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The Impact of Gratitude on Body Image, Exercise, and Eating Behaviors

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Abstract

Individuals with higher body dissatisfaction have higher disordered eating, excessive exercise, mental health concerns, and lower self-esteem. Gratitude interventions have been used to decrease body shame (objectified body consciousness), body dissatisfaction and increase positive body image. Gratitude interventions have primarily focused on changing state gratitude, leading to quick short changes. Individuals with long term, trait gratitude may have lower levels of excessive exercise, disordered eating, and a more positive body image. The current research is focused on better understanding the relationship between trait gratitude, body image, excessive exercise and disordered eating. In total 268 students from a university lifelong fitness class participated in the study, with 237 completing all measures, having a 43.66% male to female ratio. Results suggest body shame moderately increases disordered eating and compulsive exercise behaviors, while gratitude minimally decreases body shame. There are likely other factors impacting who partakes in excessive exercise, disordered eating, and body shame.

Keywords: State Gratitude, Trait Gratitude, Objectified Body Consciousness, Body Image, Body Dissatisfaction

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Chapter 1

Introduction

Preoccupations with the body have existed across time periods and societies throughout history (Rumsey & Harcourt, 2005). Recently, books, movies, talks, public figures amongst others are attempting to normalize a diverse range of body shapes and sizes. (Aniston et al., 2018; Taylor, 2018; Ted Conferences, 2014). Body image is how an individual views his or her own body. Body image is formulated through one's own observation of self, and processing the reactions of others (Grogan, 2008). This view of one's body can be negative, positive or neutral (Ahmadi et al., 2018; Cash & Smolak, 2012). When body image is positive, it can increase self-esteem, decrease mental health difficulties, and reduce distress (Dakanalis et al., 2013). When dissatisfaction with one's body is high, negative effects on wellbeing can occur (Brewis & Bruening, 2018, Vannucci & Ohannessian, 2018).

Negative View of the Body: Definition of Terms

Body dissatisfaction is a term used when one has a negative body image. It is defined as a negative evaluation of one's body shape or weight (Baker et al., 2019). Body dissatisfaction can occur at any age, for any sex, due to a multitude of factors that will be discussed further (Baker et al., 2019; Lamarche et al., 2017; Pop, 2018).

Another term that is used in the literature is body shame. Body shame is defined as feeling distressed and having negative view of one's body (Cella et al., 2019, Noser & Zeigler-Hill, 2014). Body shame is considered to be the result of constant body surveillance and

comparison with others (Noser & Zeigler-Hill, 2014). Similarly, body dissatisfaction usually occurs after comparing one's current body shape to a subjective ideal body shape (Ahmadi et al., 2018). The Objectified Body Consciousness Scale is a measure that assesses body shame. It determines the amount women examine their bodies and accept and internalize cultural body norms as their own standards (Mckinley, 2011). It is widely known that women tend to have greater issues with body image and body shame, but the impact of body surveillance and body shame on self-esteem and impacts both male and females (Choma et al., 2010). Men have been found to have lower levels of self-esteem and self-worth when self-surveillance and body shame are high (John & Ebbeck, 2008).

Influential Factors

Various factors affect body dissatisfaction. Body shape, weight, and BMI comparisons (Fuller-Tyszkiewicz et al., 2019) through social media, culture, family systems and self-talk have been found to influence body dissatisfaction (Bennett et al., 2019; de Vries, Vossen et al., 2019; Griffiths et al., 2018; Tiggemann et al., 2018). A 2019 study found self-talk (negative or positive) and comparison about one's body to impact body dissatisfaction (Fuller-Tyszkiewicz et al., 2019). Researchers suggest negative self-talk and focus on appearance based comparison may lead to greater body dissatisfaction, while positive self-talk and avoidance of body comparison may decrease body dissatisfaction (Fuller-Tyszkiewicz et al., 2019).

Comparison

In various studies body comparison was found to increase body dissatisfaction (Fitzsimmons-craft et al., 2015; Fuller-Tyszkiewicz et al., 2019). In the United States weighing individuals and comparing them to normed height and weight charts (BMI) have been used to identify weight concerns and treat obesity. Research has found these methods may cause a

negative effect on the psychological wellbeing of individuals (Ogden & Evans, 1996). Studies on weight and comparison found females tend to have greater body dissatisfaction when weight is high, whereas male's body dissatisfaction is not as affected by weight comparison (Zaccagni et al., 2014). Research also suggests adolescent females who are overweight or at risk for being overweight have higher body dissatisfaction than those who are an average weight (Thompson et al., 2007). It appears females are more negatively affected by weight and BMI comparisons than males (Ogden & Evans, 1996; Thompson et al., 2007; Zaccagni et al., 2014).

Comparison of one's body to others also impacts body dissatisfaction. Research shows comparing one's body to others can create a risk or maintain body dissatisfaction (Fitzsimmons-Craft et al., 2015; Leahey et al., 2007; Wang et al., 2019). Studies suggest participants who are exposed to images of thin models or socially idealized human bodies have increased body dissatisfaction (Moreno-Domínguez et al., 2019; Tiggemann et al., 2018). Individuals who have greater body dissatisfaction are more likely to compare their bodies to others, be activated during comparison, and have a negative self-evaluation during and after comparison (Trampe et al., 2012).

Family and Socialization

Research suggests family and childhood experiences also influence body dissatisfaction. Lev-Ari and colleagues (2014) found a woman's body ideal may be heavily influenced by females in her life (mother, sisters, best friends, etc.), especially when comparing oneself to a best friend. A recent study suggests a positive mother daughter relationship reduces body dissatisfaction (Matera et al., 2018). Similarly, childhood environments where caregivers did not validate a child's emotions or personal experiences were correlated with higher body dissatisfaction in early adulthood (17 to 25 years; Goncalves et al., 2018). In romantic

relationships, a lack of trust in the relationship was found to be a predictor of body dissatisfaction in women, whereas feeling a lack of support in the relationship was a predictor of body dissatisfaction in men. It appears there are various relational dynamics that can impact body image and body dissatisfaction.

Culture

Cultural influences also affect body dissatisfaction. In Indian culture the body is perceived as a vessel housing the human soul. Indian culture expresses this value through domains such as literature and art. Research suggests, that although Indian culture values the body and perceives the body in a positive way, peer interactions and social comparison through media have caused high body dissatisfaction (Sharma et al., 2018). Similarly, Korean culture previously valued larger body shapes as a sign of wealth and status. Korean communities focus on Confucian principles of morality and the benefit of the whole group. Due to Western societal influences, Korean communities and family structures now tend to value thinness, and currently have high levels of body dissatisfaction (Soyoung, 2018).

Materialism within cultures has been correlated with higher body dissatisfaction (Guðnadóttir & Garðarsdóttir, 2014). Individuals who are continually receiving materialistic messages, have an increased desire to consume more products in order to have body perfection. Cultures originally focused on cultural values when viewing their bodies have now become more focused on reaching an ideal beauty standard through the methods advertised to them in the media after coming in contact with outside influential messages through media about ideal beauty standards, and materialistic messages (Guðnadóttir & Garðarsdóttir, 2014, Sharma et al., 2018,; Soyoung, 2018).

Social Media

In recent years, social media has become a prevalent way for people to communicate and socialize with others (Ham et al., 2019). Social media has created a platform for users to compare one another through pictures, videos, comments and likes. Various social media outlets allow users to display edited pictures of human bodies, usually displaying thin idealized body shapes and sizes (Fardouly & Holland, 2018). Similarly to seeing thin models, social media users who are exposed to thin idealized body shapes on social media platforms have greater body dissatisfaction (Bennett et al., 2019; de Vries et al., 2019; Griffiths et al., 2018; Tiggemann et al., 2018).

These impacts of comparison through social media are prevalent among male and female, heterosexual and homosexual, minority and majority cultures in thousands of research studies in the United States and internationally (Tiggemann et al., 2018; de Vries et al., 2019; Griffiths et al., 2018; Bennett et al., 2019; Brooks, 2017; Girard et al., 2018; Rousseau et al., 2017). In the United States alone, social media usage has increased from 10% of the population in 2008 to 79% in 2019 ("Percentage of U.S. population," 2019), with 88% of 18 to 29 year olds using social media (Smith & Anderson, 2018). Currently 2.34 billion out of an estimated 7.7 billion people worldwide ("Current world population," 2019) have social media accounts, with Facebook having the highest media usage with 2.2 billion accounts ("Number of monthly active Facebook users," 2019).

A recent 2018 survey showed Americans 18 years and older spend an average of 11 hours a day interacting with media via listening, reading, and responding to media ("The Nielsen total audience report: Q1," 2018). An average of three hours and 48 minutes of media interaction was spent on smartphones, tablets and computers, with 62% of time spent searching the internet

or using an app on a smartphone ("The Nielsen total audience report: Q1," 2018). These statistics suggest a large increase in social media usage, likely increasing exposure to thin idealized bodies, increasing body dissatisfaction among people.

Effects of Negative Views of the Body

There are various effects of body dissatisfaction, body shame, body consciousness and negative body images. While these constructs have been well defined individually, we are referring to them as similar and describing their effects below.

Eating Behaviors

High body dissatisfaction has been found to increase disordered eating behaviors (Figueiredo et al., 2019). Research suggests that anxiety, depression and dieting can moderate the relationship between body dissatisfaction and disordered eating (Juarascio et al., 2011). Verstuyf and colleagues (2014) found individuals who are focused on their appearance while regulating food intake, are more likely to participate in disordered eating behaviors in comparison to people who are focused on healthy eating behaviors. Research suggests female college students may have high levels of body dissatisfaction, and use unhealthy weight management techniques to decrease their dissatisfaction (Cook-Cottone, & Phelps, 2003; Rudd, & Lennon, 2000; Wolfe & Hewitt, 2016). Overall, disordered eaters report greater mental health concerns and heightened emotional eating in comparison to individuals who are not disordered eaters (Brown et al., 2009).

Exercise Behaviors

Body dissatisfaction also influences exercise behaviors. Research indicates that body dissatisfaction can decrease with excessive exercise, however high weight preoccupation and high body focus are correlated with increased body dissatisfaction (Davis & Fox, 1993). More

and colleagues found exercise avoidance to mediate the relationship between body dissatisfaction and exercise. Individuals who actively avoided exercise, did so due to their body dissatisfaction, and feelings of exhaustion and embarrassment from exercise (More et al., 2019). Research suggests most people feel slightly more positive about their body after exercising (Vocks et al., 2009). In a study by Vocks and colleagues, individuals who had higher body dissatisfaction and motivation for thinness had higher positive perceptions of the physical changes occurring after exercising, leading to possible reinforcement of exercise for improvement of body dissatisfaction. Exercise appears to be a tool used by individuals to reduce body dissatisfaction, but can also be used excessively or avoided due to body dissatisfaction (Davis & Fox, 1993; More et al., 2019).

Self-Esteem

Research suggests body dissatisfaction negatively impacts self-esteem on a wide spectrum of individuals (Barker & Bornstein, 2010; Brytek-Matera, 2010; Herrero et al., 2018). Participants with higher body dissatisfaction were found to have lower self-esteem (Brytek-Matera, 2010; Herrero et al., 2018; Prabhu & D'Cunha, 2018; Tiggeman, 2005). Low self-esteem was also related to higher disordered eating behaviors, such as restricted or restrained eating (Damon, 2018; Kong et al., 2013; Verplanken & Tangelder, 2011). Higher self-esteem was found to buffer the negative effects of body dissatisfaction, whereas body surveillance and comparison increased body dissatisfaction (Dakanalis et al., 2013). Body dissatisfaction and self-esteem appear to impact one another in a dynamic relationship structure. Research suggests greater body dissatisfaction leads to lower self-esteem, causing psychological distress (Duchesne et al., 2017).

Mental Health

High body dissatisfaction is also associated with high levels of depression and anxiety (Brewis & Bruening, 2018; Vannucci & Ohannessian, 2018). Exposure to thin idealized bodies was found to increase body dissatisfaction and anxiety (Zapata-Pachas & Alvarado, 2017). Research suggests body dissatisfaction is associated with anxiety, especially symptoms of social anxiety and panic disorder in adolescence (Vannucci & Ohannessian, 2018). In particular, a negative self-evaluation related to body dissatisfaction can lead to fear, causing anxiety with daily behaviors, such as eating habits (Levinson & Rodebaugh, 2015).

The association between high depressive symptoms and high body dissatisfaction has been found to be prominent among generally every weight category among adolescents (Chen et al., 2015). Students with higher depressive symptoms and lower self-esteem were more likely to have higher levels of body dissatisfaction (Lim & You, 2017). Adolescents who endorsed being dissatisfied with their bodies were 3.7 times more likely to endorse depressive symptoms (Zapata-Pachas & Alvarado, 2017).

Exercise behaviors, eating behaviors amongst various other effects of body dissatisfaction interact and impact one another. A study from 2008 reported women who exercise for the purpose of controlling their weight had higher levels of disordered eating attitudes (Ware-Benkert, 2008). Women who were not using exercise to control weight endorsed higher levels of body shame, and less belief of control over their appearance (Ware-Benkert, 2008). One study found regardless of sex, individuals' reason for exercise was correlated to disordered eating and low self-esteem (Furnham, Badmin, & Sneade, 2002).

In conclusion, research suggests individuals compare themselves to unrealistic idealized human bodies, creating body dissatisfaction (Tiggemann & Slater, 2004). People then try to

reduce body dissatisfaction and body shame, and increase self-esteem through excessive exercise and restrictive eating (Davis & Fox, 1993, Furnham et al., 2002). These unhealthy weight and appearance management patterns can lead to eating disorders, depression, anxiety and greater levels of body shame, body dissatisfaction and a reduction in self-esteem (Daniali et al., 2013; Davis & Fox, 1993).

Prevalence

According to a 1997 national U.S. survey 62% of women ranging in age from 13 to 19 years were dissatisfied with how much they weighed. This increased to 67% of dissatisfaction for women over the age of 30 years (Garner, 1997). In a 2010 survey it was found that 59% of girls were dissatisfied with their bodies and 66% wanted to lose weight, while 81% of 10 year old females were fearful of becoming fat. Only 2% of women defined themselves as beautiful (Martin, 2010).

Currently there is a lack of research regarding U.S. body dissatisfaction statistics in college males and females, but it can be assumed that the percentage of those dissatisfied with their bodies has risen due to the international rise in body dissatisfaction (Pop, 2017). A 2016 study conducted on a Romanian college campus found 79% of female participants to be dissatisfied with the way their body looked, with higher body mass index (BMI) accounting for 41% dissatisfaction (Pop, 2017). Similarly in other countries body dissatisfaction ranged from 47.3% in Brazil, to 100% in Pakistan, with 65.6% in Poland, and 73.6% in Saudi Arabia (Pop, 2017). Each of these studies was solely or predominantly comprised of female participants.

Males also struggle with body shame and dissatisfaction due to continual social comparison and evaluation (Baker et al., 2019; Lamarche et al., 2017). A 1997 United States study found 43% of men were dissatisfied with their bodies (Garner, 1997). Results from a 2018

study suggest body dissatisfaction is apparent in males and females with differences in areas of dissatisfaction. Males were found to be more concerned with their height and muscle mass, whereas females focused on body mass and thinness of their bodies (Ahmadi et al., 2018).

Interventions to Decrease Negative Views of the Body

Various interventions are used to decrease body dissatisfaction and body shame, and increase a positive body image. A study conducted in 2019 by Guest and colleagues examined the effectiveness of 13 interventions to increase a positive body image and decrease body dissatisfaction. Interventions focused on self-compassion, body functionality, psychoeducation, cognitive behavioral therapy (CBT), gratitude, mindfulness, physical exercise, and cognitive dissonance. Participants of these studies were from six different countries with varying ages and genders. Interventions were administered in various domains (online, apps, in person) and in different ways (workbook, in person activity, podcasts etc.). According to the researchers, this was the first comprehensive analysis examining the effectiveness of interventions to increase positive body image.

Results suggest a strong to moderate increase in positive body image via focus on body functionality, gratitude, exercise, CBT, and mindfulness interventions. Compassion and self-compassion interventions had moderate to weak relationships with increases in positive body image. Limitations included a lack of blinding of participants across many of the studies, suggesting participants may have increased in positive body image due to possible knowledge of the research topic. Another limitation was that it was difficult to compare body image measures across various studies due to the complex and dynamic relationship of body image with eating, exercise, comparison, media usage, amongst many other factors (Guest et al., 2019).

Although many interventions have been studied and found to be effective in increasing positive body image and decreasing body dissatisfaction and body shame, less research has been conducted with regard to internal characteristics and factors of individuals who possess a positive body image without interventions. The research that is available suggests individuals with high levels of body appreciation (Swami et al., 2018), gratitude in spirituality (Tiggemann & Hage, 2019), self-compassion, engagement in exercise (Korn et al., 2013) and less social media comparison (Andrew et al., 2016) have higher positive body image.

Gratitude

Due to high body dissatisfaction and body shame in society, gratitude interventions have been used to increase a positive body image. Gratitude is defined as a state of appreciation, where an individual appreciates what is valuable and meaningful in their life (Sansone & Sansone, 2010). In general people with gratitude have greater life satisfaction (Robustelli & Whisman, 2018; Rew et al., 2019; Salvador-Ferrer, 2017). Research suggests gratitude also increases hope and happiness (Witvliet et al., 2019), quality of life, mental health, and decreases perceived stress (Valikhani et al., 2019). Homan and colleagues (2018) studied a gratitude model for body appreciation suggesting gratitude is indirectly connected to body appreciation through less self-worth found in body comparison, and appearance approval by others.

Gratitude as an intervention appears to be a quick, simple functional component of gratitude, where individuals read, write or focus on things they are grateful for (Guest et al., 2019). One of the main limitations within gratitude intervention studies for positive body image is the long term effects of gratitude interventions. Gratitude intervention studies are focused on increasing state gratitude. State gratitude is defined as temporary emotions of gratitude (Wood et al., 2008). These studies are showing quick increases in gratitude, but are unable to provide

longstanding information about long term gratitude based change. Trait gratitude refers to a long term, continual mindset and practice of gratitude (Wood et al., 2010). Research has focused on interventions improving state gratitude and its impact on body image, however observing how trait gratitude relates to body image in cross-sectional studies has not been done. Individuals with trait gratitude may have less body shame and body dissatisfaction.

A recent study found Latino Americans and European Americans experience and express significantly more gratitude than East Asian Americans (Corona et al., 2019), suggesting there are differences in gratitude awareness and expression between ethnic groups. In China gratitude in students has been linked to a decrease in loneliness (Shiguang Ni et al., 2015), death anxiety and an increase in life satisfaction (Chan, 2012). In a United States college athlete population gratitude was found to be negatively correlated to burnout, stating gratitude as a possible protective factor for burnout (Gabana et al., 2017). Little research has been done in the United States regarding the general college student population and trait gratitude.

Exploring the impact of trait gratitude on body shame, OBC, disordered eating and compulsive exercise in college students may allow for a greater understanding of gratitude's role in health and use as a protective factor against body dissatisfaction (Lowen, 2017; Tuning, 2016). Previous research suggests body shame as a significant predictor of health outcomes in college populations (Lamont, 2015). Some of these health outcomes include: compulsive exercise (Tuning, 2016), depression (Brewis & Bruening, 2018; Lamont, 2015), anxiety (Vannucci & Ohannessian, 2018), self-esteem issues (Brytek-Matera, 2010; Herrero et al., 2018) amongst many other negative health outcomes. Perhaps trait gratitude may be a protective factor against body shame, reducing negative health outcomes.

Purpose of the study

The purpose of this current study is to examine the relationship between trait gratitude body shame, disordered eating, and compulsive exercise in college students, to further understand the impact of trait gratitude on various health outcomes. This is unique, in that trait gratitude does not require an intervention, and can be an internal trait individuals already possess. This research allows for a greater exploration of the impact a mindset can have on views of self and health outcomes, possibly leading to more research focused on cultivating new long term, mindset focused interventions, for sustainable positive health outcomes.

Hypotheses

1. It is hypothesized that objectified body consciousness will be positively correlated with negative body image, disordered eating and compulsive exercise, and GRAT-S will be negatively correlated with the three subscales of the OBC scale (body surveillance, control beliefs, and body shame), disordered eating (SCOFF), and compulsive exercise (CET).
2. It is hypothesized that female individuals with higher BMI will have higher levels on all three subscales of OBC.
3. It is hypothesized that students with higher scores on the body shame subscale of the OBC will have higher levels of disordered eating (SCOFF) and compulsive exercise (CET).
4. It is hypothesized that levels of gratitude will have a linear relationship with body shame (OBC, body shame subscale) and that higher levels of gratitude (GRAT-S) will predict lower levels of body shame (OBC, body shame subscale).

Chapter 2

Methods

Participants

Participants were gathered from a fall 2014 freshman lifelong fitness class at a private, four year, Northwestern University. In total 268 students participated in the research process, with 237 individuals completing all necessary research measures. Subjects were male and female (43.66% male to female) ranging from 17 to 25 years of age, with various ethnic backgrounds (74.42% White, 5.81% Black, 9.69% Asian, 6.59% Hispanic, 1.94% American Indian/Alaskan Native, and 1.55% International Student). See Table 1. Involvement in the study was a requirement of a lifelong fitness course, with a grade of completion for the class being the only incentive offered for students in completing the research measures. No exclusion criteria, except for enrollment in the lifelong fitness class, was required for the current research.

Procedure

The study design is a cross-sectional study, analyzing a de-identified data set collected from college students at a private Christian university in the Pacific Northwest. IRB approval was sought to determine if the current research study could be conducted, that analyses on the data set and subsequent publication could be approved. Student participants signed an informed consent, stating the data obtained from the current research would keep individual responses confidential, and that the data may be analyzed and published. Data was collected via surveys measuring demographics, eating behaviors, exercise behaviors, BMI, body image, objectified

Table 1

Demographic Characteristics of the Sample

Variable	*N*	%	M(*SD*)
Age (Years)	268		19.09(1.37)
Height (Inches)	267		67.33(4.45)
Weight	267		155.91(37.62)
Male	117	43.66	
Female	151	56.34	
Ethnicity	258		
American Indian/Alaskan	5	1.94	
Native			
Hispanic	17	6.59	
White, Non-Hispanic	192	74.42	
Asian/Pacific Islander	25	9.69	
Black/Non-Hispanic	15	5.81	
International Student	4	1.55	
Year in School			
Freshman	100	38.46	
Sophomore	119	45.77	
Junior	24	9.23	
Senior	15	5.77	
Beyond Senior	2	0.77	

body consciousness and gratitude as a lifestyle trait. Data was entered into SPSS and stored on a password encrypted computer.

Measures

Demographics

Demographic information was gathered via a survey. Participants answered questions regarding their name, age, gender, ethnicity and year in school.

The SCOFF Questionnaire

The SCOFF questionnaire (Morgan et al., 2000) was completed by participants to measure eating behaviors related to anorexia and bulimia nervosa. The SCOFF contains five yes

or no questions, with an answer of yes on any question meaning an endorsement of an eating disorder symptom. The questions are as follows:

1. Do you make yourself Sick because you feel uncomfortably full?
2. Do you worry that you have lost Control over how much you eat?
3. Have you recently lost more than One stone (14lb) in a 3-month period?
4. Do you believe yourself to be Fat when others say you are too thin?
5. Would you say that Food dominates your life?

Each answer marked as yes is given one point. Individuals who circle yes on two or more questions have a probable diagnosis of anorexia or bulimia nervosa. Morgan and colleagues (2000) found the SCOFF to have 100% sensitivity to eating disorders, with 87.5% sensitivity to individuals who endorse two or symptoms having anorexia or bulimia nervosa.

The Compulsive Exercise Test (CET)

The CET (CET; Taranis et al., 2011) was completed by participants to measure compulsive exercise behaviors. This survey consists of 24 questions on a five-point Likert scale ranging from 0 as *never true*, to 5 as *always true*. Scores range from 0 to 120, with the higher the score the higher the compulsive exercise behavior. The CET has five subscales measuring specific areas of compulsive exercise: weight-control exercise, exercise rigidity, mood improvement, avoidance and rule-driven behavior, and lack of exercise enjoyment.

The CET was found to have a strong internal consistency (Chronbach's alpha = 0.85), with good concurrent validity (0.62) in relation to exercise commitment (Taranis et al, 2011, CES; Davis et al., 1993). The CET has been found to have high concurrent validity with body dissatisfaction (0.40), drive for thinness (0.53) and disordered eating (0.47) on the Eating

Disorder Inventory-2nd Edition (EDI-2; Garner, 1991). For this sample, Cronbach's alpha was 0.85, the exact same as the CET's internal consistency in general.

Body Mass Index (BMI)

BMI was calculated by measuring each participant's height and weight, then multiplying the participant's weight by 705, and dividing by their height in inches twice. This number allows for comparison, putting individuals into categories of underweight, normal weight, overweight and obese.

The Objectified Body Consciousness (OBC) Scale

The OBC scale consists of 24 items on a 7-point Likert scale, ranging from *strongly disagree* to *strongly agree* measuring three subscales: body shame, body surveillance and control beliefs (McKinley & Hyde, 1996). Each subscale consists of eight questions and is separately assessed with no final total score measuring OBC. The body shame scale measures how one's body compares to cultural expectations of physical attractiveness. The body surveillance scale measures how often an individual assesses one's body and considers it an object. The control beliefs scale measures how much an individual believes they can control their body shape and weight. Each subscale of the OBC is the mean of the responses of the items on that scale. The OBC scale was originally meant to measure women's OBC, but has been used in various studies regarding male participants as well (Dakanalis et al., 2017; Jackson & Chen, 2015). Internal consistency (Body Shame Scale = 0.75, Body Surveillance Scale = 0.89, Control Beliefs Scale = 0.72) and test-retest reliability (Body Shame Scale = 0.79, Body Surveillance Scale = 0.79, Control Beliefs Scale = 0.83) of the OBC is moderate to high (McKinley & Hyde, 1996). For the current sample the internal consistency measured through Cronbach's Alpha (Body Shame =

0.82, Body Surveillance = 0.80, Control Beliefs = 0.76) was found to be greater than the original internal consistency for the measure in general.

The Gratitude Resentment and Appreciation Test-Short Form (GRAT-S)

The GRAT-S measures trait gratitude and is composed of three subscales with various reliability: appreciation for simple things (α = .87), social appreciation (α = .76) and endorsing symptoms of having enough, loss of sense of deprivation (LOSD; (α = .80; Watkins et al., 2003). The scale is composed of 16 items on a 9-point Likert scale ranging from 1 *strongly disagree* to 9 *strongly agree*. An average score is calculated for each subscale, these scores are then added together and averaged for a total average score. The higher the score, the higher the level of trait gratitude. For the current sample the GRAT-S subscales (appreciation for simple things (α = 0.84), social appreciation (α = 0.82), and endorsing symptoms of having enough (α = 0.84)) and the overall GRAT-S through Cronbach's Alpha, had higher internal consistency than the original measure (GRAT-S (α = 0.89)).

Chapter 3

Results

Prior to running analyses, subscales and assessment measures that had missing data were withdrawn from the data analysis (see Table 2).

Table 2

Descriptive Statistics for Population and Measures

Variable	*N*	M (*SD*)	Skewness	
			Statistic	Std. Error
OBCBodyShame	253	3.05 (*1.19*)	.482	.153
OBCBodySurveillance	254	3.98 (*1.09*)	.217	.153
OBCBodyControl	253	4.87 (*.96*)	-.490	.153
SCOFF	260	.55 (*1.01*)	2.28	.151
CET	230	54.33 (*16.06*)	.108	.160
GRAT-S	237	7.22 (*1.08*)	-.570	.158
LOSD	251	6.86 (*1.52*)	-.479	.154
Female BMI	149	23.68 (*4.66*)	1.73	.199

Hypothesis 1

It was hypothesized that all three subscales of objectified body consciousness (OBC) would be positively correlated with disordered eating (SCOFF) and compulsive exercise (CET) and negatively correlated with trait gratitude (GRAT-S). Pearson correlations were run between the total average score on the GRAT-S, the three subscales of the OBC, the total number of

endorsed items on the SCOFF, and the total score on CET. As hypothesized there are significant positive correlations between the body shame subscale of objectified body consciousness (OBC) and disordered eating (SCOFF; OBC body shame, $r = .395$, $p < .00$). The body control beliefs subscale of the OBC is negatively correlated with disordered eating (SCOFF; $r = -.25$, $p = .00$), while the body surveillance subscale of the OBC is not significantly correlated with disordered eating (SCOFF; $r = .07$, $p = .24$).

As hypothesized the body shame subscale and the body surveillance subscale of the OBC are both significantly positively correlated with compulsive exercise (CET; OBC body shame, $r = .45$, $p = .00$; OBC body surveillance, $r = .26$, $p < .00$). The body control beliefs subscale of the OBC is not significantly correlated to compulsive exercise (CET; $r = .003$, $p = .964$). As hypothesized the body shame subscale of the OBC is negatively correlated with trait gratitude (GRAT-S; $r = -.245$, $p = .001$). The body control subscale of the OBC was found to be significantly positively correlated with trait gratitude (GRAT-S; $r = .245$, $p < .00$), while the body surveillance subscale of the OBC was not found to be significantly correlated with trait gratitude (GRAT-S; $r = .046$, $p = .50$).

Hypothesis 2

It was hypothesized that female participants with higher body mass index (BMI) would have higher scores on all three subscales of the OBC, inferring females with higher BMI have higher objectified body consciousness. A one-way analysis of variance (One-way ANOVA) was run three times, grouping highest and lowest quartiles of BMI of female participants, with the dependent variable being the three subscales of the OBC (body shame, control and surveillance). As hypothesized BMI was significantly related to body shame at the 0.5 level $F(1,66) = 6.55$, $p = .049$). See Table 3. The strength of relationship between female BMI and change in body shame

(OBC), as assessed by η^2, was minimal, with female BMI accounting for 6% of the variance of body shame (OBC) in female participants.

Table 3

Correlations Between Variables in the Undergraduate Student Population

Variable	SCOFF	CET	GRAT-S
N	207	187	189
OBC body shame	.395**	.447**	-.245**
N	227	200	207
OBC body control	-.250**	.003	.254**
N	233	208	214
OBC body surveillance	.077	.263**	.046

Note. * Correlation is significant at the 0.05 level (2-tailed). ** Correlation is significant at the 0.01 level (2-tailed).

The ANOVA for the body surveillance and the control beliefs subscales of the OBC and female BMI were not significant (OBC body surveillance, $F(1,61) = .620$, $p = .434$; OBC control beliefs, $F(1,66) = .507$, $p = .479$), suggesting the strength of the relationship between female BMI and change in body surveillance (OBC) and body control beliefs (OBC) is not strong. Post hoc tests were not performed for BMI quartiles, because there were fewer than three groups. In total, there were 149 female participants who reported their height and weight for BMI measurements, with an average BMI of 23.68 ($SD = 4.66$). Of this total 74 females were in the high and low quartiles of BMI, and their data used for the current analyses. Refer to Table 4 for further information.

Hypothesis 3

It was hypothesized that participants with higher scores on the body shame subscale of the OBC would have higher levels of disordered eating (SCOFF) and compulsive exercise (CET). A linear regression was computed twice to determine if body shame (OBC) had a linear relationship with disordered eating (SCOFF, dependent variable) and compulsive exercise (CET, dependent variable). As hypothesized participants with higher body shame (OBC) tend to have higher disordered eating behaviors (SCOFF) ($F(1, 205) = 48.21$, $p < .00$), with an R^2 of .16 and an adjusted R^2 of .16. See Table 4. Data supports significance because the 95% confidence interval for the slope, .246 to .440 does not contain the value zero. Approximately 16% of the variance in disordered eating behaviors is accounted for due to body shame, with increased body shame, predicting increased disordered eating.

Table 4

Analysis of Variance: One-Way ANOVA Comparing Three Subscales of the OBC (body shame, control and surveillance) Individually with the Highest and Lowest Quartiles of BMI in Female Participants.

Dependent Variable	Sum of Squares	*df*	Mean Square	*F*	Sig.
OBC body shame between groups	6.55	1	6.55	4.035	.049
OBC body control between groups	.459	1	.459	.507	.479
OBC body surveillance between groups	.932	1	.932	.620	.434

As hypothesized participants with higher body shame (OBC) tend to have higher compulsive exercise behaviors (CET; $F(1, 222) = 56.82$, $p < .00$), with an R^2 of .20 and an adjusted R^2 of .20 . The 95% confidence interval for the slope, 4.61 to 7.88 does not contain the value zero, therefore body shame is significantly related to compulsive exercise. Approximately 20% of the variance in compulsive exercise was accounted for by its linear relationship with body shame, with high body shame predicting increased compulsive exercise behaviors.

Hypothesis 4

It was hypothesized that levels of gratitude (GRAT-S) would have a linear relationship with body shame (OBC), predicting that higher the levels of gratitude would predict lower levels of body shame. A linear regression was conducted to determine if body shame has a linear relationship with gratitude. As hypothesized participants with higher levels of gratitude, tended to have less body shame ($F(1, 227) = 12.81$, $p < .00$), with an R^2 of .05 and an adjusted R^2 of .05. The 95% confidence interval for the slope, -.405 to -.118 does not contain the value zero, therefore gratitude is significantly related to body shame. Merely 5% of the variance in body shame was account for by gratitude, with high gratitude predicting low body shame.

Additional Analyses

Based on the significant correlations in the correlation matrix, follow-up analyses were conducted. A linear regression was computed to determine if body surveillance (OBC) has a positive and predictive linear relationship with compulsive exercise (CET). Findings suggest participants with higher body surveillance tend to have higher compulsive exercise behavior ($F(1, 206) = 15.34$, $p < .00$), with an R^2 of .07and an adjusted R^2 of 0.07. Data supports significance because the 95% confidence interval for the slope of body surveillance (independent

variable) to compulsive exercise (dependent variable), 2.32 to 6.06 do not contain the value zero. Approximately 7% of the variance in compulsive exercise is accounted for by body surveillance. A linear regression was computed to determine if control beliefs (OBC) has a negative and predictive linear relationship with disordered eating (SCOFF). Results suggest participants with higher control beliefs tend to have higher disordered eating ($F(1, 225) = 15.54$, $p < .00$), with an R^2 of .06 and an adjusted R^2 of .06. Data supports significance because the 95% confidence interval for the slope, -.390 and -.131 does not contain the value zero, suggesting control beliefs have a negative linear relationship with disordered eating. Approximately 6% of the variance in disordered eating is accounted for by control beliefs.

Subscales of the GRAT-S were correlated with the variables. A Pearson correlation and a linear regression were conducted to further understand the relationship between the lack of sense of deprivation (LOSD) subscale of GRAT-S and body shame (OBC). Results suggest LOSD is significantly negatively correlated to body shame ($r = -.356$, $p = .00$). The 95% confidence interval for the slope, .110 to .337 does not contain the value zero, therefore LOSD is significantly negatively related and predictive of body shame ($F(1, 241) = 22.88$, $p < .00$), with an R^2 of .10 and an adjusted R^2 of .10, accounting for 10% of the variance.

A Pearson correlation and a linear regression were conducted to further understand the relationship between the lack of sense of deprivation (LOSD) subscale of the GRAT-S and control beliefs (OBC). Results suggest LOSD is significantly positively correlated with control beliefs ($r = .241$, $p = .00$). The 95% confidence interval for the slope, .069 to .230 does not contain the value zero, therefore LOSD is significantly positively predictive of control beliefs ($F(1, 241) = 11.08$, $p < .00$), with an R^2 of .04 and an adjusted R^2 of 0.04, accounting for a minimal 4% of the variance.

A Pearson correlation and a linear regression were conducted to further understand the relationship between trait gratitude (GRAT-S) and control beliefs (OBC). Results suggest trait gratitude is significantly positively correlated with control beliefs ($r = .254$, $p = .00$). The 95% confidence interval for the slope, .110 to .337 does not contain the value zero, therefore trait gratitude is significantly positively predictive of beliefs about control of one's body ($F(1, 227) = 15.14$, $p < .00$), with an R^2 of .06 and an adjusted R^2 of 0.06, accounting for a minimal 6% of the variance.

Chapter 4

Discussion

Disordered Eating

Current findings suggest disordered eating is significantly positively correlated with body shame (OBC), significantly negatively correlated with control beliefs (OBC), and not correlated with body surveillance (OBC). Results indicate body shame is positively predictive of disordered eating, accounting for 16% of the variance. This data is consistent with previous research suggesting high body dissatisfaction increases disordered eating behaviors (Figueiredo et al., 2019).

While we hypothesized that control beliefs would have a positive relationship with disordered eating, since disordered eaters tend to participate in disordered eating habits to gain control over their body and appearance, the results of this study do not support this hypothesis. In this study, control beliefs about weight and appearance were negatively predictive of disordered eating, accounting for 6% of the variance. Researchers Moradi and Varnes (2017) tested the constructs of the OBC Scale and found control beliefs to be a weak indicator of objectified body consciousness at large, while body surveillance and body shame appeared more valid and reliable. This likely impacted the current results of this study. Another possible explanation may be that disordered eaters are attempting to gain control over their bodies, but never actually believe they are in control, leading to a negative relationship between disordered eating and control beliefs. This notion could be further supported by instances where people with extreme disordered eating, particularly anorexic individuals, can eventually die due to their perception of

never being skinny enough. They are continually striving to exert control over their bodies through extreme methods, while never fully reaching their goal, therefore not feeling in control.

It was originally hypothesized that body surveillance would positively correlate with disordered eating, since previous research suggested individuals focused on their appearance while regulating food intake are more likely to participate in disordered eating behaviors (Verstuyf et al., 2014). In this current study, body surveillance and disordered eating were not related. Body surveillance alone does not equate to disordered eating, but body surveillance and regulation of food intake can lead to disordered eating (Verstuyf et al., 2014).

Excessive Exercise

Previous research states weight preoccupation and high body focus were positively correlated with body dissatisfaction, suggesting specific aspects of excessive exercise are related to body dissatisfaction (Davis & Fox, 1993). Current study results suggest an increase in body shame is predictive of an increase in compulsive exercise, with body shame accounting for 20% of the variance in compulsive exercise. Dissatisfaction with one's body may motivate individuals to excessively exercise to reduce their body shame (Davis & Fox, 1993; More et al., 2019). Vocks and colleagues (2009) found individuals with higher body dissatisfaction and motivation for thinness will likely have positive perceptions of physical changes, causing a reinforcing cycle for compulsive exercise.

The current study results suggest body surveillance and compulsive exercise are positively correlated and body surveillance has a positively predictive linear relationship with compulsive exercise, where approximately 7% of the variance in compulsive exercise is accounted for by body surveillance. These results suggest individuals may excessively exercise because they are continually surveying their body. Body shame may have a greater impact than

body surveillance on compulsive exercise, because of the conceptual difference between the two. Body shame is the feeling of distress about one's body (Cella et al., 2019), and is the result of constant body surveillance and comparison (Noser & Zeigler-Hill, 2014). Body surveillance is an action. Body surveillance appears to be one variable, interacting with others leading to body shame. Body shame is a values-related concept. Since body shame is a values-related concept, it contains a more holistic picture, than one single behavior such as body surveillance. Body shame therefore has a greater range of impact and reach than simply body surveillance.

Female BMI and Objectified Body Consciousness

Out of the three objectified body consciousness scales, only body shame had a significant relationship with BMI in female participants. Female BMI accounted for 6% of the variance in body shame, suggesting females with higher BMI have higher body shame. Although the effect size is not large, the results are significant enough to demonstrate a direct relationship between female BMI and body shame. Previous research states females have higher body dissatisfaction when their weight is high (Zaccagni et al., 2014), and adolescent females who are overweight, or at risk for being overweight have higher body dissatisfaction then females at an average weight (Thompson et al., 2007).

In the current culture, there appears to be a preference for thin women. In a 2010 survey 81% of 10-year-old females were fearful of getting fat (Martin). Various media outlets display thin idealized edited human bodies (Fardouly & Holland, 2018), creating comparison amongst users. When a woman has a larger BMI and does not meet the standard of attractiveness in society, this can negatively impact her, causing her to feel bad about her body. One biological attribute of a person can be significantly related to a general negative emotion due to cultural norms.

Gratitude and Body Shame

Current research findings suggest trait gratitude (GRAT-S) is negatively correlated with body shame (OBC), positively correlated with control beliefs (OBC) and not correlated with body surveillance (OBC). Participants with high trait gratitude, tended to have less body shame, accounting for a small amount of the variance (5%). An additional correlation and linear regression were run to further understand the relationship between the lack of sense of deprivation (LOSD) subscale of the GRAT-S and body shame, since this subscale had stronger correlational data than the GRAT-S as a whole. Results suggest this subscale, measuring one's perception of having enough is significantly negatively predictive of body shame, accounting for 10% of the variance.

When considering the three subscales of the GRAT-S (appreciation for simple things, social appreciation, and endorsing symptoms of having enough), the LOSD subscale is the only scale not focused on the appreciation aspect of gratitude. LOSD is focused on the perception of having enough. The belief of having enough appears to be a more personal trait (with negative and positive connotations), defining a person's current perception of their life circumstance, whereas appreciation may be less personal, accounting for an individual's ability to recognize positive things in life. Perhaps an individual is able to appreciate aspects of life, but does not have a positive perception on their own personal life circumstance, therefore having a more negative perception of their body, since it is also a personal perspective of oneself.

Current findings suggest trait gratitude (GRAT-S) has a positive predictive relationship with control beliefs (OBC), accounting for a minimal 6% of the variance. Further analyses were conducted to see if the LOSD subscale of the GRAT-S would have a greater impact on control beliefs, due to its increased impact on body shame. Results were similar to the overall GRAT-S

scale, with the perception of having enough (LOSD scale), not having a more significant impact than overall GRAT-S, accounting for 4% of the variance in control beliefs. Hypotheses initially predicted GRAT-S would have a negative relationship with control beliefs. Perhaps gratitude fosters a sense of more control in one's life. It is important to note the effect size is minimal, but gratitude may have a greater impact on general beliefs about control. Previous research states gratitude is a state of appreciation (Sansone & Sansone, 2010) so gratitude may provide a space for individuals to be content in their current life, in turn gaining a sense of control through acceptance. Perhaps gratitude provides people the ability to maintain their own mental control, even when they are not able to control the world around them.

Limitations

Limitations include lack of access to a more representative demographic pool of the general population. Due to the location of research, and little access to a more diverse population, the college undergraduate student population at a private Christian university was used, with the majority of students being young white adults. This is not representative of the population at large and data should be interpreted with caution. Data was also collected via an archival system, limiting what measures researchers could use or run analyses on. Since this data was originally collected in 2014, there may have been more societal changes or other factors impacting current results. Interpretation of results should be thoughtfully considered, and held cautiously due to the various limitations in this study.

Implications

Overall, the current research suggests, increases in body shame (OBC) increase compulsive exercise behaviors and disordered eating, while increased trait gratitude decreases body shame (OBC) and increases body control beliefs (OBC). Body shame had a much more

significant impact on health behaviors than trait gratitude (GRAT-S) had on body shame. This study suggests the connection between body shame and trait gratitude is significant, but the impact is small.

Interesting findings include the predictive negative impact of the sense of deprivation scale of GRAT-S on body shame. Although differences are overall minimal, there still was a difference suggesting the perception of having enough is more impactful than general appreciation in decreasing body shame. These results suggest that body shame negatively impacts the mind, body and behaviors. When working with clients regarding body shame, disordered eating, or excessive exercise, it can be assumed that reducing one's body shame may also reduce other forms of negative coping (excessive exercise, disordered eating). The question is how do we reduce one's body shame? It may be helpful to have the patient focus on what they do have versus practicing appreciation for various things in life. This could be related to an individual's relationship with their body. Instead of having a client practice appreciation for their body, having the individual focus on what they do have regarding their body may be more beneficial in decreasing body shame.

Furthermore, Lack sense of deprivation (LOSD) from the GRAT-S was significantly negatively correlated to body shame. LOSD can also be defined as one's sense of abundance in their life. Those who feel their lives are more abundant (less deprived) have less body shame. They are more content with their bodies, or have learned to accept themselves. A popular and researched form of therapy that relates well to these concepts is Acceptance and Commitment Therapy (ACT). Specifically, ACT may assist clients in learning to accept their bodies through acceptance of their thoughts and feelings, rather than fighting them. Clients may benefit from finding contentment in their bodies and moving towards values based actions. Clients may also

benefit from normalization of their current experiences regarding views of their bodies. This may allow clients to know they are not isolated or different from others who also suffer from body shame. This could provide more space for acceptance of current their current body, reducing a need for negative coping through disordered eating or excessive exercise behaviors.

Another unexpected finding was the positive predictive impact of trait gratitude (GRAT-S) on control beliefs about one's body and appearance (OBC). Trait gratitude has a positive predictive impact on control beliefs. Perhaps gratitude creates a sense of control, through appreciation and acceptance of one's current body. It is unknown why gratitude can lead to heightened beliefs about body control, but it provides an initial foundation for greater topics regarding control and gratitude.

Future Directions

Future research may be helpful to further understand the relationship between trait gratitude and body shame. There are likely other mediating factors, influencing how individuals feel about their body. Results suggested the perception of having enough is more impactful than general appreciation in decreasing body shame. A great deal of current gratitude interventions for body shame focus on appreciation of one's body. Perhaps future body shame interventions can focus on the overall concept of having enough in life. This may lead to less body shame as one lessens their focus on their own body, and becomes more aware of the bigger picture of life. The current study focused on body specific perception of control, perhaps further research regarding gratitude and mental control could provide a greater explanation why people can be more grateful and resilient despite life circumstances.

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Appendix A

Demographic Survey

Demographic Survey

***1. Name**

***2. Age**

3. Gender

- Male
- Female

***4. Today's Date**

***5. Semester**

***6. Year in School**

- Freshman / First-year
- Sophomore / Second-year
- Junior / Third-year
- Senior / Fourth-year
- Beyond Fourth-year

***7. Height in inches**

***8. Weight in pounds**

9. Ethnicity

- American Indian/Alaskan Native
- Hispanic
- White, non-Hispanic
- Asian/Pacific Islander
- Black, non-Hispanic
- International Student

10. If you are an international student, what country do you come from?

Appendix B

SCOFF Questionnaire

SCOFF Questionnaire

Please answer "Yes" or "No" to the following questions.

20. Do you make yourself Sick because you feel uncomfortably full?

- ◯ Yes
- ◯ No

21. Do you worry that you have lost Control over how much you eat?

- ◯ Yes
- ◯ No

22. Have you recently lost more than 14 lbs (one stone) in a 3-month period?

- ◯ Yes
- ◯ No

23. Do you believe yourself to be Fat when others say you are too thin?

- ◯ Yes
- ◯ No

24. Would you say that Food dominates your life?

- ◯ Yes
- ◯ No

Appendix C

Compulsive Exercise Test (CET)

Compulsive Exercise Test

Instructions:
Listed below are a series of statements regarding exercise. Please read each statement carefully and circle the number that best indicates how true each statement is of you. Please answer all the questions as honestly as you can.

0 Never True
1 Rarely True
2 Sometimes True
3 Often True
4 Usually True
5 Always True

25. I feel happier and/or more positive after I exercise.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

26. I exercise to improve my appearance.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

27. I like my days to be organized and structured of which exercise is just one part.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

28. I feel less anxious after I exercise.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

29. I find exercise a chore.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

30. If I feel I have eaten too much, I will do more exercise.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

31. My weekly pattern of exercise is repetitive.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

32. I do not exercise to be slim.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

33. If I cannot exercise I feel low or depressed.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

34. I feel extremely guilty if I miss an exercise session.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

35. I usually continue to exercise despite injury or illness, unless I am very ill or too injured.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

36. I enjoy exercising.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

37. I exercise to burn calories and lose weight.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

38. I feel less stressed and/or tense after I exercise.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

39. If I miss an exercise session, I will try and make up for it when I next exercise.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

40. If I cannot exercise I feel agitated and/or irritable.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

41. Exercise improves my mood.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

42. If I cannot exercise, I worry that I will gain weight.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

43. I follow a set routine for my exercise sessions e.g. walk or run the same route, particular exercises, same amount of time, and so on.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

44. If I cannot exercise I feel angry and/or frustrated.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

45. I do not enjoy exercising.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

46. I feel like I've let myself down if I miss an exercise session.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

47. If I cannot exercise I feel anxious.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

48. I feel less depressed or low after I exercise.

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Appendix D

Objectified Body Consciousness Scale (OBC)

Objectified Body Consciousness Scale

INSTRUCTIONS

Circle the number that corresponds to how much you agree with each of the statements on the following pages.

Circle NA only if the statement does not apply to you. Do not circle NA if you don't agree with the statement.

For example, if the statement says "When I am happy, I feel like singing" and you don't feel like singing when you are happy, then you would circle one of the disagree choices. You would only circle NA if you were never happy.

1 Strongly Disagree
2
3
4 Neither agree nor disagree
5
6
7 Strongly Agree
NA Does not apply

49. I rarely think about how I look

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

50. When I can't control my weight, I feel like something must be wrong with me

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

51. I think it is more important that my clothes are comfortable than whether they look good on me

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

52. I think a person is pretty much stuck with the looks they are born with

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

53. I feel ashamed of myself when I haven't made the effort to look my best

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

54. A large part of being in shape is having that kind of body in the first place

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

55. I think more about how my body feels than how my body looks

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

56. I feel like I must be a bad person when I don't look as good as I could

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

57. I rarely compare how I look with how other people look

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

58. I think a person can look pretty much how they want to if they are willing to work at it

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

59. I would be ashamed for people to know what I really weigh

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

60. I really don't think I have much control over how my body looks

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

61. Even when I can't control my weight, I think I'm an okay person

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

62. During the day, I think about how I look many times

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

63. I never worry that something is wrong with me when I am not exercising as much as I should

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

64. I often worry about whether the clothes I am wearing make me look good

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

65. When I'm not exercising enough, I question whether I am a good enough person

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

66. I rarely worry about how I look to other people

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

67. I think a person's weight is mostly determined by the genes they are born with

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

68. I am more concerned with what my body can do than how it looks

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

69. It doesn't matter how hard I try to change my weight, it's probably always going to be about the same

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

70. When I'm not the size I think I should be, I feel ashamed

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

71. I can weigh what I'm supposed to when I try hard enough

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

72. The shape you are in depends mostly on your genes

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ NA

Appendix E

Gratitude Resentment and Appreciation Scale-Short Form (GRAT-S)

GRAT-S

Please provide your honest feelings and beliefs about the following statements which relate to you. There are no right or wrong answers to these statements. We would like to know how much you feel these statements are true or not true of you. Please try to indicate your true feelings and beliefs, as opposed to what you would like to believe. Respond to the following statements by selecting the number that best represents your real feelings. Please use the scale provided below, and please choose one number for each statement

43. Respond to each question below on the 1-9 scale provided

	strongly disagree	2	disagree somewhat	4	neutral	6	mostly agree	8	strongly agree
1. I couldn't have gotten where I am today without the help of many people.	○	○	○	○	○	○	○	○	○
2. Life has been good to me.	○	○	○	○	○	○	○	○	○
3. There never seems to be enough to go around and I never seem to get my share.	○	○	○	○	○	○	○	○	○
4. Oftentimes I have been overwhelmed at the beauty of nature.	○	○	○	○	○	○	○	○	○
5. Although I think it's important to feel good about your accomplishments, I think that it's also important to remember how others have contributed to my accomplishments.	○	○	○	○	○	○	○	○	○
6. I really don't think that I've gotten all the good things that I deserve in life.	○	○	○	○	○	○	○	○	○
7. Every Fall I really enjoy watching the leaves change colors.	○	○	○	○	○	○	○	○	○
8. Although I'm basically in control of my life, I can't help but think about all those who have supported me and helped me along the way.	○	○	○	○	○	○	○	○	○
9. I think that it's important to "Stop and smell the roses."	○	○	○	○	○	○	○	○	○
10. More bad things have happened to me in my life than I deserve.	○	○	○	○	○	○	○	○	○
11. Because of what I've gone through in my life, I really feel like the world owes me something.	○	○	○	○	○	○	○	○	○
12. I think that it's important to pause often to "count my blessings."	○	○	○	○	○	○	○	○	○

13. I think it's important to enjoy the simple things in life.	○	○	○	○	○	○	○	○	○
14. I feel deeply appreciative for the things others have done for me in my life.	○	○	○	○	○	○	○	○	○
15. For some reason I never seem to get the advantages that others get.	○	○	○	○	○	○	○	○	○
16. I think it's important to appreciate each day that you are alive.	○	○	○	○	○	○	○	○	○

Appendix F

Curriculum Vitae

ALISHA M. WENGER

EDUCATION

PsyD **George Fox University, Clinical Psychology: APA Accredited** April 2021
Expected Completion

- Relevant Coursework: Neuropsychological Assessment, Projective Assessment, Consultation, Supervision, Integrated Care Psychology, Multicultural Therapy.

- Doctoral Dissertation Titled, "*The Impact of Gratitude on Body Image, Exercise and Eating Behaviors*." December 2019

MA **George Fox University, Clinical Psychology** April 2018

- Passed SFE qualifying exam to enter doctoral program.

- Relevant Coursework: Cognitive Assessment, Personality Assessment, Ethics, Multicultural Diversity, Child Adolescent Therapy and Assessment, Family Therapy Diverse Culture, Cognitive Behavioral Psychotherapy, Psychodynamic Psychotherapy.

BS **Western Oregon University, Psychology** June 2015
Minor in Writing

- Received Academic Honor Roll both years in school.

- Relevant Coursework: Interview and Appraisal, Research Methods, Developmental, Social, Cognitive, Forensic, Industrial and Organizational Psychology.

BS **Western Oregon University** June 2015
Public Policy and Administration
Concentration in Healthcare Administration

- Received Academic Honor Roll both years in school.

- Received "Outstanding Student in Public Policy and Administration Award 2014.

- Relevant Coursework: Intercultural Communication, Epidemiology, Professional Communication, Social Research Methods, Business Writing, Bioethics/Public Health.

CURRENT CLINCIAL PLACEMENT

Behavioral Health Provider, Doctoral Intern
Community Mental Health, Aleutian Islands Association
Anchorage, Alaska

- *Dates:* June 2020-Expected Completion June 2021
- *Supervisor*: Dr. Seth Green, PhD
- *Duties*: Individual, and group therapy, family coordination, psychological testing, risk assessment, serving low SES patients and individuals and communities native to the Aleutian Islands, and other regions of Alaska. Coordinating care with various supports for Aleutian Islands.

PREVIOUS CLINCIAL EXPERIENCE

Behavioral Health Provider, Practicum Therapist
Primary Care Clinic, Providence Medical Group
Sherwood, Oregon

- *Dates:* May 2018-May 2020
- *Supervisor:* Jeri Turgesen, PsyD
- *Duties:* Individual therapy, parent training, family coordination, assessment for high needs patients, collaborative care with PCP and Immediate Care, risk assessment, patient warm handoffs, patients range from toddler to geriatric populations from various ethnic and cultural backgrounds.

Behavioral Health Crisis Screener
Behavioral Health Crisis Consultation Team
Providence Newberg and Willamette Valley ED, ICU, and Medical Surgical Units
Newberg and McMinville, Oregon

- *Dates*: April 2018-Present
- *Supervisors:* Mary Peterson, PhD, William Buhrow, PsyD, Joel Gregor, PsyD, and Luann Foster, PsyD.
- *Duties:* Risk assessment (suicidality, homicidality, and psychosis), consultation and case management with medical staff, patient, family, law enforcement and inpatient care team.

Community Mental Health, Integrated Assessment
Behavioral Health Center
Newberg, Oregon

- *Dates*: July 2019-August 2019
- *Supervisor*: Shaun Davis, PsyD
- *Duties*: Intake session, cognitive, achievement, memory, and personality assessment administration and interpretation, report writing and feedback to the client and family members in a community mental health setting.

Bariatric Group Presenter and Facilitator, Practicum Therapist
Bariatric Surgery Center, Salem Health, Salem Hospital
Salem, Oregon

- *Dates*: July 2017-August 2019
- *Supervisor*: Steven Besing, PhD
- *Duties*: Present 20-30 minute psychoeducational presentations to pre and post bariatric surgery patients and their support people; lead 40-60 minute group discussion regarding various bariatric topics such as: fear, anxiety, outcomes, eating practices, family involvement, stress etc.

University Counseling Staff, Practicum Therapist
Health and Counseling Center, George Fox University
Newberg, Oregon

- *Dates:* October 2017-April 2018
- *Supervisors*: Luann Foster, PsyD and William Buhrow, PsyD
- *Duties*: Individual therapy, chart notes, intake sessions, cognitive, achievement and personality assessment and psychological report writing for undergraduate students.

School Based Health, Practicum Therapist
Clackamas High School
Clackamas, Oregon

- *Dates*: September 2017-June 2018
- *Supervisors*: Fiorella Kassab, PhD, Sarah Pearlz, MA
- *Duties*: File reviews, achievement, cognitive, and behavioral testing and observation related to report writing for special education (IEP) services, coordination of care (via email, IEP meetings etc.) with teachers, parents, school counselors and school psychologist, and individual therapy for high school students from various ethnic and cultural backgrounds in an urban setting.

University Counseling, Pre-Practicum Therapist
George Fox University, Graduate Psychology Department

Newberg, Oregon

- *Dates*: January 2017-May 2017
- *Supervisor*: Glena Andrews, PhD

Duties: Individual therapy, intake sessions, electronic record keeping and case management.

TEACHING AND SUPERVISORY EXPERIENCE

Teaching Assistant, Clinical Foundations
George Fox University, Graduate Psychology Department
Newberg, Oregon

- *Dates*: July 2019-Present
- *Supervisor*: Glena Andrews, PhD
- *Duties*: Lead weekly one hour small group discussion for support, collaboration, and supervision; grade and provide supportive feedback regarding papers, therapy videos and other coursework; model genuineness and openness through leadership in weekly meeting and annual diversity marker presentation with other teacher assistants; meet and collaborate for one hour weekly with other teaching assistants and supervisor for increased monitoring and support of first year PsyD students for introductory interactive therapy course.

Senior Level Graduate Student, Supervisory Support
George Fox University, Graduate Psychology Department
Newberg, Oregon

- *Dates*: August 2019-Present
- *Supervisor*: Roger Bufford, PhD, Mary Peterson, PhD
- *Duties*: Meet one hour weekly to support, collaborate, provide resources, and advocate for second year PsyD student in first practicum placement experience.

Presenter for Suicidality Treatment, Crisis Screener
George Fox University, Graduate Psychology Department
Newberg, Oregon

- *Dates*: October 2019
- *Supervisor*: Luann Foster, PsyD
- *Duties*: Presented research based treatment, support, and resources related to suicidal patients in the hospital emergency department, medical surgical unit and intensive care unit to risk screeners for competency in future risk screenings.

Teaching Assistant, Cognitive Assessment
George Fox University, Graduate Psychology Department
Newberg, Oregon

- *Dates*: August 2018-December 2018
- *Supervisor*: Celeste Jones, PsyD
- *Duties*: Lead weekly one hour small group discussion for support, collaboration and supervision; grade and provide supportive feedback regarding psychological assessment administration and report writing and interpretation; meet and collaborate for one hour weekly with other teaching assistants and supervisor for increased monitoring and support of second year PsyD students in interactive cognitive assessment course.

OTHER PROFESSIONAL EXPERIENCE

Administrative Assistant, Member of Irish Parliament
House of Oireachtas, Parliament
Dublin, Ireland

- *Dates*: April 2015-June 2015
- *Supervisor*: Michael Healy-Rae, Irish Independent Politician
- *Duties*: Communicated professionally via email, phone, in person etc., with various parliamentary staff, political leaders, and constituents; created hundreds of informational based letters to interact, and support constituents; created, produced and dispersed hundreds of diverse educational booklets related to welfare benefits, resources etc. for constituents; supported supervisor with schedule and content regarding meetings, presentations etc.; continually ordered office materials, and restocked the office when needed.

RESEARCH INVOLVEMENT

Wenger, A., Goodworth, M., Peterson, M., and Turgesen, J. (2019). The Impact of Gratitude on Body Image, Exercise and Eating Behaviors (unpublished doctoral dissertation). George Fox University, Newberg, Oregon.

Marston, A., Johnson, A., **Wenger, A.,** David, A., and Goodworth, M. (2018). Body Shame differences between Clergy and non-Clergy in Women in the Church of the Nazarene. *Poster presented by Alisha Wenger at American Psychological Association Annual Convention 2019,* in San Francisco, CA.

UNIVERSITY INVOLVEMENT

Interview Day Involvement
George Fox University, Graduate Psychology Department
Newberg, Oregon

- *Date*: February 2017, 2019
- *Supervisor*: Roger Bufford, PhD, Kristie Knows His Gun, PsyD
- *Duties*: Co-lead PsyD interview process with graduate psychology professor, answered interviewee questions, provided information about PsyD program, evaluated interviewee, and collaboratively discussed interviewee potential with graduate psychology professor.

Student Interest Group Coordinator: Professional Interests

- *Dates*: May 2018-January 2019
- *Duties*: Co-lead group of PsyD students regarding professional interests including curriculum vitae writing skills, and business practices for psychology.

Serve Day Involvement
Juliette's House, Child Abuse Intervention Center
McMinnville, Oregon

- *Date*: September 2016
- *Duties*: Paint railings, cut surrounding shrubbery and pick up trash and debris for the upkeep and maintenance of the facility.

PROFESSIONAL TRAININGS

Acceptance Commitment Therapy February 2021
Rebecca Robinson, PhD

Diabetes and Mental Health February 2021
Doug Tynan, PhD

Social Media Use and Mental Health February 2021
Robyn Hunter, MA

Perinatal Mood and Anxiety Disorders (PMADS) Overview February 2021
Ginny Parret

Balint Groups January 2021
Sarah Dewane, PhD

CBT for Insomnia January 2021
Mark Holman, PhD

Accelerated Experiential Dynamic Psychotherapy November 2020
Joshua Burton, MA

CAMS-Care Suicide Prevention November 2020
Melinda Moore, PhD

Autism Spectrum Disorders November 2020
Gwendolyn Barnhart, PhD
Norton Sound Health Corporation

Historical Trauma October 2020
Iva Greywolf, PhD
The Alaska Psychology Internship Consortium

Liberation Psychology October 2020
Sarah Sanders, PhD
Providence Family Medicine Family Center

Motivational Interviewing September 2020
Jane Grey, PhD
The University of Texas

Complex Trauma Model September 2020
Rebecca Robinson, PhD
The Alaska Native Tribal Health Consortium

How to Establish and Maintain a Private Practice August 2020
Greg Keilin, PhD
The Alaska Psychology Internship Consortium

Drugs of Abuse and Addiction August 2020
Seth Green, PhD
Aleutian Pribilof Islands Association

Clinical Hypnosis August 2020
Seth Green, PhD
Aleutian Pribilof Islands Association

Suicide Intervention/Prevention for Alaska August 2020
Ginny Parret, PhD
Providence Family Medicine Center

Ethics and Mandatory Reporting in Alaska July 2020
Lindsey Hickey, PhD
Norton Sound Health Corporation

Intercultural Communication October 2019
Cheryl Forster, PsyD
George Fox University

Promoting Forgiveness September 2019

Everett Worthington Jr., PhD
George Fox University

Foundations of Relationships Therapy-The Gottman Model March 2019
Douglas Marlow, PhD
George Fox University

Opportunities in Forensic Psychology February 2019
Diomaris Safi, PsyD and Alex Millkey, PsyD
George Fox University

Old Pain in New Brain October 2018
Scott Pengelly, PhD
George Fox University

Spiritual Formation, and the Life of a Psychologist: Looking Closer at Soul-Care September 2018
Lisa Graham McMinn, PhD and Mark McMinn, PhD
George Fox University

Integration and Ekklesia March 2018
Mike Vogel, PsyD
George Fox University

The History and Application of Interpersonal Psychotherapy February 2018
Carlos Taloyo, PhD
George Fox University

Telehealth November 2017
Jeff Sordal, PsyD
George Fox University

Using Community Based Participatory Research (CBPR) to Promote Mental Health in American Indian/Alaska Native (AI/AN) Children, Youth and Families October 2017
Eleanor Gil-Kashiwabara, PsyD
George Fox University

Difficult Dialogue, Diversity and Intercultural Communication March 2017
Winston Seegobin, PsyD, Mary Peterson, PhD,

Mark McMinn PhD, and Glena Andrews, PhD

Domestic Violence: A Coordinated Community Response March 2017
Patricia Warford, PsyD and Sgt. Todd Baltzell
George Fox University

Native Self Actualization: Its Assessment and Application in Therapy February 2017
Sydney Brown, PsyD
George Fox University

Divorce, an Attachment Trauma November 2016
Wendy Bourg, PhD
George Fox University

Sacredness, Naming and Healing: Lanterns along the Way October 2016
Brooke, Kuhnhausen, PhD
George Fox University

EXTENDED EDUCATION

American Psychological Association, Convention August 2018
San Francisco, California

Attachment in Psychotherapy, Certificate Course January 2018
George Fox University, Graduate Psychology Department
Brooke Kuhnhausen, PhD

AFFILIATIONS

APA Division 38 Association for Health Psychology 2018-Present
American Psychological Association, Student Member 2016-Present

ASSESSMENT AND SCREENERS

Previously Administered and/or Completed Competency

16 Personality Factors Questionnaire (16PF)
Achenbach System of Empirically Based Assessment (ASEBA)-Child Behavior Checklist (CBCL)
Adaptive Behavior Assessment System, Second Edition (ABAS-II)
Adult ADHD Self-Report Scale (ASRS)

Barkley Deficits in Executive Functioning Scale (BDEFS)
Behavior Assessment System for Children, Third Edition (BASC-3)
Behavior Rating Inventory of Executive Function 2 (BRIEF-2)
Booklet Categories Test (BCT)
Boston Naming Test (BNT)
California Verbal Learning Test, Second Edition (CVLT-2)
Collaborative Assessment and Management of Suicidality (CAMS)
Colombia Suicide Risk Assessment
Compulsive Exercise Test (CET)
Comprehensive Test of Non-Verbal Intelligence (CTONI)
Connors Adult ADHD Rating Scales-Observer and Self Report
Connors Continuous Performance Test-2
Delis-Kaplan Executive Function System (D-KEFS)
Depression Scale for Children (CES-DC)
Family Adaptability and Cohesion Evaluation Scales, IV (FACES IV)
Geriatric Depression Scale (GDS)
Generalized Anxiety Disorder, Seventh Addition (GAD-7)
Gratitude Resentment and Apperception Scale-Short Form (GRAT-S)
Grooved Pegboard Test (GPT)
Jordan Left-Right Reversal Test, Third Edition (Jordan-3)
Life Events Checklist for DSM-5 (LEC-5)
Millon Adolescent Clinical Inventory (MACI)
Millon Clinical Multiaxial Inventory-III (MCMI-III)
Mini-Mental State Examination, 2nd Edition (MMSE-II)
Minnesota Multiphasic Personality Inventory-II (MMPI-II)
Minnesota Multiphasic Personality Inventory-II, Restructured Format (MMPI-II-RF)
Montreal Cognitive Assessment (MoCA)
NEPSY, Speeded Naming
NICHQ Vanderbilt Assessment Scale
Objectified Body Consciousness Scale (OBCS)
Outcome Rating Scale (ORS)
Patient Health Questionnaire (PHQ)
Patient Health Questionnaire, Depression (PHQ-9)
Pediatric Short Form v2.0-Anxiety 8a
Personality Assessment Inventory (PAI)
Repeatable Battery for the Assessment of Neuropsychological Status (RBANDS)
Rey-Osterrieth Complex Figure (Rey-O)
Roberts Apperception Test for Children, Second Edition
Rorschach Test, Exner and R-PAS Scoring
SCOFF Questionnaire
Session Rating Scale (SRS)
Stroop Color and Word Test
Structured Clinical Interview for DSM-5 for ADHD, Bipolar, Learning Disability, OCD etc.
Tactual Performance Test (TPT)
Test of Memory Malingering (TOMM)
Thematic Apperception Test (TAT)

Thurston-Craddock Test of Shame (TCTS)
Vineland Adaptive Behavior Scales, Third Edition
Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV)
Wechsler Individual Achievement Test, Third Edition (WIAT-III)
Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV)
Wechsler Memory Scale (WMS)
Weiss Functional Impairment Rating Scale (WFIRS)
Wender Utah Rating Scale (WURS)
Wisconsin Card Sorting Test (WCST)
Woodcock-Johnson Tests of Cognitive Ability
Woodcock-Johnson Tests of Achievement

REFERENCES

References available upon request.