that participants coped with body dissatisfaction. However, we approached these interviews in an open, receptive manner, in that participants' responses often directed the interview rather than a specific set of required questions.

Data Analysis

Prior to data analysis, we discussed personal biases and experiences that may affect our approach to the data (McLeod, 1996). The first author is a counselor educator in a counseling master's degree program accredited by the Council for Accreditation of Counseling and Related Educational Programs. At the time of the research interviews, the second author was a master's degree student in this program. During data analysis, this author had attained her master's degree and was working as a therapist in the eating disorder field. The third author

is a master's degree student in the previously mentioned counseling program. The first and second authors noted personal emotions of empathy related to individuals who struggle with body dissatisfaction. The first author also discussed an expectation that participants would be protected from eating disorder symptoms as a result of having value systems that did not emphasize an ideal weight or appearance. The third author hypothesized that the avoidance of eating disorder symptoms may have to do with participants' sense of control. She suggested that participants would have things in their lives that they can control and thus would be protected from eating disorder symptomatology. All of the researchers noted cognizance of media pressures that could play a role in participants' body dissatisfaction.

We used interpretive phenomenological analysis (IPA; Smith et al., 2009) to analyze the interview transcripts. This qualitative analysis method blends staying close to the participant's experience while also encouraging careful researcher interpretation of the participant's commentary. Smith et al. (2009) described IPA as "empathic *and* questioning" (p. 36) in that the researcher not only strives to understand what the participant is experiencing in an empathic manner, but also aims to offer an interpretation of the participant's experience from a "different angle" (p. 36).

As described by Smith et al. (2009), the specific steps of IPA are as follows. Researchers conduct an "initial noting" (p. 83) procedure, which has been described as a "free textual analysis" (p. 83). In this process, researchers comment on the data by attending to three levels of analysis: descriptive, linguistic, and conceptual. In descriptive noting, researchers comment on the obvious, surface-level meaning of the participant's language. They note issues such as subject matter or the context of the participant's experience. In linguistic noting, researchers add a layer of interpretation to their commentary by drawing attention to the language patterns of participants, such as the repetition of words or phrases and the use of metaphors. In conceptual noting, researchers add yet another layer of interpretation to the data by commenting on deeper layers of meaning beneath the overt words of participants. For example, researchers may hypothesize about issues of identity and meaning making relevant to the participant's experiences. Following this three-level coding process, researchers begin to identify emergent themes in a participant's transcript. Next, researchers refine this list of emergent themes by identifying connections among these emergent themes. A chart of these themes is created, with quotes from participants included to illustrate each theme. This process is then completed for the next participant.

In the present study, the first and third authors reached consensus on descriptive comments, linguistic comments, conceptual comments, and emergent themes for all participants. We then reached consensus on a final theme list, wherein we identified patterns in the emergent themes across the participants' stories. The second author then carried out an audit; the auditor read three

transcripts (42.9% of the data) and offered confirmation of and suggestions for refinement on this final theme list. The first and third authors then returned to the data and refined the final themes on the basis of this audit. For example, the first theme was originally titled *love of food* but was retitled *enjoyment of food is important* after the audit, which drew attention to a value system imbued in the participants' commentary. Participants were then contacted for a member check. Unfortunately, six participants were unable to be contacted because of invalid contact information; one participant responded and expressed agreement with the themes.

RESULTS

Following the IPA method described previously, we identified four themes. Each theme dealt with a manner in which participants were protected from engaging in eating disorder symptoms. These themes were (a) enjoyment of food is important (n = 6), (b) eating disorder symptoms do not work (n = 4), (c) valuing health (n = 5), and (d) support system (n = 5). In the following section, we describe these themes in detail and provide quotes from participants to offer a rich description of these themes.

Enjoyment of Food Is Important

Many participants indicated that a "love" or fondness for food protected them from engaging in eating disorder symptoms. For example, in discussing why she does not engage in eating disorder symptoms, Ansley noted that "I think it's more that I love food. Why can't I just eat? I just feel, like, if I'm hungry, I'm going to eat." Similarly, Luann indicated that "I'm a big fan of food" when she described reasons why she has eschewed eating disorder symptoms. Willa also noted that a "love" of food has protected her from engaging in eating disorder symptoms. In discussing how this enjoyment has allowed her to combat thoughts about dieting, Willa said,

> I always want to go on a diet or something, but I grew up in an Italian Jewish family, which a big thing with Italians or a big thing with Jews is eating. So I've never stopped eating, although I've thought about it but not seriously. But I love food too much.

In a related manner, Maybell talked about going on a weeklong diet at one point in her life and disliking it: "I was just—I was missing out on some of the foods that I loved."

Overall, these participants shared an underlying value system, wherein esteeming the enjoyment of and pleasure afforded by food seemed to outweigh an urge to change their bodies through unhealthy patterns. Although this value system was discussed briefly by many participants (e.g., a quick comment about

"loving" food), it tapped into a core value that offered protection from eating disorder symptoms.

Eating Disorder Symptoms Do Not Work

Participants shared a sense that eating disorder symptoms are often unsuccessful and counterproductive for weight loss or attractiveness. For example, in discussing why she does not engage in disordered eating, Arielle said, "Well, I think that first of all you usually don't lose weight, so that's something, like, something you need to realize." Harriet also mentioned that engaging in eating disorder symptoms will "mess up your metabolism." In a related manner, Luann discussed a teacher from high school who had an eating disorder and noted how being aware and educated helped her realize the ineffectiveness of eating disorder symptoms:

> She always told her classes . . . that [eating disorder symptoms] kind of ruined her metabolism, and so I just always know that to, like, if you want to lose weight, I know that starving yourself isn't the way to do it because it can backfire in the end.

Overall, these participants shared a belief that eating disorders symptoms are irrational and not long-term solutions for weight loss or attractiveness. Participants indicated a core belief in the unsuccessfulness of such symptoms, which offered protection from eating disorder symptoms.

Valuing Health

Many participants shared a value of being healthy, which assisted them in avoiding eating disorder symptoms (which were viewed as unhealthy). For example, Ansley said, "I knew a girl in my school [who] struggled with her weight so much that she had the worst eating disorder and it didn't even look healthy. I don't want to look unhealthy." In a related manner, Maybell discussed society's views about physical appearance, stating, "It shouldn't be about how much you weigh; it should be about how healthy you are." Likewise, in discussing the difference between valuing health and losing weight through eating disorder symptoms, Arielle noted, "You're going to have to work at it [losing weight] either way so you might as well do it in a healthy way and feel good about yourself while you're doing it." Luann also described the physical effects from undernourishment, thus underscoring the importance of being healthy: "I also just can't, like, I get really shaky if I don't eat enough."

In summary, many participants shared an underlying value of being healthy. For these participants, taking care of their bodies and being healthy seemed to outweigh an urge to change their appearance through unhealthy eating disorder behaviors. Ultimately, this value of health seemed to assist participants in avoiding eating disorder symptoms.

Support System

Many participants indicated that they received support from other people (e.g., parents, significant others), which helped them avoid eating disorder symptoms. This support was specific to participants' body images and eating behaviors (e.g., positive affirmations about their appearance, encouragement to eschew problematic eating patterns or weight struggles). For example, Luann stated, "But I always question myself, um, I always like to hear that reassurance, you know, from my husband." Similarly, in describing how she coped with her body dissatisfaction with the support from her boyfriend, Willa indicated that "he makes me comfortable with everything."

In a related manner, Ansley described how her mother's support helped her avoid developing an eating disorder:

> I think if my mom wasn't who she is, I think I would have way more of an issue with myself, like, eating-disorder-wise. There are times when I'll be like, "Mom, I just want a toned stomach like you." She'll be, like, "[Ansley] you're beautiful. You don't have to think like that. Eat what you want."

In discussing how her mother influenced the way she thought about eating and appearance and how her mother protected her from eating disorder symptoms, Beatrice said, "If you're hungry, you eat. That's just what happens. If you're thirsty, you drink. If you're tired, you sleep. That's just the way it's always been. And that's just kind of what my mom has always taught us." Overall, many participants indicated that they received support in the form of positive comments about their body image or eating behaviors. Even though participants experienced body dissatisfaction, this support seemed to offset an urge to engage in eating disorder symptoms.

DISCUSSION

The four themes identified in this study have potential implications for research and counseling practice. In particular, participants' comments about the enjoyment of food, the futility of eating disorder symptoms, the value placed on health, and the importance of a support system extend the extant research on moderators of the body dissatisfaction–eating disorder symptoms link. In addition, these themes suggest directions for prevention and treatment efforts to address body dissatisfaction and eating disorder symptoms. In discussing our findings, we note that participants were not sharing experiences related to the development of eating disorder symptoms. Participants underscored their successful defense against eating disorder symptoms—not the varied factors and theories related to the etiology of eating disorder symptomatology.

In the first and third themes, participants spoke about a value system that protected them from engaging in eating disorder symptoms. In the first theme,

participants discussed their "love" of food. These participants shared a sense that enjoying food was important to them. They communicated a value placed on the pleasure associated with eating—a value that contradicted the habits of a person with an eating disorder who might restrict or purge food. In the third theme, participants indicated that they valued being healthy. These participants viewed eating disorder symptoms as running counter to their values of health and self-care. The first theme appears to be a novel finding, in that, to our knowledge, no previous research has examined a self-reported "love" of food as a factor that could buffer the negative effect of body dissatisfaction and protect women from engaging in eating disorder symptoms. In contrast, previous qualitative research on body-dissatisfied women without eating disorder symptoms has demonstrated that valuing health is a protective factor in avoiding eating disorder symptoms (Buser & Parkins, 2015).

These themes indicate a divergent value system that differentiates individuals with and without eating disorder symptoms. This notion of a different set of values between groups is supported by the literature. For example, Gunnard et al. (2012) found that participants who struggled with eating disorder symptoms valued appearance to a greater degree than did participants who did not struggle with these symptoms. As noted previously, Leahey et al. (2011) suggested that a greater value on appearance to determine self-esteem may differentiate body-dissatisfied women with and without eating disorder symptomatology.

In the second theme, participants discussed the failure of eating disorder symptoms to achieve their intended outcome (i.e., weight loss or attractiveness). Participants spoke about issues such as the ways in which eating disorder symptoms can disrupt an individual's metabolism and ultimately lead to greater weight gain. Regarding treatment for clients struggling with eating disorder symptoms, previous authors have discussed the inclusion of education about the detriments of eating disorder symptoms (e.g., the ineffectiveness of laxative use to lose weight, the likely progression from restrictive eating to binge eating; Choate, 2010). Our findings suggest that awareness of the futility of eating disorder symptoms and their tendency, as one of our participants noted, to "backfire" could protect body-dissatisfied women from engaging in eating disorder symptoms.

The fourth theme dealt with the critical nature of a support system in the defense against eating disorder symptoms. Participants discussed the helpfulness of receiving positive feedback and encouragement from other people about their body image or eating behaviors. In previous research, Tylka (2004) found that having a friend or family member with eating disorder symptoms intensified the link between body dissatisfaction and eating disorder symptoms. It is possible that, in Tylka's study, positive support regarding one's body image and eating behaviors was not available to participants, who were instead affected by the negative examples of friends and family members who struggled with detrimental eating attitudes and behaviors. Our results are aligned with research on recovery from eating disorder symptoms. Individuals who struggled with

eating disorder symptoms reported that the support of others was important in their recovery, whereas isolation and negative reactions from others were detrimental (Linville, Brown, Sturm, & McDougal, 2012).

Counseling Implications

Counselors who work with women struggling with body dissatisfaction, eating disorder symptoms, or both can refer to our results in designing treatment interventions. Given the protective nature of specific values shared by our participants, counselors may want to inquire into the value systems of their clients. Choate (2010) wrote about the use of value-related discussions in the treatment of clients. In addition, acceptance and commitment therapy emphasizes asking clients to explore their value systems (Sandoz, Wilson, & DuFrene, 2010).

In working with clients, counselors should also stay attuned to small words or phrases that may communicate a protective value system. For example, in the present study, most participants discussed a love of food as being protective, but this idea was frequently a quick comment that could potentially be overlooked in a therapeutic encounter (by either the client or counselor). Yet a client's brief comment about enjoying food may point to a strongly held value about the enjoyment and pleasure associated with food.

Larger scale prevention efforts may also be informed by the themes on divergent value systems. Because of the prevalence of body dissatisfaction among women (Fiske et al., 2014), counselors may consider conducting prevention programs targeted at a general female population (e.g., women on a college campus) to assist body-dissatisfied women in avoiding eating disorder symptoms. Our participants communicated a value of health that dissuaded them from engaging in unhealthy eating disorder symptoms. Valuing a healthy lifestyle could be discussed in prevention efforts as a holistic dedication to mental, physical, and spiritual health. Participants in these prevention programs could discuss the ways eating disorder symptoms damage these domains. For example, problematic eating behaviors have been associated with detrimental physical health outcomes (e.g., heart damage; Oflaz et al., 2013) and mental health issues (e.g., depression; Allen, Byrne, Oddy, & Crosby, 2013). Authors have also discussed the potential for eating disorder symptoms to signify a spiritual void (Lewica, 1999).

Our participants also shared the protective benefit of believing that eating disorder symptoms are ultimately unsuccessful for weight loss or attractiveness. Counselors can include such information in treatment efforts (Choate, 2010). Also, hearing or reading personal accounts of an individual's struggle with eating disorder symptomatology and the unsuccessfulness of such behaviors (e.g., disrupting one's metabolism) may be a powerful way for clients and/or participants in prevention programs to gain cognizance of the ineffectiveness of eating disorder symptoms for weight loss or physical beauty. However, when including personal accounts in treatment or prevention programs, counselors

will want to screen such accounts to ensure that eating disorders are presented appropriately and are not normalized or glamorized (Mann et al., 1997; Piran, 1998), given research on the potential downsides of using personal accounts (Mann et al., 1997).

Our finding indicating the importance of having a support system to help defend against eating disorder symptoms also has potential counseling implications. Given previous research on how body-dissatisfied women are negatively affected by having a friend or family member with eating disorder symptoms (Tylka, 2004), counselors will want to assess clients' support systems. Specifically, counselors will want to understand the messages about weight, appearance, and eating habits that clients receive on a regular basis. Clients who lack positive influences in this area may be vulnerable to developing eating disorder symptoms. Counselors could work with clients to identify potential sources of positive support regarding their body image and eating behaviors and discuss their interest in cultivating such relationships. Given the association between eating disorder symptoms and certain types of body talk (e.g., saying negative things about one's body to others, hearing others say negative things about one's body, engaging in corumination about body dissatisfaction; Rudiger & Winstead, 2013), counselors will likely want to help clients gain positive sources of support about body image and eating patterns.

Strengths and Limitations

The present study attended to a paucity of research on factors that can protect body-dissatisfied women from eating disorder symptoms. This study also examined this issue from a qualitative lens to attend to the nuances of participants' experiences. Our study methodology was also strong; we chose a method that emphasized an in-depth engagement with participants' stories and used multiple coders and an auditor to improve the trustworthiness of our findings.

Limitations of the study include a lack of diversity among the participants, specifically in the areas of race/ethnicity, sexual identity, and geographic location. This study may also have been improved with multiple participant interviews. Also, we were unable to contact many participants for a member check and were thus unable to gather their feedback on our themes. Finally, our study was limited in that we did not determine the degree of body dissatisfaction with which participants were struggling; this may be relevant in the identification of protective factors.

Future Research and Conclusion

This study identified four variables that may attenuate the association between body dissatisfaction and eating disorder symptoms. The importance of the enjoyment of food appeared to be a unique finding to this study. Our findings also offer directions for future research. Researchers may investigate these variables in quantitative studies and conduct statistical tests of moderation (Frazier et

al., 2004). Future researchers should also increase the diversity of samples and recruit participants from different sites. The present study is an important step in attending to the research gap on factors that may weaken the link between body dissatisfaction and eating disorder symptoms.

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